

Evaluating the impact of selected cases under the Human Rights Act on public services provision

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CONTENTS

ACKNOWLEDGEMENTS.....1

EXECUTIVE SUMMARY2

CHAPTER 1:

INTRODUCTION.....22

1. Context of the report22

2. Aims of this report23

3. Selection of cases24

4. Methodology.....24

5. Guide to the report26

CHAPTER 2:

PROTECTING LIFE: *OSMAN V UK*.....28

1. The case and its context28

2. The impact of *Osman*.....29

 2.1 The impact on policing29

 2.1.1 The process of policy change29

 2.1.2 *Osman* in policing policies and practice.....32

 2.1.2.1 Threat to life policies32

 2.1.2.2 Practical Measures.....34

 2.1.2.3 Other Policies.....35

 2.2 The impact of *Osman* beyond the police.....38

 2.3 Recognition of the *Osman* Principles39

3. Conclusion39

CHAPTER 3:

THE RIGHTS OF DETAINEES KEENAN, MIDDLETON, AMIN,
WRIGHT AND EDWARDS.....40

1. The cases and their context40

2. The impact of these cases41

 2.1 The process of change: prisons41

 2.2 The process of change: healthcare in prisons.....43

 2.3 *Keenan*: changing the use of segregation.....44

 2.4 *Middleton*: expanding the role of inquests.....46

2.5 <i>Wright, Edwards and Amin</i> : more elaboration of investigative obligations.....	48
2.5.1 The case of <i>Wright</i>	49
2.5.2 The case of <i>Edwards</i>	49
2.5.3 The case of	50
2.6 Meeting the investigative obligations	50
2.7 Other impacts: information sharing, risk assessments, healthcare, suicide prevention.....	51
2.8 Police Custody.....	54
3. Conclusion	55

CHAPTER 4:

THE POSITIVE OBLIGATION TO ADDRESS DIFFERENCE:

<i>PRICE V UK</i>	56
1. The case and its context	56
2. The impact of the case	57
2.1 The impact of the case on Lincolnshire Police	58
2.2 The impact of <i>Price</i> beyond Lincolnshire	59
3. The relevance of <i>Price v UK</i> and continued concerns for disabled detainees	62
4. Conclusion	64

CHAPTER 5:

DESTITUTION IN THE ASYLUM SYSTEM: THE CASE

OF <i>LIMBUELA</i>	65
1. The case and its context	65
2. The impact of the case	67
2.1 Impact on the application of section 55.....	67
2.2 The narrow interpretation of <i>Limbuela</i> by UKBA	69
2.2.1 The use of Section 55 to refuse subsistence-only claims	69
2.2.2 Destitution among failed asylum-seekers: the use of section 4 ...	71
2.3 Impact on local authority decision-making	73
2.3.1 Relevance of <i>Limbuela</i> to local authorities	74
2.3.2 Variation in practice between local authorities.....	75
2.3.3 Broader climate of decision-making	76
3. Conclusion	77

CHAPTER 6:

- BALANCING RIGHTS: THE CASE OF *EAST SUSSEX*78
- 1. The case and its context78
- 2. The impact of the case80
 - 2.1 Manual handling before *East Sussex*.....80
 - 2.2 “Bottom-up” change81
 - 2.3 Impact on policy and guidance.....82
 - 2.4 Impact on training84
 - 2.5 Impact on day-to-day service delivery.....84
 - 2.5.1 Improved transparency and accountability85
 - 2.5.2 Improved health and safety for staff.....85
 - 2.5.3 Enriching the concept of dignity86
- 3. Limits to impact86
 - 3.1 Lack of systematic policy review and guidance.....87
 - 3.2 Persistence of blanket policy or practice and restrictive88
 - working cultures
 - 3.3 Divergent perceptions of human rights89
 - 3.4 Contracting out.....90
- 4. Issues for the future91
 - 4.1 Direct payments and personalised care91
 - 4.2 Promoting compliance92
- 5. Conclusion93

CHAPTER 7:

- THE POSITIVE OBLIGATION TO SECURE DIGNITY AND INTEGRITY: THE CASE OF *BERNARD*.....94
- 1. The case and its context94
- 2. The impact of the case96
 - 2.1 Impact on the London Borough of Enfield96
 - 2.2 Impact on other public authorities98
 - 2.2.1 Policy review and revision98
 - 2.2.2 Constraints on resource and capacity.....99
 - 2.2.3 Multiple drivers for change.....100
 - 2.2.4 The role of financial penalties102
- 3. Conclusion102

CHAPTER 8:

- CONCLUSION104
- 1. Limits to assessing impact104
 - 1.1 Multiple drivers for change.....104
 - 1.2 The passage of time105
 - 1.3 Media coverage and advocacy105
- 2. Potential barriers to impact.....105
 - 2.1 Divergent perceptions of human rights105
 - 2.2 Resources and capacity: an issue of supply and demand106
 - 2.3 Variable mechanisms to monitor case law and review policy against it108
 - 2.4 Variable mechanisms to disseminate the lessons of case law109
- 3. Human rights as a driver for change111
 - 3.1 A principles based approach111
 - 3.2 Promoting “smart compliance” through formal and informal networks112
 - 3.3 Communicating human rights114

LIST OF ANNEXES

- Annex 1: Bibliography116
- Annex 2: Webpages123
- Annex 3: Table of cases.....124
- Annex 4: Nationality, Immigration and Asylum Act 2002, Section 55126
- Annex 5: Sample human rights assessment form128
- Annex 6: Anonymised list of participants.....136
- Annex 7: An example of an *Osman* warning138
- Annex 8: Glossary140
- Annex 9: Briefing for interviewees141
- Annex 10: Human Rights Survey - the *Osman* case145
- Annex 11: Human Rights Survey - Legal Directors149

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EXECUTIVE SUMMARY

Introduction

Context and aims

This report was commissioned by the Equality and Human Rights Commission to inform its Human Rights Inquiry. The Commission is carrying out the inquiry under its statutory duties under the Equality Act 2006 to:

- Promote understanding of the importance of human rights
- Encourage good practice in relation to human rights
- Promote awareness, understanding and protection of human rights, and
- Encourage public authorities to comply with the Human Rights Act (HRA) (section 9 of the Equality Act).¹

The report covers England and Wales. It aims to:

- Explore the impact of the outcome of a number of strategic human rights legal cases on a range of public authorities in England and Wales
- Explore with service providers from different sectors whether and how the principles established in these cases have been incorporated into policy and practice
- Explore the positive impact within these sectors of implementing human rights principles, and
- Identify the barriers that prevent or obstruct the use of human rights principles in these sectors.²

1 <http://www.equalityhumanrights.com/en/projects/humanrightsinqury/Pages/HumanrightsInquiry.aspx>. The inquiry includes several strands of evidence gathering including a call for written evidence, inquiry panels and research projects on 'the impact of human rights culture on public sector organisations: lessons from practice' and 'the role and experience of inspectorates in promoting human rights in public services'.

2 Case law is just one among a number of mechanisms that facilitate implementation of the HRA among public authorities. Others include the training of public authorities, advocacy by and on behalf of service users, guidance to public authorities, and the use of levers like inspectorates and inquiries.

The selected cases

Cases brought under the Human Rights Act and at the European Court of Human Rights (ECHR) were selected because, among other criteria, they relate to an underlying human rights principle which is applicable to a range of different sectors and because they are strategic decisions, in that the judgments have implications for many people and could require changes to commonplace policy and/or practice. The cases are:

- ***Osman v UK, No. 23452/94, Judgment of 28 October 1998 / Osman v UK (2000) 29 EHRR 245***
- A cluster of five cases involving vulnerable detainees and Article 2, the right to life³
- *Price v UK* (2001) 34 EHRR 128
- *R (Limbuella and Others) v Secretary of State for the Home Department* [2005] UKHL 66, 3 November 2005
- *R v East Sussex County Council Ex parte A, B, X and Y* [2003] EWHC 167
- ***Bernard v Enfield LBC [2003] HRLR 4***

Methodology

Interviews: Our research used qualitative methods; we conducted 65 individual in-depth interviews and engaged 12 people in two focus group discussions. The choice of interviewees was driven by the particularities of each case. For *East Sussex* and *Bernard*, we concentrated on service directors, operational managers and frontline practitioners in local authorities. The cases of *Osman*, *Price*, *Limbuella* and the detainees cluster have implications both for national policy and guidance and for operational practice; we spread our interviews between the national, regional and local levels accordingly.

We have engaged (via interviews and a questionnaire) with frontline police officers, and those who train them, to explore how the *Osman* judgment has impacted upon routine practice. In the prison sector, we interviewed national level policy officers and practitioners responsible for delivering healthcare in prisons; however, research constraints prevented us from interviewing prison governors or officers.

3 Keenan v UK (2001) 33 EHRR 38; R (on the application of Middleton) v Coroner for the Western District of Somerset [2004] 2 AC 182; R (on the application of Amin) v S/S for the Home Department [2004] 1 AC 653; R (on the application of Wright) v S/S for the Home Department [2001] 1 Lloyd's Rep Med 478; [2001] EWHC Admin 520; 2001 WL 606447; Edwards v UK (2002) 35 EHRR 19.

We also obtained the views of organisations that have specialised knowledge or experience relating to the cases and the sectors they affect, both from the practitioner and service user perspective.

Surveys: We did three surveys of senior operational figures within local authorities - directors of adults' and children's social services (17 responses), directors of housing (24 responses) and directors of legal services (36 responses). These are not statistically robust but provide a useful corrective to the anecdotal experience in our interviews.

Literature: We refer to both published and unpublished material, including guidance, policies, "on the ground" research and material produced by civil society groups, professional associations and other interested bodies.

Protecting life: *Osman v UK*

SUMMARY: Case law is a significant part of the policy development process within policing. Many policing policies, as well as practical options for protecting life, are informed by the case of *Osman*. Awareness of the case is high among police, although concern is sometimes expressed as to whether awareness translates into understanding.

In *Osman*, the ECHR established criteria for when authorities had failed in their obligations to protect life. The court held that in order to show a violation of the positive obligations of Article 2 it is necessary to establish that "the authorities knew or ought to have known at the time of the existence of a real and immediate risk to the life of an identified individual or individuals from the criminal acts of a third party and that they failed to take measures within the scope of their powers, which, judged reasonably, might have been expected to avoid that risk".

Nearly 10 years on, *Osman* principles have become part of policing policy and practice across a range of areas – indicating acceptance of the underlying principles of the case and their applicability to a range of situations wider than those examined by the court. Further, *Osman* is referred to in documents on standards by which police forces are assessed.

The process by which cases are integrated into policy involves both national and local level "scanning" – by the National Policing Improvement Agency (NPIA) and by individual forces. The sources that both NPIA and forces draw upon are wide. As well as case law they include the Association of Chief Police Officers (ACPO), Her Majesty's Inspectorate of Constabulary, government ministries, the Independent

Police Complaints Commission (IPCC), professional journals and the experiences of individual forces.

Some interviewees noted that reference to case law features in their dissemination of policy changes. Interviewees emphasised the importance of using a variety of methods to disseminate policy changes, including those derived from case law. Our interviewees spoke of using training, email, intranets and face-to-face meetings.

The majority of the 43 police forces of England and Wales have in place policies on handling threats or risks to life. Senior police officers state that such policies derive directly from the obligations of Article 2 of the ECHR and from *Osman*. An examination of a selection of these policies confirms this.⁴ Policies are put into practice using a wide variety of preventive measures. These include “Osman warnings”, which are sent by police to individuals whose lives the police have reason to believe are at risk.

This project interviewed a number of individuals working in the area of prison healthcare, where the *Osman* principles could be expected to be particularly relevant. In contrast to those working in policing most of those interviewed had not heard of *Osman*. However, on being told the broader principles of the case – all said that it accorded with their understanding of their obligations under Article 2.

There is a high level of awareness among the police we interviewed of the *Osman* case and its principles, as well as clear examples of its imprint on policy and practice. However some interviewees sounded caution about using case names as short-hand for particular principles which could encourage a “tick box” approach to implementation.

The rights of detainees: *Keenan, Middleton, Amin, Wright and Edwards*

SUMMARY: We have discerned few clear chains of impact: the issues that arose in these cases are complex and are affected by fundamental structural change as well as lower level policy change. However, in some policies cases are explicitly identified as driving forces. Where the cases concern the investigative obligation it is easier to identify an impact within the broader legal system.

The cases of *Keenan, Middleton, Amin, Wright and Edwards* all involve deaths in prison custody. They build on the principles of the *Osman* case – applying them in a

4 This project examined the publicly available policies of the Metropolitan Police, Devon and Cornwall Constabulary, West Mercia Constabulary, and Leicestershire Constabulary. In some cases these are to be read in conjunction with other, confidential, documents that this project was not able to examine. This project was also provided with the confidential text of one other policy.

different context. Further, they establish principles of their own. The cases we have selected each have a different focus. *Keenan* involved a suicide in custody of an individual with mental illness. *Middleton* concerned the investigative obligations triggered by a suicide in prison. *Wright* involved an individual who died from an asthma attack. The *Amin* judgment was concerned with the investigative obligations of Article 2 following the killing of Zahid Mubarek by his cell-mate. The case of *Edwards* also involved a killing by a cell-mate; in this case both individuals had mental health problems, and the judgment discussed both the investigative obligations and the preventive measures that might have been taken to avert the risk to life.

The impact of these cases is variable and difficult to discern given the multiple initiatives to reduce deaths in custody. Asked about the role of case law and human rights law generally in policy formation, interviewees frequently said other drivers were more significant. Asked about their role in motivating good practice, interviewees associated with prisons said that values such as decency were more important. Interviewees associated with healthcare provision were keen to embrace human rights but often expressed uncertainty about how to do so.

Prison policy and practice are governed by rules, regulations and guidelines in the form of the Prison Rules, Prison Service Orders (PSOs) and Prison Service Instructions (PSIs).⁵

The case of *Keenan* resulted in changes to the PSO on segregation.⁶ The changes were explicitly linked to the case and cited by the government as steps taken to address the violation of Article 3 found in Mark Keenan's case.

The case of *Middleton* was identified by coroners and experts as having had a concrete impact on coroners' verdicts, with a notable increase in the use of narrative verdicts, although all our interviewees spoke of the impact being geographically variable.

5 Individual prisons are obliged to comply with PSOs and PSIs, however, they use them as the basis for local policies, guidelines and practices. The review process to which PSOs and PSIs are subject takes into account a variety of sources – including case law – but also including legislation, best practice, learning from previous incidents and recommendations from inquiries.

6 Another instance where a direct link is identifiable between a case and policy changes, as reflected in PSOs, is the “prison babies” case (*R [on the application of P and Q] v S/S for the Home Department* [2001] EWCA Civ 1151). PSO 4801 on the Management of Mother and Baby Units notes: “in a few (legal) cases we have accepted the need to modify our approach and MBU staff have been informed of developments as they arose”. The PSO goes on to cite the case and reflects its findings in the section on age limits.

In some cases it is possible to identify an indirect impact on policy and practice. The *Amin* case, for example, resulted in the Mubarek inquiry. The inquiry gave rise to 88 recommendations about relevant areas of policy and practice. In parallel the death of Zahid Mubarek is cited as giving rise to policy changes before the inquiry took place. Police interviewees told this project that the inquiry led them to review custody policies – though often the outcome was that little needed changing. The aspects of the *Wright* case that dealt with the investigative obligations also resulted in an inquiry.

The cases – especially *Edwards* and *Wright* – had implications for healthcare provision. Here there have been substantial changes in policy and practice. Responsibility for healthcare in prisons has moved to the NHS. Healthcare related prison policies – especially those on mental healthcare - have also evolved. Our interviewees all noted that both these factors had resulted in improvements in healthcare provision. However the link to our selected cases is uncertain. Interviewees cited more fundamental concerns as having driven the changes.

The positive obligation to address difference: *Price v UK*

SUMMARY: Policy documents on disability and detention draw on a variety of sources to facilitate better practice. These include the Disability Discrimination Act 2005 (DDA) which has brought some of the issues raised in *Price* into sharper focus. However, we have not seen evidence of a distinct human rights focus - or the case of *Price* - as a driver for change in this area.

Price, who is four-limb deficient, spent a night in a Lincolnshire police cell which was wholly unsuited to her needs and dangerous to her health, before being transferred to prison. The court found a violation of Article 3. Separate opinions held that the “primary responsibility” for the violation lay with the judicial authorities for not ensuring that adequate facilities existed, and that to avoid unnecessary hardship, *Price* should have been treated differently from others because her situation is significantly different.

We have found no indication that *Price* has had a discernable impact on policy or practice in the police or prison services.

A policy manager in Lincolnshire Police said the force could not locate files on the case nor trace ways in which lessons were learned, however, the case “would not happen now”. A Custody Policy was put in place in 2006 – five years after *Price*. The policy reflects the national Guidance on the Safer Detention and Handling of Persons in Police Custody and the force’s own Disability Equality Scheme. Measures are now

in place to integrate learning from case law, complaints and the work of other forces. The force also undertakes a human rights appraisal for all policies. There is no indication that *Price* was a driver behind these changes.

Police personnel from other forces we interviewed were largely unaware of *Price*. Many viewed the circumstances of the case as unusual and said current policy and legislation would prevent the situation recurring. The DDA, the national Safer Detention guidance and the Home Office Police Custody Buildings Design Guide – all subsequent to *Price* – were noted by interviewees as likely to forestall a recurrence. However, we cannot explicitly link this legislation and guidance to *Price*: driving forces and source material for them are multiple.

The Safer Detention guidance notes that officers must determine if an individual is fit to be detained and consider alternatives to police detention. However, interviewees noted that seeking alternatives is an option with limited applicability in prisons. A senior policy maker said that where time allows, forward planning can allow relevant authorities – including prisons – to make appropriate plans for a disabled person. However in the *Price* case this was not an option open to the police or prison authorities – nor, she comments, would it be if they were placed in exactly this situation again.

While most interviewees cited the DDA as a tool in preventing situations like *Price*'s from recurring, some also expressed doubt. One police officer commented that, notwithstanding the DDA, he very much doubted every force would be in a position to accommodate an individual as severely disabled as *Price*. A senior prison policy maker saw the DDA as an instrument that only partially addresses the issues raised by *Price*, as its requirements deal primarily with the built environment and not the careful planning required to meet individual needs. Further, she saw the case as raising questions as to whether there is a level of disability that prisons “simply cannot cope with”. She did not feel this possibility was something that had been integrated into either policy or practice.

Destitution in the asylum system: the case of *Limbuela*

SUMMARY: *Limbuela* had a direct impact on reducing destitution within the asylum system by changing the use of a statute which denied late asylum applicants support. The UK Government has interpreted the case narrowly and *Limbuela* has had no impact on the rising incidence of destitution among failed asylum seekers.

Limbuela focused on the application of section 55 of the Nationality, Immigration and Asylum (NIA) Act 2002 which allowed support to be refused to individuals who failed to apply for asylum “as soon as reasonably practicable”, causing many to become

destitute. The case established the principle that where the fate of individuals is in the hands of the state – because it denies them support and bars them from working or claiming mainstream benefits – severe destitution that results constitutes inhuman or degrading treatment under Article 3.

Judgments by the Court of Appeal (2004) and House of Lords (2005) had a direct and immediate impact on the way section 55 was used, as these figures show:

Year	Number of asylum seekers referred for section 55 decision	Number of applicants deemed ineligible for support under section 55
2003	14,760	9,410
2004	10,570	1,360
2005	3,780	355
2006	n/a	910
2007	n/a	990

Revised guidance to asylum case workers and policy teams (now part of the UK Border Agency, UKBA) adopts the destitution threshold set out in *Limbuella*. It states that where an asylum applicant lacks overnight shelter and basic provisions such as food and access to sanitary facilities, support should be provided to prevent a breach of Article 3, even if the claimant is judged to have applied late. Unlike pre-*Limbuella* guidance, it indicates how to apply the Article 3 test in practice.

A senior legal officer within UKBA said *Limbuella* changed “quite markedly” the way that section 55 was used by taking “a different view on how the acts and omissions of the agency actually amount to treatment of an individual in a way that engages Article 3”.

Limbuella has been interpreted narrowly by the UK Government to apply only to the specific matrix of factors arising in the case. The parliamentary Joint Committee on Human Rights has expressed concern that section 55 is still being used to deny cash-only support to late applicants, and wants it to be repealed.⁷ *Limbuella* has had no impact on government policy in addressing the rising incidence of destitution among failed asylum seekers.

7 Our interviewee in the UKBA says repeal “will be considered” as part of a process of legal simplification, but gave no timeframe.

Attempts have been made at the Asylum Support Tribunal to invoke *Limbuella* in support of failed asylum seekers denied support under section 4 of the NIA Act 2002.⁸ These failed because it was deemed that the solution to the applicants' destitution lay in their own hands by voluntarily leaving the UK. Advocacy organisations say section 4 places an unrealistic demand on failed asylum seekers to prove they are taking all reasonable steps to return.⁹

For their part, local authorities are prohibited from assisting failed asylum seekers, except when doing so would lead to a violation of Convention rights. There is considerable variation and uncertainty in the way local authorities conduct human rights assessments (if they do so at all). We interviewed one authority that uses *Limbuella* explicitly when conducting human rights assessments. However, interviewees generally said *Limbuella* was not “high on the radar” of local authorities and had not influenced decision-making.

Some service directors and managers in local authorities said the **principles** of *Limbuella* are relevant in that they set a baseline of acceptable treatment and remind decision makers that omissions as well as actions can breach Convention rights. One director said the case could be pertinent to local authorities who face unfamiliar challenges such as an influx of migrant workers living in destitute conditions. Others said the case could regain prominence in relation to destitution among newer European migrants who lack support networks.

In summary, *Limbuella* has had a direct and quantifiable impact in reducing “beginning of process” destitution but not in reducing “end of process” destitution. A case has not been made in the literature as to whether the factors causing destitution among failed asylum seekers who fall foul of the current criteria might amount to “acts or omissions for which the state is directly responsible” as established in *Limbuella*.

Balancing rights: the case of *East Sussex*

SUMMARY: The imprint of East Sussex is visible in some policy, guidance and debate within public authorities and professional associations and networks. Manual handling practitioners describe its beneficial impact on their work. However, the impact across all public authorities and care providers is highly variable and uncertain.

8 Section 4 support is available to failed asylum seekers who have either signed up to return voluntarily or are, according to various criteria, unable to leave the UK through no fault of their own.

9 Concern is especially focused on applicants who are stateless, whose nationality is in dispute, who do not possess identity documents or whose safe route home is in dispute.

The family of two profoundly disabled young women challenged a local authority ban on care workers lifting them manually. The High Court found a violation of Article 8 and provided a framework for public authorities to balance the interests of the dignity of the individual with the health and safety of employees by means of individualised risk assessments.

The Disability Rights Commission (DRC) intervened in the case, saying it was “the tip of a no-lifting iceberg”. The Ministry of Justice told us the case was “very much a ‘one off’ with extreme circumstances”¹⁰. This apparent discrepancy shows how difficult it is to generalise about manual handling practice which is diffused across the social care field.

The principles established in *East Sussex* were not, in the main, **new**; there was some earlier (non HRA) case law and guidance, and professional debate, which promoted them. However, the case exerted a “bottom up” impact by validating the efforts of practitioners who were already challenging restrictive policies. One interviewee described the case as “a ray of sunlight that allowed us to do [manual handling] properly and legitimately”. Another said it “speeded up the process of evolution without being a revolution”.

The imprint of the case is clearly visible at the level of policy and guidance – notably in the “gold standard” guidance on manual handling.¹¹ The editor said the guidance differs essentially from pre-*East Sussex* editions in that it is “not prescriptive; it’s about equipping people to make balanced judgments”.

The case is expressly referenced in several public authority manual handling policies we have seen. An interviewee on the Welsh Local Government Association Manual Handling Forum said “there’s plenty of evidence that all [Welsh authorities] provide a balanced assessment process”.¹²

Identifying the case’s impact on everyday practice is uncertain: policy and practice don’t run on straight lines. Interviewees identified some positive impacts on their practice which they attributed in part to their knowledge and understanding of the case.

- Individualised risk assessment can bring about **improved transparency and accountability** (“at least [service users] are not completely disempowered”)

10 Ministry of Justice submission to this project, August 2008 (unpublished)

11 Smith, J (ed) (2005), *The Guide to the Handling of People*, 5th Edition (London: Back Care). This guidance was produced in collaboration with the Royal College of Nursing, the National Back Exchange, the Chartered Society of Physiotherapy and the College of Occupational Therapists.

12 The forum plans to replicate Scottish guidelines (developed with explicit reference to *East Sussex*) for the moving and handling of children and young people with disabilities.

- Balanced decision-making was **beneficial to staff**; previously they had done manual handling “on the quiet”, without protection or supervision.
- The case had **enriched the understanding of dignity**, for example in relation to the lifting of morbidly obese patients.

However, our findings caution against overstating the overall impact “on the ground” of *East Sussex*. Our interviews suggest consistency is not always achieved within a single authority, less still between authorities. There is anecdotal evidence of restrictive policies persisting both within public authorities and private providers. One interviewee reported “shocking” practices among both public authorities and private providers, including some which say: “we don’t do stairs” or “we don’t do legs”. Occupational therapists in a London borough said “no lifting” policies persist among private care agencies sub-contracted by their authority.

Interviewees said the contracting out of services can dilute the impact of manual handling policies that enshrine the primacy of individual risk assessment. Local authority staff we interviewed also raised the issue of direct payments¹³ as presenting new challenges: they were all unsure how far they can or should promote good manual handling practice to care workers employed by direct payment recipients, and some feared the possibility of legal challenges.

Some interviewees said “sensationalised” media coverage had created erroneous perceptions of the case and prompted defensive responses among care staff (“before we couldn’t lift and now we have to”, “what about our rights?”). Among occupational therapists employed by a London borough a unanimously positive view of the *East Sussex* case co-existed with a generally negative view of human rights law and language (“there’s a lot of fear around it”). However, these attitudes were not shared by all interviewees: one said the principle of balanced decision-making was seen as empowering by care assistants because it helped them understand how decisions are made and allowed them to raise concerns about their own safety.

Professional associations and networks have played a significant role – often informally – in disseminating information about the *East Sussex* case and debating its implications for practice.¹⁴ Our interviews highlight the strong potential these informal channels have for translating and disseminating the lessons of case law.

13 Cash payments made to individuals assessed as needing services.

14 For example the National Back Exchange, which has a network of local groups and an online forum; <http://www.nationalbackexchange.org/>.

The positive obligation to secure dignity and integrity: the case of *Bernard*

SUMMARY: The *Bernard* case is widely cited as illustrating the potential of human rights to improve public services. Our findings suggest this potential has not been fulfilled: we have found no impact on local authorities or at a national policy level. Factors include constraints on capacity and a tendency to view *Bernard* as an aberration. The sheer breadth of areas the case holds lessons for means any potential impact is lost amid a raft of other drivers.

The *Bernard* case concerned a severely disabled woman who had knowingly been left in unsuitable accommodation for 20 months, confined to one room and unable to use the toilet. The council had a positive obligation to secure her dignity and integrity; its failure to act without undue delay was a breach of Article 8 and the court awarded £10,000 in damages.

According to our interviews, this case has had no discernable impact on policy or practice among local authority housing or social care departments, or at a national policy level. In our survey of housing directors, fewer than half of respondents had heard of the case; just over a third said their authority had examined policies in the light of it, and only one individual said their authority had changed policy. Legal directors were more familiar with the case, but only one out of 36 said their authority had changed policy because of it.

Housing directors and managers and national policy officers said the case was viewed as aberrant: “it couldn’t happen here”. The majority suggested that existing legislation and statutory duties should have prevented it; the HRA and case law were peripheral to stronger drivers of policy and practice, notably housing legislation, the DDA and disability equality duties, and other performance indicators and codes of practice which already enshrine the principle of no undue delay. A policy officer in the Local Government Association said *Bernard* was “extreme”; she could not recall it being raised in any discussions with senior officers in local authorities. National officers in the Chartered Institute of Housing and the Housing Corporation (which regulates housing associations) agreed. *Bernard* was not a “landmark case” in the housing sector. Cases which had gained a higher profile were those which appeared to expose a “systemic failure” which placed authorities at risk of breaching the law, or those which “go to the very core of the mechanics of how tenancies work”.

One director of housing said the recourse to case law is very council specific – and frequently determined by limits on capacity. In central London boroughs, the scarcity of housing means that councils habitually operate “on the edge of the law”. In authorities with more plentiful stock, “we rarely encroach on any case law, human

rights or otherwise”. A disability housing advisor in Hull said he handles some 400 cases a year, many comparable to *Bernard* – “and that’s the tip of the iceberg”.

A senior housing manager in LB Enfield said changes had been made since the case, especially in the interface between housing and social care and the handling of cases of complex housing need. She emphasised that none was a **direct** result of the case. Instead, it was a subsidiary element in a continuum of other developments, notably the government’s drive for greater personalisation of care. The case did not feature prominently in staff training.

Most of our interviewees, including the manager in LB Enfield, said the £10,000 penalty was not sizeable enough to be a significant factor for most authorities.

Our findings suggest that the potential of the HRA to drive improvements in public services has been particularly under-explored in relation to housing. There was a marked tendency to view the HRA as peripheral to other drivers, including equalities legislation. It might be argued that this perspective neglects the role played by the HRA as overarching legislation that renders visible groups that fall outside the patchwork of anti-discrimination legislation and gives them a voice and a channel for legal redress. This suggests further potential to develop integrated human rights and equality approaches within public authorities.

Conclusions

In this section, we analyse the themes that emerge from our qualitative research on the impact of selected cases. These illustrate the inherent limitations of any exercise to determine the impact of case law (section 8.1) and the barriers which might prevent case law principles from changing policy or practice in non-compliant authorities (section 8.2). We examine how, in practice, the lessons of human rights case law have been put into practice and ways of communicating human rights to gain consent (section 8.3).

Limits to assessing impact

Multiple drivers for change

At an institutional level, the HRA and human rights cases are rarely the sole or principal driver for change. Others include: statutory requirements, performance targets, codes of practice, inspectorate standards, media coverage and broader policy directions set by government. The limits to assessing impact are not uniform, however. Where a case has direct and immediate implications for policy and guidance set nationally, the impact is visible and even quantifiable. Impact is harder to ascertain where cases have implications for diverse practice across a range of

public authorities, or where they involve complex circumstances from which it appears hard to generalise.

As individual practitioners, interviewees frequently struggled to disentangle their knowledge of case law from other factors (such as their professional ethos and training) as an influence on specific decisions or habitual behaviour.

Passage of time

The time lag between an incident, a legal judgment, and resulting policy changes reaching operational managers can make it difficult to determine what is attributable to case law and what relates to the evolution of good practice. Policy changes may be made in response to an incident review ahead of any legal case; they may also be made in response to inquiries that stem from the legal case. In each case, determining the impact of the case itself is uncertain.

Media coverage and advocacy

In some cases, there has been high profile media reporting of a judgment and/or subsequent inquiries, or vocal campaigns by relatives and advocacy organisations to challenge poor practice. Arguably, the HRA underpins any resulting changes to policy and practice, however, a note of caution is needed when assessing the impact of the case on its own.

Potential barriers to impact

Divergent perceptions of human rights

We found both positive and negative views about human rights and the HRA at different levels of seniority in public authorities.

Some service directors and managers had experienced human rights as a “stick to beat us with” or as the basis for unrealistic or unfounded claims. This had led to what one London housing manager described as a case-hardened attitude to the HRA. Some said human rights were debated in an oppositional manner, making it harder to win consent to change (“what about my rights?”). Others spoke of the HRA as being “almost taboo”, an object of derision or something threatening, in contrast to the DDA which was viewed positively by all those who referred to it.

However, other interviewees emphasised that such views are neither universal nor insurmountable. Service directors spoke positively about human rights as a set of underpinning principles for their work and a constructive challenge function.

Practitioners spoke about learning from human rights cases to approach seemingly intractable problems (such as the moving and handling of morbidly obese patients) and as a framework within which to resolve competing interests.

Opinions in a single authority can differ hugely. One frontline police officer told this project the *Osman* case had contributed to a “bureaucratic nightmare with frontline officers bearing the brunt” while another from the same force said *Osman* was “another example of how the Police are becoming more professional/accountable”.¹⁵

Resources and capacity – an issue of supply and demand

Interviewees said a significant barrier to applying the lessons of case law systematically is the need for additional resources (for example, the cost of a social care budget) or additional capacity (for example, accessible prison space or housing stock).

In some cases, public authorities appear to develop ways of interpreting the obligations they might be expected to take on as a result of case law to fit within available resources. For example, a regional asylum policy officer said hard-pressed local authorities with large numbers of destitute failed asylum seekers effectively apply a higher threshold for community care than neighbouring authorities with fewer claimants.

In other instances, case law which, like *Bernard*, is concerned with a minimum level of decency and respect for a claimant’s human rights can struggle to gain purchase in a system driven by the equitable and transparent rationing of resources. The case may be a salient reminder of the “bottom line” but does not, interviewees said, assist an authority to make hard decisions about allocating adapted housing stock in conditions of overall scarcity.

On the demand side, variations in the availability of legal representation or advocacy can create something akin to a “post code lottery”. Interviewees spoke of “advice deserts” and of applicants struggling to make headway through the system without representation. Disability organisations say demands by service users to operationalise case law are patchy and certainly have not achieved a sufficient critical mass to drive change.

Variable mechanisms to monitor case law and review policy

From the evidence we have seen, monitoring arrangements are variable and often highly specific to each authority.

Some local authority service directors and managers said mechanisms to review policy and guidance in the light of case law are sometimes haphazard, reactive and overly dependent upon personal initiative.

¹⁵ These views were obtained via an anonymous questionnaire of detective constables and police inspectors in the same force.

Other interviewees (both in local and national government, including NOMS and the UKBA) were confident that mechanisms exist to ensure that fresh case law is scanned for its implications for policy and guidance. Police officers in four out of five forces we interviewed were able to outline internal mechanisms for monitoring case law and disseminating relevant points.

Variable mechanisms to disseminate the lessons of case law

We encountered variable experience within the public authorities we interviewed and surveyed, both as to the perceived effectiveness of dissemination and the extent to which policy responses to human rights case law are signposted as such, especially to “frontline” practitioners.

In our surveys, fewer than half of all director-level respondents consider that frontline staff in their authorities receive sufficient, timely or accessible guidance about the lessons of case law. Anecdotally, the service managers and practitioners we interviewed generally could not recall getting guidance about *East Sussex* or *Bernard* (or any resulting policy changes) through their authority.

There is debate about how far down an organisation it is helpful to label a policy change or guidance as being based on human rights. Some said this can be off-putting or unnecessarily legalistic; others said it helped frontline staff to know that changes were not arbitrary and that a human rights framework could protect them and those using their service.

Interviewees in different sectors said that, in some instances, practitioners **do** find it helpful to understand the human rights origin of guidance or policy changes. Interviewees working in prison healthcare articulated a need for more explicit advice on human rights case law, framed as positive guidance based on sound, reasoned judgment. An interviewee in NOMS noted that explicit references to human rights cases in policy documents can prevent staff from becoming “cellular” and forgetting that experiences from other prisons are relevant to them. Service managers and practitioners noted that understanding the origin of the *East Sussex* principles had helped staff see that resulting changes to policy or protocol were not arbitrary and involved a balancing of rights, including their own.

Human rights as a driver for change

A principles based approach

Legal judgments are generally specific interpretations of the law applied to a particular set of circumstances. This can discourage any culture within public authorities of identifying **generalisable** principles arising from case law. Moreover, there appears to be a generic tendency to view some human rights cases as arising from extreme or aberrant circumstances.

Professor Francesca Klug has promoted the idea of “smart compliance”: that is, providing guidance to public authorities on the implications of human rights case law which extend beyond the specific facts of a particular case in ways that may not be immediately apparent. We found some examples of smart compliance, such as a Welsh county borough council which said human rights principles had been one driver behind a decision to stop applying a blanket policy on intentional homelessness because it was disadvantaging vulnerable children.

Interviewees across the public service areas we have explored suggest that there is a need to equip service directors and operational managers to be able more confidently to apply human rights principles across a range of circumstances. One director of housing and social care, who is active in the disability network of the Association of Directors of Adult Social Services (ADASS), said:

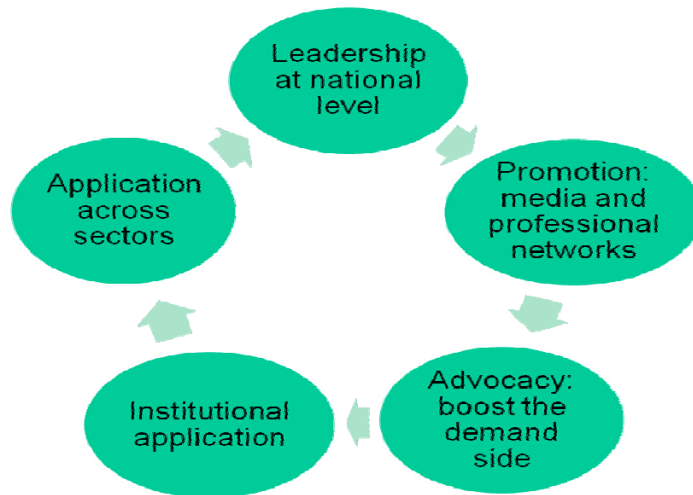
What we'd like to know is: what is generalisable, what does this [case law] suggest should be done in a broad way across all areas? That's the area that needs to be developed.

The absence until 2007 of an organisation charged with this role of promoting human rights and “translating” the lessons of law into effective practice may well, our interviews suggest, have led to the potential of the HRA being under-sold and under-exploited.

Promoting “smart compliance”

Our findings suggest different dynamics by which case law can exert impact. Sometimes the lever is top down: for example, instructing case workers to process asylum support applications differently. Impact can also be achieved by less mechanistic routes from the bottom up: such as influencing professional debate and reinforcing the efforts of practitioners to evolve good practice.

Our interviews suggest several levers for promoting the implications of human rights case law to public authorities, which we show here as a cycle.



Our interviews suggest the potential for **national leadership** to promote the principles of human rights case law – in particular from central government policy departments in partnership with national associations such as ADASS, together with the Equality and Human Rights Commission.¹⁶

Promotion via the media, both specialist and mainstream, is an effective way to reach practitioners, particularly given the patchy institutional application of case law. One service manager said legal officers were more likely to examine policies where a case was seen as a “live issue” posing greater reputational risk. Our findings also suggest the potential to promote human rights principles through professional associations and networks, using new technology such as online forums. The engagement of those who can act as “multipliers” is critical (such as manual handling co-ordinators in the case of *East Sussex*).

Advocacy - both legal representation and campaigning advocacy – can boost the “demand side” in relation to human rights cases. In the case of *Bernard*, our interviews suggest that the £10,000 penalty was not a sufficient incentive for change. A greater awareness among service users and advocacy organisations might increase the potential leverage of future cases.

Effective **institutional application** involves monitoring, review and “lessons learned” mechanisms, dissemination, training and the translation of principles into messages that make sense to practitioners’ everyday roles. Our findings suggest these systems

16 Our interviewee in the College of Occupational Therapists (COT) offered the “spectacular” roll out of the Mental Capacity Act as a model for how to get a co-ordinated message across to those delivering public services.

vary considerably between authorities and in particular that the lessons of case law may not always filter down to those on the frontline.

Application across sectors: The principles arising from legal cases, and the implications for practice, are not always immediately transparent to practitioners and are sometimes disputed. This brings us back to the role of national leadership to identify and champion key principles and lessons to a wider range of sectors and circumstances than might be suggested by the facts of the individual case.

Communicating human rights

Our interviews suggest that, in order to become more embedded in public services, human rights principles need to be communicated to professionals within those services (the “supply” side) and to those using services and the wider public (the “demand” side).

Our interviews with those delivering public services suggest several strategies for communicating rights in a way which taps into existing organisational cultures.

In some cases, practitioners are already delivering services in a way which meets human rights standards, sometimes whilst under pressure to cut costs. Guidance that suggests they can have confidence in their judgments is seen by our interviewees as a useful validation. Our interviews on *East Sussex* suggest that, where there are rights to be balanced, setting out guidance in a way which makes the resolution of competing interests clear can help gain consent. Where an absolute right is engaged, and where obligations are strong because someone is in the state’s care, interviewees (especially those new to detention settings) articulated a need to have these obligations explained explicitly and in a way that makes sense to their job.

Where we encountered negative perceptions of human rights, this was in part based on a sense of their being burdensome. However, some interviewees working in housing and social care emphasised that the time invested in considering every aspect of a person’s needs – and involving service users and carers in devising solutions – can effect a qualitative change in the relationship between those who use and deliver public services.

Human rights and the HRA are viewed as one among many drivers of policy and practice in public authorities. In local government, as a senior interviewee in the Improvement and Development Agency put it:

... equalities is seen as a home issue – I don’t think human rights is an ‘owned’ issue in the same way ... It’s not in the DNA.

This suggests potential to develop integrated equality and human rights approaches which build consensus around the HRA as a means to extend existing approaches to inequality and set a threshold of treatment to secure dignity and respect for those in vulnerable situations.

Our findings suggest that the effective promotion of “smart compliance” requires a pragmatic understanding of the complex legal and policy environment in which new principles need to be applied and a readiness to work with the grain of organisational cultures. Equally, we have detected an appetite among some of our interviewees to operationalise the lessons of case law based upon a more confident understanding of how human rights principles can be applied across public services, thus promoting both the transformative and remedial roles the HRA was anticipated as playing a decade ago.

CHAPTER 1

INTRODUCTION

1. Context of the report

This report was commissioned by the Equality and Human Rights Commission (EHRC) to inform its Human Rights Inquiry. The Commission is carrying out the inquiry under its statutory duties under the Equality Act 2006 to:

- promote understanding of the importance of human rights
- encourage good practice in relation to human rights
- promote awareness, understanding and protection of human rights, and
- encourage public authorities to comply with the Human Rights Act (section 9 of the Equality Act)¹⁷

The terms of reference of the inquiry are:

- to assess progress towards the effectiveness and enjoyment of a culture of respect for human rights in Great Britain
- to consider how the current human rights framework might best be developed and used to realise the vision of a society built on fairness and respect, confident in all aspects of its diversity¹⁸
-

The inquiry involves several strands of evidence gathering including research projects, a call for written evidence and Inquiry Panels.¹⁹

17 <http://www.equalityhumanrights.com/en/projects/humanrightsinquiry/Pages/HumanrightsInquiry.aspx>

18 <http://www.equalityhumanrights.com/en/projects/humanrightsinquiry/Pages/HRIConsultation.aspx>

19 The EHRC has commissioned reports on 'the impact of human rights culture on public sector organisations - lessons from practice' and 'the role and experience of inspectorates in promoting human rights in public services'.

2. Aims of this report

Public authorities have an obligation to comply with the Human Rights Act (HRA). They must refrain from harm, and in some instances, also take pro-active steps to protect and promote human rights. One way to ensure this compliance is through legal challenge. But victory in the courtroom is no guarantee that the desired institutional response will be forthcoming.²⁰ The scoping project for the inquiry found strong evidence pointing to the urgent need for more systematic and timely guidance for public authorities on the implications of relevant case law.²¹

The aims of this report are:

- to identify key human rights cases from the UK and European Court of Human Rights (ECtHR) case law
- to explore the impact of the outcome of those cases on a range of public authorities
- to explore with service providers from different sectors whether and how the principles established in these cases have been incorporated into policy and practice
- to explore the positive impact within these sectors of implementing human rights principles
- to identify the barriers that prevent or obstruct the use of human rights principles in these sectors

This report which covers England and Wales focuses on case law - just one among a number of mechanisms that facilitate implementation of the HRA in public services. Others include the training of public authorities,²² advocacy by and on behalf of service users,²³ guidance to public bodies,²⁴ and the use of levers like inspectorates and inquiries.²⁵

20 Equality and Human Rights Commission, Research Specification, Evaluating the impact of selected cases under the Human Rights Act on public service provision.

21 Equality and Human Rights Commission (2008) Human Rights in Britain since the Human Rights Act 1998: A Critical Review.

22 The British Institute of Human Rights (BIHR), for example, provides comprehensive training programs to public authorities. See <http://www.bihar.org.uk/>.

23 *The Human Rights Act – Changing Lives*, by the BIHR, outlines 15 case studies of the HRA being used in practical ways to challenge aspects of service provision by public authorities. See <http://www.bihar.co.uk/sites/default/files/The%20Human%20Rights%20Act%20-%20Changing%20Lives.pdf>.

3. Selection of cases

In discussion with the EHRC we developed criteria and selected key cases across a range of sectors in order to be able to explore different public authorities including social care, policing, prisons, immigration and housing. Cases chosen were of relevance to different sections of society – including those with particular vulnerabilities or that face particular hurdles in accessing rights – for example those in contact with the criminal justice system, asylum seekers, and disabled people. Each case is ‘strategic’: their judgments have implications for many of us and may require changes to commonplace policy or practice. They also have underlying principles that have the potential to be applied in different sectors. We included decisions of the domestic courts applying the HRA and UK cases at the ECtHR.

The cases are:

- Osman v UK, No. 23452/94, Judgment of 28 October 1998 / Osman v UK (2000) 29 EHRR 245
- A cluster of five cases involving vulnerable detainees²⁶
- Price v UK (2001) 34 EHRR 128
- R (Limbuela and Others) v Secretary of State for the Home Department [2005] UKHL 66
- R v East Sussex County Council Ex parte A, B, X and Y [2003] EWHC 167
- R (Bernard) v Enfield LBC [2003] HRLR 4

4. Methodology

This study used qualitative research methods, conducting 65 individual in-depth interviews and engaging 12 more in two focus group discussions (see Annex 6). The choice of interviewees was driven by directions provided by the EHRC. At their request we identified relevant staff at senior, management and service delivery levels

24 Examples include guidance on the HRA issued by the Ministry of Justice (<http://www.justice.gov.uk/guidance/humanrights.htm>); *Human Rights Act Toolkit* by Jenny Watson and Mitchell Woolf issued by the Legal Action Group (<http://www.lag.org.uk/Templates/System/Publications.asp?NodeID=89151&Mode=display>); and the Human Rights in Healthcare Project undertaken by BIHR and the Department of Health (<http://www.bihhr.co.uk/projects/human-rights-in-healthcare-project>).

25 The Joint Committee on Human Rights, for example, has conducted inquiries into the treatment of asylum seekers; people with learning disabilities and older people in healthcare.

26 Keenan v UK (2001) 33 EHRR 38; R (on the application of Wright) v S/S for the Home Department [2001] 1 Lloyd’s Rep Med 478; R (on the application of Amin) v S/S for the Home Department [2004] 1 AC 653; [2001] EWHC Admin 520; 2001 WL 606447 Edwards v UK (2002) 35 EHRR 19; R (on the application of Middleton) v Coroner for the Western District of Somerset [2004] 2 AC 182.

in a number of public authorities, including local authorities, police forces and health authorities.²⁷ We did not focus on inspectorates or national government, although interviews in these areas contributed significant policy understanding and contextual information.²⁸ The particularities of each case also drove the choice of interviewees.

For *East Sussex* and *Bernard*, we concentrated on service directors, operational managers and frontline practitioners in local authorities. The cases of *Osman*, *Price*, *Limbuela* and the detainees strand have implications both for national policy and guidance and for operational practice; we spread our interviews between the national, regional and local levels accordingly.

Where possible we have “drilled down” within individual public authorities and where appropriate on more than one case. We have also engaged (via interviews and a questionnaire) with operational and rank and file police officers and those who manage them to explore how the *Osman* judgment has impacted upon routine practice. For each of the cases, we obtained the views of organisations that have specialised knowledge or experience relating to the cases and the sectors they affect from the practitioner and service user perspective.

We conducted three surveys of senior operational figures within local authorities - directors of adults’ and children’s social services (73 sent, 17 responses), directors of housing (405 sent, 24 responses) and directors of legal services (417 sent, 36 responses). We also surveyed local authority housing practitioners.²⁹ These surveys are not statistically robust but provide a useful corrective to the anecdotal experience in our interviews; they aimed to identify whether policies have been reviewed or changed in the light of case law, as well as the availability of guidance on HRA case law for the staff for whom the respondents are responsible.

We refer to both published and unpublished material, including guidance, policies, “on the ground” research and material produced by civil society groups, professional associations and other interested bodies.

27 Owing to time constraints and the requirement that research in the prison sector go through a formal approval procedure, these authorities did not include prisons. Healthcare staff in prisons were interviewed.

28 As part of its inquiry the EHRC has commissioned a research project, “The role and experience of inspectorates in promoting human rights in public services”.

29 Via the Chartered Institute of Housing (13 responses).

5. Guide to the report

Chapter 2 looks at *Osman v UK* and the obligations on public authorities to take steps to protect life, under Article 2 of the European Convention on Human Rights and Fundamental Freedoms (ECHR). The chapter provides an overview of the ways in which case law is translated into policy and practice in the area of policing. It identifies a range of policing policies that have taken into account the *Osman* case. The chapter examines briefly the impact of *Osman* on prison policies.

Chapter 3 looks at a group of cases involving deaths in custody. The chapter looks at the role of case law in the process of policy development in prisons and in the provision of prison healthcare. It examines the case of *Keenan v UK* and its impact on segregation, the case of *Middleton* and the way in which it has shaped the practice of inquests, and the cases of *Wright*, *Edwards* and *Amin* and their impact on meeting the investigative obligations under Article 2. Chapter 3 looks at the evolution of prison policies on information sharing, risk assessments, healthcare, suicide prevention, although it notes difficulties in relating such changes to the cases under examination. The chapter makes brief observations about the impact of these cases on police custody. We conclude that the process of policy change is complex and multi-faceted, and that it is difficult to identify clearly the impact of specific cases and chains of cause and effect. In some cases however, it is possible to see the imprint of cases and in some they are explicitly identified as driving forces. Where these cases concern themselves with the investigative obligation it is easier to identify an impact within the broader legal system. Broader changes initiated by government are precipitated, if not caused, by the cases collectively.

Chapter 4 examines *Price v UK* and issues around disability and detention. The chapter looks at the impact the case had on the police force that had originally detained Adele Price and at the broader impact on other police forces. It concludes that relevant detention policies have evolved since the case but that the case itself was not a key driver in these changes; instead the Disability and Discrimination Act 2005 (DDA) was a major influence.

Chapter 5 focuses on the case of *Limbuela*. It looks at the impact of the case on refusals to provide support to asylum seekers under section 55 of the National Immigration and Asylum (NIA) Act (2002). The chapter looks at the impact beyond section 55, including on local authorities. It concludes that *Limbuela* has had a direct and quantifiable impact on reducing “beginning of process” destitution by changing the way section 55 is applied in policy and practice, but that it is not possible to identify a direct impact of *Limbuela* in reducing “end of process” destitution. Contrary to the narrower interpretation of the case by the UK Border Agency (UKBA), local authority interviewees **do** see the case as having some relevance for their work in

setting a baseline of acceptable treatment and reinforcing the principle that omissions as well as actions can breach Convention rights. However, subsequent case law more directly applicable to local authority responsibilities was said to be significantly more influential.

Chapter 6 is about the *East Sussex* case. It looks at the impact of the case on manual handling policies, on the provision of training and on service delivery. It identifies impacts on transparency and accountability, on the integration of the concept of dignity and on the health and safety of staff. We conclude that the impact of the case across the range of care sectors is variable and uncertain.

Chapter 7 is about *Bernard v Enfield*. It examines whether there was any impact on the defendant authority or on other local authorities. It concludes that the case achieved little traction in the housing and social services sectors. The reasons for this include a proliferation of legislation and case law, constraints on resources and capacity, and a tendency to view the case as an aberration.

Chapter 8 draws together and analyses themes that arose across the selected cases. It notes the limits of assessing the impact of legal cases as well as some of the potential barriers to impact. It examines the ways in which human rights more broadly can operate as a driver for change.

CHAPTER 2

PROTECTING LIFE: *OSMAN V UK*

In this chapter we look at *Osman v UK* and the obligations on authorities to take steps to protect life, under Article 2 of the ECHR. The chapter looks at the ways in which case law is translated into policy and practice in the area of policing and identifies a range of policing policies that have taken into account the principles established in the *Osman* case. The chapter examines briefly the impact of *Osman* on prison policies.

1. The case and its context

The *Osman* case established key principles about the positive duty on authorities to take steps to protect life and found these steps to be part of the authorities' obligations under Article 2 of the ECHR, on the right to life. The key principles are:

- That a violation of the positive obligations of Article 2 exists where “the authorities knew or ought to have known at the time of the existence of a real and immediate risk to the life of an identified individual or individuals from the criminal acts of a third party and that they failed to take measures within the scope of their powers, which, judged reasonably, might have been expected to avoid that risk”.³⁰
- There is no need to show gross negligence for there to be a violation of Article 2: “it is sufficient for an applicant to show that the authorities did not do all that could be reasonably expected of them to avoid a real and immediate risk to life of which they have or ought to have knowledge”.³¹

The case concerned a teacher, Paul Paget-Lewis, who had developed an obsession with one of his pupils, Ahmet Osman. The family of Ahmet Osman experienced harassment and criminal damage. The school was concerned for Ahmet Osman's safety and police were aware of the situation. These events culminated in an attack by Paget-Lewis in which Ahmet Osman was injured and his father, Ali Osman, killed. Paget-Lewis pleaded guilty to and was convicted of manslaughter on the grounds of diminished responsibility.

30 *Osman v UK* (2000) 29 EHRR 245 at para 116.

31 *Osman v UK* (2000) 29 EHRR 245 at para 116.

ECHR heard the family's claim that the police had failed to take appropriate and adequate measures to secure effective protection for their lives in 1998. While the family identified measures the police could have taken and did not, the court found no violation of Article 2. The judgment gave consideration to the circumstances in which authorities may fail to meet their positive obligation "to take preventive operational measures to protect an individual whose life is at risk from the criminal acts of another individual".³²

The application of the *Osman* standard is wide. In its original formulation it was intended as a generalisable principle for the court to use to assess whether authorities had met their obligations in the particular case. Since 1998 the standard has been used in a number of other judgments including cases that are explored in Chapter 3.

2. The impact of *Osman*

2.1 *The impact on policing*

Nearly 10 years on, *Osman* principles have become part of policing policy and practice across a range of areas – indicating acceptance of the underlying principles of the case and their relevance to a range of situations beyond those examined by the court. *Osman* is also referred to in documents on standards used to assess police forces. As a member of the Association of Chief Police Officers (ACPO) explained:

It's found in Public Protection Guidance about vulnerable people, children, the mentally ill...it's found in the Murder Investigation Manual. It's relevant to protecting witnesses, to investigating child abuse and investigating domestic violence. There's guidance currently being drafted on managing violent offenders...which will allude to Osman.

To understand the impact of *Osman* on policing policy and practice at national and local levels, we interviewed nine police officers at senior and middle levels from five different forces. We could not assess the immediate impact of the case and the specific policy changes that occurred in its immediate wake. However senior police officers who remember the case told us that the policy and cultural impact of the case was huge. They showed the lasting significance of the case by providing examples of how the principles of the case imbue their practice to this day.

³² *Osman v UK* (2000) 29 EHRR 245 at para 115.

2.1.1 The process of policy change

To understand how the Osman principles shape policing and are communicated to the force, we looked at the monitoring and interpretation of case law at a national level and how this informs policy.

The National Policing Improvement Agency (NPIA)³³ monitors case law relevant to police operations to help inform the development of “doctrine” by the agency.³⁴ Doctrine aims to develop and promote best practice in the Police Service – it includes legally binding Regulations, Code, for which Chief Officers are required to “have regard”, Guidance and Advice. Regulations and Code are commissioned by the Home Secretary. Guidance and Advice are requested by ACPO and Home Office Policy Units. One senior police officer commented that this system works well – reacting swiftly to legal judgments and issuing communications in days or even hours. Another officer commented that the content is usually good: “Ninety per cent of doctrines are excellent”.

The speed with which individual police forces are able to operationalise these communications from NPIA varies. Senior police officers comment that a large police force will “localise” NPIA notes, that is, make them relevant to and fit with force-level policies, which can take time. Smaller forces may have less detailed procedures for NPIA communications to go through. When there is an urgent need to change practice, senior officers said that police forces use email to make all relevant police officers aware immediately. More detailed policies, or sometimes changes to relevant legislation, follow later. Forces disseminate amended policies, including through the use of intranets.

NPIA-issued doctrine documents also inform the inspection methodologies of Her Majesty’s Inspectorate of Constabulary (HMIC). HMIC examines compliance with a range of doctrine documents during inspections.

Individual police forces also monitor case law and develop their own policies and processes on a range of different issues. Precise mechanisms for this vary. Police officers talked about “environmental research”, or “environmental scans”, undertaken by a learning and development department, a professional standards and performance department, or a policy unit. None of these mechanisms focus exclusively on case law – drawing also on outputs from NPIA, ACPO, HMIC, the Home Office, the Independent Police Complaints Commission (IPCC), professional

33 NPIA was preceded by the National Centre for Policing Excellence, also known as Centrex.

34 In addition to case law, sources for doctrine documents include legislation, recognised good practice, evidence-based research, the work of relevant experts and extensive consultation (<http://www.npia.police.uk/en/index.htm>).

journals, and the experiences of their own police force and others. This research informs the collaborative review and development of local policies.

A senior police officer with a role in custody described this process in his force:

We have an environmental researcher in our Professional Standards and Performance Department. She periodically sends out a detailed document with all the relevant legislative changes and cases. My policy officers will go through that document and will inform me and others of any significant changes that might inform our business. If it's important for the way we run custody suites then we'll send out a Criminal Justice Department Brief...that goes out to all custody staff and to anyone else whose role we think is affected.

As well as forming part of the environment case law impacts policy in other ways. For example, two forces told this project that they had policy writing templates, designed to ensure that human rights considerations form part of the policy design process.

The policy outcomes of case law monitoring are disseminated in a variety of ways. The Metropolitan Police, for example, publishes new policy on the policy and news pages of the force's intranet, and sends email communications to Custody Managers in each of the 33 boroughs, and to all custody users.

Reference to case law features in the dissemination of policy changes. One officer commented that information disseminated about a change in policy triggered by case law would usually include reference to the case, but rarely any details: "Briefs must be brief – they can't be four pages or they wouldn't get read". Another commented that his force had recently started to include a summary of new policies, incorporating the reasons for the changes, whether case law, IPCC investigations, coroners' verdicts or something else. This provides both a history of the evolving policy and a history of how the force has responded to cases.

Forces recognised the role of training in disseminating policy changes. The Metropolitan Police told us that they hold training seminars for Custody Managers three to four times a year. Another force provided a rolling programme of weekly sessions, usually over a five week period, covering every aspect of the work, structured and repeated in order to maximise participation. An officer noted that cases – especially new ones – are incorporated into relevant training, but that the ongoing nature of training and the evolution of the law means it is not possible to say that all relevant individuals had accessed relevant information through training, and it would always need to be complemented with other methods of disseminating information. The outcome of training, one officer comments, is knowing what she needs to know, not talking about a case itself with any authority.

Another senior officer noted the importance of regular discussion, for example at daily management meetings:

It's all very well publishing something, but it needs to be translated into a reality... (used in) everyday language.

She believed that police officers need to discuss the principles of case law and real-life policing experiences in order to understand the implications for decisions on practice. Regional meetings also facilitate the sharing of good practice and lesson learning but, again, the focus is wider than case law. Talking about regional meetings one officer commented that cases – in the sense of incidents – are important and are part of learning from a breadth of sources including other forces:

We're all striving for best practice. We learn from the IPCC; we learn from legislation. We learn from every possible area that we can...

The same officer notes the importance of learning lessons as quickly as possible. He notes that he sees IPCC reports before they are finalised. If he sees aspects of relevance that he can change and that he feels should be changed in his own force he will do so, rather than wait for a final report.

2.1.2 *Osman* in policing policies and practice

This section looks at selected national and local police policies influenced by the *Osman* case.³⁵ It looks first at policies on handling threats or risks to life. It then looks at relevant practices including issuing “*Osman* warnings”. Finally it looks at a selection of other policies.

2.1.2.1 *Threat to life policies*

Osman was primarily concerned with police protecting individuals in the community from other individuals who present a risk to life. At local level the majority of the 43 police forces of England and Wales have in place specific policies on handling threats or risks to life. One police force interviewed for this project is formulating a regional guide for managing threat to life with four other forces. Senior police officers state that such policies derive directly from the obligations of Article 2 of the ECHR and from the *Osman* case. Examination of a selection of these policies confirms this.³⁶

35 Policing policies are too many and too detailed for a comprehensive review of all policies to form part of this project.

36 This project examined the publicly available policies of the Metropolitan Police, Devon and Cornwall Constabulary, West Mercia Constabulary and Leicestershire Constabulary. In some cases these are to be read in conjunction with other, confidential, documents that this project was not able to examine. This project was also provided with the confidential text of one other policy.

The Metropolitan Police' Dealing with Threats to Life Policy, for example, notes in its introduction:

*The right to life is enshrined in Article 2 of the European Convention on Human Rights, and in the Human Rights Act 1998. Obligations on the police service to take reasonable steps to protect the life of people where there is a real and immediate risk to them from the acts of another have been determined in European and domestic case law, notably in Osman v UK 1998.*³⁷

Devon and Cornwall Constabulary's Management of Threats to Human Life policy refers to the Human Rights Act and to the *Osman* case. It describes the right to life as having been "a fundamental right for many years and a cornerstone to policing."³⁸ Leicestershire Constabulary's Dealing with Threats to Life policy references the European Convention, the Human Rights Act and the *Osman* case,³⁹ as does West Mercia Constabulary's Management of Threat and Risk to Life.⁴⁰

These policies reflect the core components of the *Osman* case – the principle that they apply to cases where they "knew or should have known", of a "real and immediate risk to life". The Metropolitan Police' Dealing with Threats to Life Policy notes that it applies:

... to all cases in which the Metropolitan Police Service knows, or ought to know, of the existence of a real and immediate risk to the life of an individual.

Other policies include near identical wording.

One policy made confidentially available to this project defines "real and immediate danger" as:

... a risk that has been reasonably assessed to be real and that the potential assailant has the intention and current ability to carry it out.

37 Metropolitan Police, Dealing with Threats to Life Policy, available at: http://www.met.police.uk/foi/pdfs/policies/threats_to_life_policy.pdf.

38 Devon and Cornwall Constabulary, Management of Threats to Human Life, available at: http://www.devon-cornwall.police.uk/v3/pdfstore/Crime_D339.pdf.

39 Leicestershire Constabulary, Dealing with Threats to Life, available at: http://www.leics.police.uk/files/library/documents/threats_to_life_200601.pdf.

40 West Mercia Constabulary, Managing Threat and Risk to Life Policy 2008, available at: <http://www.westmercia.police.uk/foi/JUNE%20POLICY%20S-V/Threat%20and%20Risk%20to%20Life%20Force%20Policy%20LATEST.pdf>.

These policies reflect further some of the detail of the *Osman* case, committing forces to “take all reasonable steps” in the circumstances in which the policy applies, that is where there is a “real and immediate” risk to life. One policy lays down a sequence of events: receipt of information, assessment of risk, “devising and initiating a strategy for preventative or disruptive measures”, resolution and monitoring.

These threat or risk to life policies also provide guidance on the interpretation of “known or should have known” – a crucial element of the principles of the case. By including an understanding of the circumstances in which the force should have known, these policies are laying down the basis for ensuring that where they should have known, the police force does know. Three of the publicly available policies looked at by this project, plus one other policy provided privately, state that if an individual police officer has information that would lead others to “deduce reasonably that a real and immediate threat to the life of an individual exists”, then the force as an entity ought to know of it. One of the policies provides officers with precise details of the processes to be followed to record and share information.

2.1.2.2 *Practical measures*

Police use a wide range of tactical options to meet the principles of the *Osman* case in protecting life. Officers noted that acting on *Osman* means assessing the level of risks and then deciding on an appropriate course of action – the proportionate and reasonable level of response will vary depending on the level of risk and the details of the case. Options include but are not limited to increasing police patrols in a particular area, closing licensed premises, surveillance, overt filming, placing marked cars in relevant areas, installing alarms or radio links to police control rooms, ensuring people at risk have both land-lines and mobile telephones, and relocation of people at risk.

One particular circumstance in which police use a range of tactics in order to operationalise their obligations, as defined in *Osman*, is in witness protection work. Officers saw the *Osman* case as key to informing such work.⁴¹

One officer notes that the principles of *Osman* only go so far in assisting decision-making – they provide a framework but actually deciding on a reasonable course of action is complex:

Who decides what’s reasonable and what you know or ought to know?...it’s down to individual assessment and experience.

41 The House of Lords recently ruled that the *Osman* threshold for showing a violation of Article 2 is not lowered in cases involving witnesses. A violation of Article 2 exists where there is failure to take steps to safeguard life when authorities know or ought to know of a “real and immediate risk” (*Chief Constable of the Hertfordshire Police v Van Colle* [2008] UKHL 50).

He notes too that threat to life policies have to be flexible, not prescriptive: “You can’t write a policy for every situation”.

In addition to the tactics mentioned above police forces operationalise their commitment to protect life by means of “Osman warnings”, sent by police to individuals whose lives the police have reason to believe are at risk. In 2007 police forces in England and Wales issued warnings to at least 1,028 individuals.⁴² An example is attached in Annex 7.

Our interviews and a brief questionnaire completed by six frontline officers indicate at least the perception that there is a high level of awareness of this particular practice. One ACPO officer noted:

All inspectors and above know that in all cases (where there is a real and immediate threat to life) we issue formal notes telling people they’re at risk.

Osman warnings serve the purpose of both alerting an individual to a possible risk and to measures that could reduce that risk. The Northamptonshire document, for example, notes:

I therefore suggest that you take such remedial action as you see fit to increase your own safety measures e.g. house burglar alarms, change of daily routines, always walk with an associate, carry a mobile phone, install a domestic CCTV door guard system, increase house security measures e.g. locks and bolts. It may even be that you decide that it is more appropriate for you to leave the area for the foreseeable future. That is a matter for you to decide.

Osman warnings may not always be appropriate. Our police interviewees cited intelligence considerations – such as revealing information about sources that could expose someone to heightened risk – as something that can weigh against their use. One of the right to life policies mentions that such warnings could in fact exacerbate levels of violence.

2.1.2.3 Other policies

National level policies focused on a diverse range of issues reflect the Osman principle that authorities have an obligation to take reasonable measures to protect the right to life.⁴³ One such example is the ACPO policy Police Officers Who Commit

42 *Police tell more than 1,000 people that someone wants to kill them*, Adam Fresco, The Times, June 9, 2008.

43 It is expected that the national level policy documents identified below are reflected in force-specific policies, however identifying such policies is beyond the scope of this project.

Domestic Violence-Related Criminal Offences.⁴⁴ This sets out ways of ensuring that police officers who perpetrate domestic violence are held accountable. It notes its purpose as being that:

... all offenders of domestic violence-related criminal offences (are) accountable through the Criminal Justice System.

The policy outlines the principles that inform this – noting that the HRA:

... includes positive obligations on the part of public bodies to safeguard an individual's right to life...

It uses *Osman* to show that this obligation means that:

Police and other agencies with special powers to protect individuals from violence can be held liable for failure to use those powers... These obligations are clearly applicable in cases where police officers are alleged to have committed domestic violence-related criminal offences.

The Practice Advice on Core Investigative Doctrine 2005, issued by the National Centre for Policing Excellence incorporates an understanding of the duty of care held by the police and defined in the *Osman* case:

A crucial case relating to this duty of care was that of Osman v UK 29 EHRR 245 where the court held that Article 2 ECHR (the right to life) imposes a positive duty on states to safeguard the lives of those within their jurisdiction. The court went on to hold that in certain circumstances the police have a duty to take all reasonable steps to protect potential victims from a real and immediate threat to their lives arising from... Actual or threatened criminal acts of another (and) Suicide... 45

This advice explains that for the police to be held accountable the police must have been aware of the likelihood of the danger or risk to the individual concerned. It notes explicitly that this duty extends to witnesses, victims, members of the public and defendants.⁴⁶

Osman is referred to in a range of other documents. The NPIA practice advice on policing roads contains references that are nearly identical to those found in the

44 ACPO Policy, Police Officers Who Commit Domestic Violence-Related Criminal Offences, available at: <http://www.acpo.police.uk/asp/policies/Data/Police%20perpetrators%20policy.doc>.

45 Practice Advice on Core Investigative Doctrine, 2005, produced on behalf of the Association of Chief Police Officers by the National Centre for Policing Excellence, p.39.

46 Practice Advice on Core Investigative Doctrine, 2005, produced on behalf of the Association of Chief Police Officers by the National Centre for Policing Excellence, p.39.

Practice Advice on Core Investigative Doctrine, cited above.⁴⁷ The Guidance on the National Intelligence Model includes guidance on handling information:

... relating to any risk or threat to the life or personal safety of any known individual or identifiable group against which action may be taken/is possible (R v Osman)⁴⁸.

ACPO has produced a set of minimum standards relevant to protective services.⁴⁹ Protective services are defined as including:

... counter-terrorism and extremism, serious organised and cross-border crime, civil contingencies and emergency planning, critical incident management, major crime (requiring the appointment of a senior investigating officer), public order, strategic roads policing and protecting vulnerable people.⁵⁰

ACPO's minimum standards are to be used as a "threshold by which each force will be assessed" and include ones where the Osman principles are either implicit or explicit.⁵¹ The standards for counter-terrorism, for example, include the need to have processes which allow intelligence to inform preventive action; under the section on major crime intelligence must be disseminated to partner agencies and other forces "where appropriate". Counter-terrorism and serious organised crime work is to be assessed on whether there is "a good understanding of OSMAN warnings";⁵² homicide/violence reduction strategies "should include OSMAN".⁵³

A number of police told this project that *Osman* in particular, and human rights in general, loom large in their current work to improve protection of individuals when they are released from custody. Clearly understanding that the *Osman* principles can be applied to cases of suicide, two forces we spoke to mentioned that they are grappling with the problem of how to handle an individual currently in detention, who, according to the Police and Criminal Evidence Act should be released, but who

47 Practice Advice on the Policing of Roads, 2007, Produced on behalf of the Association of Chief Police Officers by the National Centre for Policing Excellence.

48 Guidance on the National Intelligence Model, 2005.

49 Gaps in protective services were identified in Closing the Gap, HMIC Thematic Report, (September 2005), triggering debate about the structures of the police forces.

50 <http://police.homeoffice.gov.uk/police-reform/protective-services1/>

51 Protective Services Minimum Standards, ACPO.

52 Protective Services Minimum Standards, ACPO, section 3.1.2. The ways in which intelligence should inform preventive action are laid out in the ACPO/Centre for Policing Excellence Guidance on the National Intelligence Model (2005).

53 Protective Services Minimum Standards, ACPO, section 3.4.2.2.

threatens suicide should this occur.⁵⁴ The case of *Osman* is cited by one officer as a reason why “simply” releasing the individual is not a preferred approach, as well as a fundamental consideration of “doing the right thing”. The difficulty of balancing “doing the right thing”, the principles of *Osman* and the right to life, the legal framework protecting the right to liberty, and rights to privacy and family life are apparent – and discussion is still ongoing about how best to do this.⁵⁵

2.2 The impact of *Osman* beyond the police

The *Osman* principles have been found to be relevant to agencies other than the police. Most notably the obligation to take protective measures has been recognised as applying to situations of prison custody.

This project interviewed a number of individuals working in the area of prison healthcare, where the *Osman* principles are particularly relevant. They included healthcare professionals working in prison settings and a small number of people involved in policy development and management. In contrast to those working in policing most of those interviewed had not heard of *Osman*. Those that had known the case through independent study or research. However, on being told the principles of the case – that a violation of Article 2 exists where authorities knew or ought to have known of a real and immediate risk to life and failed to take measures within their scope that could have averted the risk – all said that it accorded with their understanding of their obligations. One commented, “I would assume the standard is applicable – and would always have expected this to be the case”.

This project also examined published prison policies dealing with relevant aspects of the prison regime. These, and their relationship to other cases being considered by this project, are examined in more detail in Chapter 3. With regard to *Osman*, and in contrast with policing, the policies examined do not explicitly mention the case or its principles.

2.3 Recognition of the *Osman* Principles

Among the police officers this project spoke to there was a high level of awareness of the case and some senior level officers were well-versed in its principles and ways in which these are reflected in policy and practice. A small number of police in less senior positions completed a short questionnaire on *Osman* for this project. The group was so small – just six individuals – that it is not possible to draw any generalised conclusions from it, however, all of those completing the questionnaire

54 Other forces are also grappling with this issue. However of the five the project engaged with only two mentioned it to us.

55 For example the officer had concerns that referring the individual to relevant agencies or contacting family might raise issues around the right to privacy and family life.

recognised the principles of the case as something that guided their work. As a group they were less sure about implementing the principles in practice – only two were confident that they knew what “known or ought to have known” means in practice.

This accords with comments from some of our interviewees who sounded a note of caution about the apparently high level of awareness of the *Osman* case. As reflected in this project’s limited contact with frontline officers a certain level of awareness of a case does not, in itself, guarantee understanding of the case’s principles nor that they are put into practice. According to our more senior interviewees that lies more with robust policies, robust policy development mechanisms and thorough dissemination.

One senior officer expressed concern about the dangers of referring to ideas and principles using labels such as the case from which they derive. In some cases this can cause people to believe they are complying with relevant principles without actually thinking critically – it can, she warns, become a box-ticking exercise – “Have we done *Osman*? Yes”.⁵⁶

Among those interviewed by this project working in the area of prisons, awareness of the case was markedly lower. However anecdotal evidence suggests that this may not mean a lack of understanding of the principles of the case. Cases involving prison custody in which the *Osman* principles have been used, and relevant prison policies are considered below – they could be argued to indicate a different approach to case law but not necessarily a different outcome.

3. Conclusion

Our research revealed that case law is a significant part of the policy-development process within policing. It identified a wide range of policing policies, as well as practical options for protecting life, that are informed by the case of *Osman*. The case also features in ongoing policy and practice development. Awareness of the case is high, although concern is sometimes expressed as to whether awareness translates into understanding.

56 Officers referred to the case of *R v Johnson* [1998] 1 WLR 1377 as having a similar status as a label for certain processes.

CHAPTER 3

THE RIGHTS OF DETAINEES: *KEENAN, MIDDLETON, AMIN, WRIGHT AND EDWARDS*

This chapter looks at the cases of *Keenan*, *Middleton*, *Wright*, *Edwards* and *Amin*. All involve deaths in prison custody.⁵⁷ We examine the role of case law in the process of policy development in prisons and in prison healthcare. The chapter looks at the case of *Keenan* and its impact on segregation, the case of *Middleton* and the way in which it has shaped the practice of inquests, and the cases of *Wright*, *Edwards* and *Amin* and their impact on meeting the investigative obligations under Article 2. The chapter goes on to look at the evolution of prison policies on information sharing, risk assessments, healthcare and suicide prevention. The chapter makes brief observations about the impact of these cases on police custody.

1. The cases and their context

Keenan concerned a suicide in custody of an individual with mental illness, following a period of segregation. *Middleton* concerned the investigative obligations triggered by a suicide in prison. *Wright* concerned an individual who died from an asthma attack. The case looked at the investigative mechanisms and at Article 3. *Edwards* involved a killing by a cell-mate. Both individuals had mental health problems, and the judgment discussed both the investigative obligations and the preventive measures that might have been taken to avert the risk to life. The *Amin* judgment was about the investigative obligations of Article 2 following the killing of Zahid Mubarek by his cell-mate.

The impact these cases have had on policy and practice is difficult to discern given widespread consensus that reducing deaths in custody is an aspiration that should be embraced. As one senior manager within the National Offender Management Service (NOMS) put it: “I don’t need persuading that trying to stop people dying is a good idea”.

A wide range of initiatives feed into efforts to reduce deaths in custody. In 2004 the Joint Committee on Human Rights (JCHR) published a report on deaths in custody

57 *Keenan v UK* (2001) 33 EHRR 38; *R (on the application of Middleton) v Coroner for the Western District of Somerset* [2004] 2 AC 182; *R (on the application of Amin) v S/S for the Home Department* [2004] 1 AC 653; *R (on the application of Wright) v S/S for the Home Department* [2001] 1 Lloyd’s Rep Med 478; [2001] EWHC Admin 520; 2001 WL 606447; *Edwards v UK* (2002) 35 EHRR 19.

which examined prison overcrowding, risk assessment, healthcare and more.⁵⁸ The report's "principal conclusion" was the need for a central forum to address the problem of deaths in custody. The Forum for Preventing Deaths in Custody, bringing together government, police, healthcare, prisons, coroners and the independent sector, met for the first time in November 2005. The government response to the JCHR report noted a range of initiatives relevant to reducing deaths in custody.⁵⁹

2. The impact of these cases

This project looked at national level prison policies and spoke to a number of those involved in their development in order to discern the imprint of these cases and to understand the policy-making process. The cases all have implications for the delivery of healthcare in prisons and we spoke to individuals involved in delivery.⁶⁰ We also spoke to some police forces about their custody work.

2.1 The process of change: prisons

In 2008 new structures have been put in place, as part of the restructuring of the Ministry of Justice (MOJ), bringing together the Probation Service and HM Prison Service, under NOMS. NOMS is now responsible for prison policy and for delivery of prison services through HM Prison Service and through private suppliers.

Prison policy and practice are governed by legislation in the form of the Prison Rules, Prison Service Orders (PSOs) and Prison Service Instructions (PSIs). PSOs and PSIs are developed nationally, reflect relevant legislation and include rules, regulations and guidelines by which prisons are governed. PSOs and PSIs are mandatory – PSOs are used for rules intended to be in place for an indefinite period. PSIs have an expiry date and are also used to amend PSOs.⁶¹ Individual prisons must comply with PSOs and PSIs and will use them as the basis for local policies, guidelines and practices. One NOMS policy maker comments:

(t)here's enough flexibility in a PSO to allow governors to mould it to their own needs. They should take hold of it and develop their local instructions.

NOMS policy staff told this project that PSOs and PSIs are subject to a three-yearly review process. This takes into account a variety of sources including case law, investigations, legislation, best practice, learning from previous incidents, and recommendations from inquiries.

58 <http://www.publications.parliament.uk/pa/jt200405/jtselect/jtrights/15/1502.htm>.

59 <http://www.publications.parliament.uk/pa/jt200506/jtselect/jtrights/60/6002.htm> and <http://www.publications.parliament.uk/pa/jt200405/jtselect/jtrights/69/6902.htm>

60 Interviews with other prison staff would give a more complete picture but the approval process was too lengthy for this project.

61 <http://www.hmprisonservice.gov.uk/resourcecentre/psispsos/>

Asked about the role of case law and human rights law more generally in policy formation one NOMS senior manager noted that cases from the ECtHR had always formed part of their policy debates – including before the HRA. Legal advice was an important element of the process with a legal adviser on the NOMS management board. The aim is to be “human rights compliant” and this is a constant process:

Like all bits of law, as the courts interpret the Act and case law builds round it, actually the law moves slightly so you're not always sure which way it will move...you sometimes have to respond to movements on what you previously thought was ok.

In some cases of policy revision case law is referred to expressly. One NOMS policy-maker noted that this “helps staff understand”. He wouldn’t expect staff to read the case but a quick reference helps people implementing policy appreciate the drivers for change. One NOMS senior manager expected that Prison Governors would know leading cases and know the reasons behind policy changes, but did not think awareness of cases beyond governors was helpful. He expressed concern that staff would “worry” about applying learning from cases and the result would be confusion:

It's important we give them guidance that's based on the law but in an understandable coherent form that they can manage.⁶²

When asked about training provision for prison workers the Prison Service College told us that their training curriculum does not include specific training on human rights – although certain aspects of human rights would be integrated into various courses. “The right to life wouldn’t be covered, but the sentiments would”. Similarly Article 3 would not be covered as such but issues of treating prisoners with “respect and dignity” would.

2.2 The process of change: healthcare in prisons

Health services in the prisons of England and Wales have undergone radical changes in the last five years, with responsibility passing from the Prison Service to the National Health Service, mainly through Primary Care Trusts (PCTs), in 2003.

62 In addition to the case of *Keenan*, considered below, another instance where a direct link is identifiable between a case and policy changes, as reflected in PSOs, is with regard to the “prison babies” case (*R [on the application of P and Q] v S/S for the Home Department* [2001] EWCA Civ 1151). PSO 4801 on the Management of Mother and Baby Units notes: “in a few (legal) cases we have accepted the need to modify our approach and MBU staff have been informed of developments as they arose”. The PSO goes on to cite the case and reflects its findings in the section on age limits.

These changes were kick-started by the November 1996 report, *Patient or Prisoner?* by then HM Inspector of Prisons David Ramsbotham. The underlying principle of these changes is that of equivalence – that prisoners should be able to access the same healthcare in prison as non-prisoners do in the community.

Our interviews with healthcare professionals working with or in the prison system revealed a low level of awareness of the cases selected. Nearly all said they did not receive training or guidance on case law. They had not received and were not aware of training or guidance on human rights more generally. Healthcare professionals expressed a high level of interest in human rights and commitment to the underlying principles. One prison psychiatrist said:

*I don't work with **case law** at the front of my mind but I do work with the driving principle that this is a very marginalised under-represented group so I would say that human rights **principles** are very much at the forefront of my mind.*

Several expressed concern that they lacked the requisite knowledge to understand fully the implications of human rights for their work and to ensure they were putting human rights principles into practice. Some noted that working in prisons was – relative to the overall work of a PCT - such a small and specialised area of healthcare that they felt their work was not given appropriate priority.

Most healthcare interviewees were unsure whether case law was monitored by PCTs and the extent to which it played a role in policy development. One said that case law plays an indirect role in health policy, and another that his PCT had a legal department that would monitor case law and alert staff to relevant cases. He also mentioned best practice guidance from the Department of Health as something he felt would include learning from case law. This interviewee – who had studied human rights independently – felt that it was important that case law did play a role in the formulation of healthcare policies and that policies and procedures are seen as positive guidance, not just about risk aversion. A number of interviewees felt that Clinical Governance mechanisms help ensure compliance with human rights standards and law.

One interviewee noted that a recent driver of change around engagement with human rights has been the Healthcare Commission's introduction of human rights into its consideration of the work of PCTs:

... it has made us start to think about human rights in the way previously we have thought about equality and diversity.

Interviews revealed interesting and relevant changes in policy and practice but the cases could not be identified as particular drivers for these changes. Changes to healthcare provision have been driven by much wider considerations and institutional restructuring.

As NHS employees, rather than prison employees, healthcare professionals are not bound by PSOs, however all commented that they operate within them, one saying that this co-operation was “to enable the running of the prison as one”. Interviewees were unable to provide examples of NHS-originated prison-related policies.

2.3 Keenan: changing the use of segregation

Mark Keenan committed suicide in prison in 1993. He had a long history of mental illness. While in prison he assaulted prison officers. He was placed in segregation and had extra days of detention added to his sentence.

- The court applied the *Osman* criteria – that Article 2 is violated if authorities knew or should have known of the risk and failed to take reasonable steps that would have prevented it. No violation of Article 2 was found.
- The court held that the punishments imposed on Mark Keenan were: “not compatible with the standard of treatment required in respect of a mentally ill person. It must be regarded as constituting inhuman and degrading treatment and punishment within the meaning of Article 3 of the Convention”.⁶³

Segregation in prisons is governed by PSO 1700.⁶⁴ This was revised in the light of *Keenan*.⁶⁵ One NOMS policy maker said: “(w)e looked at the judgment with our legal advisers and identified key areas of failure”. This causation is backed up by explicit reference to the case in the PSO:

The importance of treating prisoner’s (sic) as individuals and taking into account their personal circumstances when making decisions was emphasised in the judgment of the European Court of Human Rights in Keenan v. the United Kingdom (April 2001).

The government cited the revision of the PSO as part of its response to the *Keenan* case, as reflected in the Council of Europe’s assessment of implementation:

63 *Keenan v UK* (2001) 33 EHRR 38 at para 116.

64 PSO 1700 – Segregation, available at: <http://pso.hmprisonservice.gov.uk/pso1700/default.htm>.

65 The PSO is currently under further review. This process, interviewees told this project, was initiated by the requirement that all PSOs are reviewed every three years. The current review is a “tripartite” review being carried out by Offender Health – a partnership between the Ministry of Justice and the Department of Health, and the Safer Custody Group and Security Policy Unit which operate within NOMS.

*In the view of the United Kingdom authorities, a revision of the Segregation Policy (Prison Service Order 1700) and a revision of the Prison Rules by Statutory Instrument 2005 No. 3437 have solved the problem in respect of Article 3 of the Convention.*⁶⁶

The PSO cites empirical research, in addition to the case, as a reason for ensuring the possible impact of segregation on mental health is taken into account.

One of the key changes to the use of segregation is the use of a new “Initial Segregation Safety Screen” which has to be completed by a registered nurse or a doctor within two hours of a prisoner being segregated. The screen includes specific questions that may lead to the conclusion that “there are healthcare reasons not to segregate at this time”. This conclusion must be fully taken into account by the manager authorising segregation. Our NOMS and healthcare interviewees noted the manager has to balance this with other considerations, including the safety of staff and other prisoners; healthcare workers said that whilst they can offer their opinion the final decision lies with prison officials. Most welcome this change from the previous system under which a doctor had to certify an individual “fit” for segregation. The PSO is explicit in noting that individuals identified as at risk of suicide or self-harm “must only be kept in segregation in exceptional circumstances”.

Processes for monitoring segregation have also changed. A segregation review board – including a healthcare representative – must meet within 72 hours of an individual being segregated. The Chair of the board has final authority over decisions.

The PSO notes a range of measures, clearly related to the *Keenan* case, to protect the mental health of those in segregation. These are provided as ways in which prisons can take into account individual circumstances, as referred to in *Keenan* and include removal from segregation, increasing medical support, active management of a case incorporating both medical and prison staff, and provision of listening services.

After PSO 1700 was introduced the Independent Monitoring Board (IMB) carried out a review of its implementation, concluding that all prisons were implementing the PSO, despite some “initial problems”.⁶⁷

66 Implementation of judgments of the European Court of Human Rights, Committee on Legal Affairs and Human Rights, Council of Europe: Introductory memorandum 26 May 2008.

67 Independent Monitoring Boards, Review of PSO 1700, 22 March 2005, available at: <http://www.imb.gov.uk/docs/dc-05-05.pdf?view=Binary>.

Healthcare professionals involved in segregation interviewed by this project were aware of the PSO and were aware of the need for careful consideration of mental health issues in undertaking segregation. The interviewees were not aware of the *Keenan* case, or the finding that his treatment had been in violation of Article 3, however, or the ways in which the case had influenced changes in policy.

Asked about the current use of segregation a number of interviewees expressed concern but none indicated that its current use might fall short of the findings of *Keenan*. The Prisons and Probation Ombudsman (PPO) told this project that a disproportionate number of self-inflicted deaths occur in segregation and that it remains a concern for him:

Are the conditions in seg conducive to the care of someone who is a threat to himself? Evidently not... Are we better at caring for people in seg than we used to be? Yes.

The case of *Keenan* was key in bringing about changes in the way that segregation is used, though other factors also influenced the policy review. The case prompted a review of policy aimed at ensuring segregation not be used in a way that falls short of Article 3 of the ECHR. Medical practitioners interviewed by this project were aware of these policies, though they were not aware of the *Keenan* case.

2.4 *Middleton: expanding the role of inquests*

Colin Middleton committed suicide in custody. The court examined whether or not the inquest regime, established by the Coroners Act 1988 and the Coroners Rules 1984, met the investigative requirements of the ECHR. The court held:

- that an inquest, as a means of discharging the state's investigative obligation, ought to culminate in expression of the jury's conclusion on the central factual issues;
- that narrow interpretation of the Coroners Act (1988) and Coroners Rules (1984) – outlining what the jury may do – meant that the regime did not meet the Article 2 requirements;
- that, in order for inquests to discharge the state's investigatory obligation, coroners must use a broader interpretation of "how" – in the Act and the Rules – as not simply meaning "by what means" but as meaning "by what means and in what circumstances".

The case of *Middleton* has had an identifiable effect on the work of coroners. Putting the principles of a legal case into practice is part of a coroner's everyday role and this has simplified the process of change. Further, it would be expected that legislative

change around the coronial system would reflect case law. However several interviewees with expertise in inquests referred to the implementation of the *Middleton* principles as patchy – citing the absence of national support for coroners, resources, lack of legal aid for families, and the length of time taken.

The key aspect of *Middleton* that has had an effect is the broadening of the interpretation of “how” into “by what means and in what circumstances”. Coroners have always been able to use narrative verdicts however there is agreement that the *Middleton* case has increased their use – they are being used by coroners to meet this requirement for a broader interpretation. One coroner summed up the impact:

It means that juries now are able to deliver much more detail on the events that they find to be proved...it's taking longer...more complex issues are dealt with...juries are actually being asked to make much more complex decisions and...the vast majority of juries are really living up to the task...I've had some wonderful narrative verdicts...very complex sometimes quite long...they are becoming...less inquisitorial and more accusatorial...

Deborah Cole co-director of the group, Inquest, noted:

Families were very frustrated prior to the Middleton case with the very limited, one word almost, verdicts...and the juries were very frustrated that they could have presided over an inquest for a couple of weeks and weren't allowed to express any kind of comment...it (the narrative verdict) plays a symbolic role in ordinary citizens expressing views on the conduct of state agents and the regimes and conditions within state institutions...where coroners recognise the importance of an Article 2 compliant investigation it has shone a spotlight into the closed world of the prison system...

Interviewees concurred that one impact of *Middleton* has been an increase in the length of time taken to reach verdicts and subsequent pressure on resources. One tied this to the case of *Middleton* specifically and to the Human Rights Act in general – which has brought with it increased concern about meeting the investigative obligations of Article 2:

If a case was to have lasted an hour, after the Human Rights Act it would last a day and if it was to have lasted a week it would last several weeks and prison cases very, very rarely are concluded within a few days now...And that's...because there is far more detailed investigation required to comply with the state's responsibility to investigate where life has not been protected or where life has been taken by state action...

One prison expert that we spoke to sounded caution about the impact of *Middleton*. While acknowledging that it has had a clear impact on the work of coroners he expressed doubt as to the extent these broader verdicts will have wider impact, “(t)he prison system isn’t geared to picking these things up and learning from them”. This view is echoed by others. Deborah Cole said:

*I’d like to say it had made a difference in preventing deaths but that’s a more difficult process. In the absence of proper mechanisms to ensure ‘accountable’ learning from deaths - such as a Standing Commission On Custodial Deaths, it is difficult to be positive as to the potential impact of Middleton.*⁶⁸

Another note of caution is the consistency with which the judgment has been acted upon by coroners – one interviewee summed this up by saying, “there’s a post-code lottery, depending on which coroner you get”.

Legislative reform of the coronial system was outlined by government in a draft bill published in 2006 but not yet been brought before parliament. In a written response to this project the MOJ noted that the Coroners Bill appears in the draft legislative programme for the next session:

The Bill has been drafted so as to ensure that investigations into deaths under the Bill are compatible with the ECHR as determined by Middleton. Subsection (1) of clause 8 provides that the purpose of an investigation is to ascertain who the deceased was, and when, where and by what means he or she died. Subsection (2) provides that where necessary for the purpose of avoiding a breach of Convention rights, the purpose of an investigation is to be read as including the purpose of ascertaining in what circumstances the person died.

2.5 Wright, Edwards and Amin: more elaboration of the investigative obligations

This section provides a brief outline of key aspects of the cases of *Wright*, *Edwards* and *Amin* on the investigative obligations under Article 2. The following section looks at how these investigative obligations are being met.

68 In July 2008 Rule 43 of the Coroners’ Rules was amended giving Coroners a wider remit to make reports aimed at preventing future deaths and placing an obligation on those who receive such reports to respond.

2.5.1 The case of *Wright*

Wright - who had a history of serious asthma - died in prison on November 7, 1996, as a result of a severe asthma attack. An inquest was held at which the family participated without legal representation. A key witness – Wright’s cellmate – did not give evidence. The court held:

- That where the victim had died and it was arguable that there has been a breach of Article 2, the investigation should have the general features identified in *Jordan v United Kingdom*;⁶⁹
- That the holding of an inquest may or may not satisfy the implied obligation to investigate arising under Article 2. This depended upon the facts of the case and the course of events at the inquest;⁷⁰
- That the inquest in this case did not constitute an effective official investigation, because the cell-mate was not called to give evidence and his statement was disregarded, there was no consideration at the inquest of the shortcomings in the medical treatment given to Wright; the role of the restrictions placed on the doctor primarily in charge were not considered; and the claimants were not represented at the inquest.⁷¹

2.5.2 The case of *Edwards*

Christopher Edwards was killed in custody on remand in 1994 by his cell-mate, Richard Linford, also on remand. Linford had a history of mental illness and pleaded guilty to manslaughter on the grounds of diminished responsibility. In its consideration of investigative obligations the ECtHR held:

- That the purpose of an investigation “is to secure the effective implementation of the domestic laws which protect the right to life and...to ensure their accountability for deaths occurring under their responsibility”;⁷²
- That the authorities must act of their own motion; that investigations must be independent and prompt; there must be sufficient public scrutiny and next of kin involvement;⁷³

69 *Jordan v UK* (2001) 27 EHRR 52.

70 *R (on the application of Wright) v S/S for the Home Department* [2001] 1 Lloyd’s Rep Med 478, at para 43.

71 *R (on the application of Wright) v S/S for the Home Department* [2001] 1 Lloyd’s Rep Med 478, at para 60.

72 *Edwards v UK* (2002) 35 EHRR 19 at para 69.

73 *Edwards v UK* (2002) 35 EHRR 19 at paras 70-73.

- That the lack of power to compel witnesses “must be regarded as diminishing the effectiveness of the inquiry as an investigative mechanism”;⁷⁴
- That the involvement of Edwards’ parents had not been sufficient (they were not represented; most of the inquiry was conducted in private).⁷⁵

2.5.3 The case of *Amin*

Zahid Mubarek, serving a custodial sentence in a young offenders’ institution, was, like Edwards, killed by his cell mate who had a history of violence and racism. The House of Lords upheld an appeal against the Court of Appeal’s decision that an inquiry was not required. The court held:

- That the principles held in *Jordan v UK* applied to cases not involving deliberate or alleged killing by state agents.⁷⁶ These principles were, inter alia, that the obligation to carry out an effective investigation into death in custody included, as a minimum, sufficient public scrutiny to secure accountability and an appropriate level of participation by the next-of-kin to safeguard their legitimate interests;⁷⁷
- That the family had not played an effective part in investigations held to date and that investigations to date had not been fully independent.⁷⁸

2.6 ***Meeting the investigative obligations***

The judgments in all these cases – *Middleton*, *Wright*, *Edwards* and *Amin*, had implications for the investigative obligations of Article 2.

In the case of *Amin* the direct impact was the Mubarek Inquiry whose terms of reference were:

*To investigate and report to the Home Secretary on the death of Zahid Mubarek, and the events leading up to the attack on him, and make recommendations about the prevention of such attacks in the future, taking into account the investigations that have already taken place - in particular, those by the Prison Service and the Commission for Racial Equality.*⁷⁹

74 *Edwards v UK* (2002) 35 EHRR 19 at para 79.

75 *Edwards v UK* (2002) 35 EHRR 19 at para 84.

76 *Jordan v UK* (2001) 27 EHRR 52.

77 *R (on the application of Amin) v S/S for the Home Department* [2004] 1 AC 653 at para 20.

78 *R (on the application of Amin) v S/S for the Home Department* [2004] 1 AC 653 at para 36.

79 <http://www.zahidmubarekinquiry.org.uk/>.

Government has changed the way deaths in custody are investigated as part of its efforts to ensure compliance with these investigative obligations. Since 2004 deaths in police custody are investigated by the IPCC and deaths in prison custody, approved premises and detention centres, by the PPO. This is intended to complement coroners' inquests to meet Article 2 requirements. The PPO told us that the addition of such investigations to his mandate was a huge change that reflected a variety of cases, none of which forced the government into making this change "but thoughts of Article 2 compliance were not far away". A senior NOMS policy-maker held the same view – saying that all these cases contributed to the decision to hand the investigative role to the PPO. In its response to the JCHR report on deaths in custody the government confirmed that the purpose of this change was to ensure independence in carrying out investigations:

The prime purpose of involving the IPCC and PPO in investigating deaths in custody was to ensure independence from the police and Prison Service respectively.⁸⁰

Another effect of this change in approach may be a counter to the length of time inquests take. The PPO noted that his investigations take place more quickly than inquests and assist in meeting the requirement that investigations are prompt.

One coroner told this project:

It (the HRA) has given us a great deal more to do and I think that's a good thing. These cases are having an impact. They are changing practice. They will improve things... (but) more resources are required.

2.7 Other impacts: information sharing, risk assessments, healthcare, suicide prevention

This section looks at further changes in areas of policy and practice relevant to the selected cases. It is clear that it is difficult, however, to identify a direct link between single cases and the changes. We found some indirect links, thanks to the detail and high profile of the final Mubarek inquiry, with its 88 recommendations. This case illustrates the way in which an incident, a legal judgment and an inquiry can become merged. When asked about the case interviewees were aware of the incident and the inquiry, but often less aware of the judgment. In some cases it is possible to identify a cumulative impact – though arguably of incidents as much as legal judgments. The cases of *Edwards* and *Amin* bore such similarities that both fed into relevant changes. This section briefly outlines possible impact, indirect impact and joint

80 Joint Committee on Human Rights, Second Report, Appendix 1, Government Response, available at: <http://www.publications.parliament.uk/pa/jt200506/jtselect/jtrights/60/6005.htm>.

impact, as well as feedback from interviewees about the relevance of the cases and the impact of these changes to policy and practice.

Information sharing was an issue highlighted by the court in the *Edwards* case. One key policy change in this area has been with regard to the use of Prisoner Escort Records (PER). A substantial revision of their use was introduced in 2000 (after Edwards was killed but before the ECtHR case), with a PSO binding on prisons and escort contractors and separate guidance issued to police.⁸¹ The aim of the PER is to ensure information about risk – whether to the prisoner or to others – is effectively communicated.

Healthcare interviewees acknowledged that overall systems – including records beyond the PER – had improved but expressed continued concern about incomplete records and late transfers of records. Others noted the high turnover of prisoners as a problem in ensuring good record-keeping. Interviewees commented that computer systems are limited and that different agencies – prisons, police, healthcare providers – have different systems, complicating the mechanics of sharing information. The cost of any form of integration would be enormous. One psychiatrist gave the example of an individual who had schizophrenia and was detained for six months before the psychiatrist was made aware of his being in the prison. In another case an individual whom he was in the process of assessing was sent to another prison and, whilst he sent relevant records to the receiving prison, he was not aware of a systematic approach to ensuring this happened and that records were received and made available to those that needed them.

All interviewees when asked about the impact of these cases said that risk assessment procedures have evolved. A new risk assessment form on cell-sharing was introduced in 2002.⁸² It notes:

A recent judgment by the European Court in the case of the tragic murder of Christopher Edwards, found that the Prison Service was in breach of Article 2 of the Human Rights Act in that it failed to have in place an adequate risk assessment procedure. Although improved procedures, such as the Prisoner Escort Record (PER) form have since been introduced, the murder of Zahid Mubarek at HMYOI Feltham revealed continuing weaknesses in our ability to risk assess and to track potentially violent or racist prisoners who should not share cells with other prisoners.

81 PSO 1025: Communicating Information about Risks on Escort or transfer: the Prisoner Escort Record, available at:
http://pso.hmprisonservice.gov.uk/PSO_1025_the_prisoner_escort_form.doc.

82 PSI: Cell Sharing Risk Assessment, available at:
http://psi.hmprisonservice.gov.uk/PSI_2002_026_cell_sharing_risk_assessment.doc.

In 2007 a broader policy document – PSO 2750 – on violence reduction was introduced.⁸³ This brings together “policy on violence reduction, anti-bullying and cell sharing risk assessment under one PSO”. Healthcare workers told us that risk assessment procedures had improved considerably. One notes that she felt confident such procedures would prevent situations such as those in *Edwards* or in *Amin* from arising again. Others express concern – noting the need not just for policies but for them to be implemented by the right people with the right training.

A challenge in ensuring policies on risk assessment and violence reduction are translated into practice, identified by interviewees, is capacity. One prison expert noted that the underlying principle of PSO 2750 – that conflict and risk management requires early identification of sources of conflict – was good, but that staff lacked the capacity to put this proactive approach fully into place. At HM Young Offender Institution & Remand Centre Feltham capacity pressures mean that there are now 72 individuals sharing cells⁸⁴ which increases the need for careful risk assessment, and changes staff/prisoner ratios. In July 2008 HMIP expressed concern about cell-sharing at HMP Doncaster where a number of cells had been converted to accommodate three individuals⁸⁵

In the case of *Wright* the court noted shortcomings in his medical treatment, including monitoring and treating a long-term chronic illness. Interviewees noted an improvement in this area, which they attributed to the structural changes outlined above. Most believed that there was continued scope for improvement – for example the lack of staff trained on a wide range of chronic conditions would hinder access to treatment equivalent to that received by people in the community.

Provision of mental health services and associated work on suicide prevention were also cited by interviewees as areas of change relevant to these cases. Again the drivers for these changes are multiple – overall structural change to healthcare, a shared desire to reduce suicide, academic research and, according to the PSI that outlines the changes:

83 PSO 2750: Violence Reduction, available at: http://pso.hmprisonservice.gov.uk/PSO_2750_violence_reduction.doc.

84 Numbers of prisoners change rapidly. This number was provided by a member of the Independent Monitoring Board who had visited HMP Feltham days before our interview in late August.

85 Report on an unannounced full follow-up inspection of HMP Doncaster, 11–15 February 2008 by HM Chief Inspector of Prisons.

*... existing good practice, the results of piloting in five establishments, and learning from previous incidents of suicide and self-harm.*⁸⁶

Interviewees were not aware of the specific cases playing a particular role. One of the key changes in this area has been the introduction of the Assessment, Care in Custody & Teamwork (ACCT) plans, in 2005, replacing the risk of self-harm forms.⁸⁷ The ACCT plans are premised on inter-agency and multi-disciplinary co-operation. It is not enough to identify risk, but comprehensive plans, including health plans, need to be put in place to address that risk. Healthcare interviewees, prison experts and the PPO all said that the system was an improvement. Another key change has been the introduction of mental health “in-reach” teams – new teams situated in prisons providing mental health services.

2.8 Police Custody

We spoke to a number of police officers about these cases to assess their impact on police custody. Awareness of the cases varied. Most were aware of the killing of Zahid Mubarek and the subsequent inquiry. A small number were aware of the *Edwards* case. One senior officer noted that both she and colleagues she had consulted with had not known the cases but, on reading them, “recognised the content” and “knew the principles”.

All the forces that this project engaged with noted that the main source of guidance on their custody procedures was legislation – either the Police and Criminal Evidence Act 1984 or national Guidance on the Safer Detention and Handling of Persons in Police Custody.⁸⁸

A number of police cited the killing of Mubarek as having resulted in reviews of their policies. One senior officer noted that in her force the policy review prompted by Mubarek resulted in a more explicit explanation of the importance of not cell-sharing, and reminders about the importance of risk assessments.

86 PSI: Introducing ACCT (Assessment, Care in Custody & Teamwork) – the replacement for the F2052SH (Risk of Self-Harm), available at: http://psi.hmprisonerservice.gov.uk/PSI_2005_18_assessment_care_in_custody_and_teamwork_A_CCT.doc.

87 PSI: Introducing ACCT (Assessment, Care in Custody & Teamwork) – the replacement for the F2052SH (Risk of Self-Harm), available at: http://psi.hmprisonerservice.gov.uk/PSI_2005_18_assessment_care_in_custody_and_teamwork_A_CCT.doc.

88 Guidance on the Safer Detention and Handling of Persons in Police Custody, produced on behalf of ACPO and the Home Office by the National Centre for Policing Excellence, 2006. See http://police.homeoffice.gov.uk/publications/operational-policing/Safer_Detention_and_Handlin1.pdf?view=Binary.

3. Conclusion

From our research it was apparent that these cases concerning various deaths in custody cannot be isolated from their context in order to isolate their impact on policy and practice. There is a basic level of widespread agreement that the aspiration to reduce deaths in custody is one that should be embraced. The issues that arose in the cases are complex – they are deeply embedded and impact on each other and on other areas of policy and practice. They are also affected by fundamental structural change as well as lower level policy change. Chronologies of associated change are complex since policy changes occur at different stages – including before legal judgments. For these reasons it is difficult to identify clearly the impact and chains of cause and effect. However we have seen the imprint of cases and in some they are explicitly identified as driving forces. Where these cases concern themselves with the investigative obligation it is easier to identify an impact within the broader legal system. Broader changes initiated by government are seen as having been precipitated, if not caused, by the cases collectively.

Where human rights cases have had impact awareness of the drivers for change appears to be in place at the levels of policy-makers and managers. This project was not able to engage with frontline prison workers but comments from others indicate that a low level of awareness of cases could be expected. Engagement with frontline prison health workers showed a high level of interest in human rights with many desiring more information.⁸⁹

89 It should be noted that agreeing to be interviewed for this project obviously acted as a filter, and perhaps high level of interest in human rights issues among those who agreed to be interviewed could be expected.

CHAPTER 4

THE POSITIVE OBLIGATION TO ADDRESS DIFFERENCE:

PRICE V UK

This chapter examines the case of *Price v UK*. It looks at the impact of the case on the police force involved and looks at the impact on other forces. It asks whether or not the case is still relevant in light of substantial changes relevant to detaining people with disabilities.

1. The case and its context

Adele Price, a severely-disabled person with four-limb deficiency and kidney problems, was committed to prison for seven days for contempt of court in January 1995. She was taken to Lincoln Police Station where she spent one night in a cell not adapted for a disabled person. The bed was not suitable, she had to sleep in her wheel chair, emergency buttons and light switches were out of reach and she could not use the toilet. She was seen by a doctor who confirmed that the cell was unsuitable and too cold for someone who could not move around. Next day she was transferred to New Hall Women's Prison, Wakefield and detained in their health care centre. The centre had wheelchair access and other adaptations. She stayed there for the remainder of her period of detention –three nights and four days.⁹⁰ She alleged that she was left with no option but to allow male staff to assist her with going to the toilet; and that female staff had removed her bed clothes in the presence of male staff. The government denied that these incidents had occurred.⁹¹

The court found a violation of Article 3:

*The Court considers that to detain a severely disabled person in conditions where she is dangerously cold, risks developing sores because her bed is too hard or unreachable, and is unable to go to the toilet or keep clean without the greatest of difficulty, constitutes degrading treatment contrary to Article 3 of the Convention.*⁹²

90 *Price v UK* (2001) 34 EHRR 128 at paras 7-11.

91 *Price v UK* (2001) 34 EHRR 128 at para 15.

92 *Price v UK* (2001) 34 EHRR 128 at para 30.

Two separate opinions identified further issues. Judge Bratza, joined by Judge Costa, notes that the “primary responsibility” for the violation lay with the judicial authorities. The opinion notes:

... failings in the standard of care provided by the police and prison authorities...stemmed in large part from the lack of preparedness on the part of both to receive and look after a severely handicapped person in conditions which were wholly unsuited to her needs.

However the responsibility lay with judicial authorities taking the decision to commit the applicant to an immediate term of imprisonment without at the very least ensuring in advance that there existed both adequate facilities for detaining her and conditions of detention in which her special needs could be met.⁹³

Judge Greve linked the case to the ECHR’s provisions on discrimination. She makes the point that in order to avoid unnecessary hardship – that is, hardship not implicit in the imprisonment of an able-bodied person – she has to be treated differently from other people because her situation is significantly different.

She also notes that the judge, the police and prison authorities contributed, and that each of them should have ensured that the applicant was not put into detention until special arrangements had been made such as were needed to compensate for her disabilities, arrangements that would have ensured that her treatment was equivalent to that of other prisoners.

2. The impact of the case

The case of Price relates to both police and prison detention; the judgment is not explicit in linking the violation to both settings but conditions it lists as cumulatively contrary to Article 3 include treatment experienced in both. This project focused on the impact of Price on police policy and practice, though some relevant indications concerning prison custody are mentioned.

Police we interviewed about the case of Price were largely unaware of it. Many viewed the circumstances of the case as unusual and took the view that current policy and legislation would prevent a similar situation from recurring.

93 Judges that this project spoke to were unaware of the case.

2.1 The impact of the case on Lincolnshire Police

When asked about the case of *Price*, Lincolnshire Police said they had been unable to locate relevant files and were unsure what measures had been taken by them in response to the case. They outlined a number of policies and procedures that they felt would mean a situation like *Price* would not occur now.

A Custody Policy was put in place in 2006 – five years after the case was heard in Strasbourg.⁹⁴ Lincolnshire Police said that at the time of Adele Price's detention the force did not have such a policy. They said that the new Custody Policy reflects the national Guidance on the Safer Detention and Handling of Persons in Police Custody⁹⁵ and the force's own Disability Equality Scheme.⁹⁶ Lincolnshire Police provided the examples of new custody buildings at Grantham – recently completed, and designed and constructed in accordance with Home Office Police Custody Buildings Design Guide. Further they have an ongoing project to bring their practices in line with the Safer Detention Guidance. The force commented that resources were a key issue in bringing all facilities into line with the guidance, and considered improved training for all those involved in custody work to be a main priority.

They have measures in place to ensure learning is integrated into the police force. The force is currently reviewing its Lessons Learned policy, for example, and has horizon-scanning and risk management processes, which together should ensure awareness of developments – such as court cases, IPCC reports and the work of other forces – that should affect its work. The force also works with others in the region to develop their approaches and learn from each other.

The force undertakes a human rights appraisal for all policies which identifies which areas of human rights are or might be engaged by a new or revised policy. The legal section then examines the policy in detail in order to ensure compliance with human rights obligations and those completing the initial appraisal are provided with guidance to assist in identifying possible human rights issues.

94 Lincolnshire Police Custody Policy, available at: <http://lincs.police.uk/index.asp?locID=470&docID=-1>.

95 Guidance on the Safer Detention and Handling of Persons in Police Custody, produced on behalf of ACPO and the Home Office by the National Centre for Policing Excellence, 2006. See http://police.homeoffice.gov.uk/publications/operational-policing/Safer_Detention_and_Handlin1.pdf?view=Binary.

96 Lincolnshire Police Disability Equality Scheme 2006-2009, available at: <http://lincs.police.uk/index.asp?locID=470&docID=-1>.

2.2 The Impact of Price beyond Lincolnshire

The case of *Price* was not well known among police officials interviewed by this project. However interviewees were aware of the issues raised and were able to point to policies or legislation that they felt would, or should, avoid a *Price*-like situation from arising again.

Some were able to give examples of specific considerations in detaining an individual with disabilities. One senior officer gave the examples of call bells being accessible and of shower facilities being suitable. However, this officer said that his awareness of issues of adaptation for people with disabilities derives from the Disability Discrimination Act 2005 (DDA), not from human rights law generally or from *Price*. Other officers commented on the importance of being able to recognise and respond appropriately to less visible disabilities – such as learning difficulties.

The main relevant policy documents cited by interviewees were the Guidance on the Safer Detention and Handling of Persons in Police Custody⁹⁷ and the Home Office Police Custody Buildings Design Guide, which provides basic standards for the design and construction or refurbishment of custody facilities. Compliance with the DDA – itself a requirement of the Safer Detention Guidance – was also noted as something individuals felt would forestall a recurrence. In its response to this project the MOJ noted that, “the police service is now subject to the duty to make reasonable adjustments for disabled people in respect of its carrying out of its public functions.” The MOJ notes:

It seems clear that the law has moved on since Price as the Disability Discrimination legislation imposes higher standards on the police than those required in Price, as it may be reasonable to make adjustments for a disabled person even though a failure to make such adjustments would not breach Article 3.

The Safer Detention Guidance – published since the case of *Price* was heard – is also relevant. Firstly the document includes guidance on carrying out risk assessments – which include assessing risks to the detainee.⁹⁸ The condition of the detainee forms an important part of the risk assessment. The guidance notes:

(i)n assessing these risks consideration should be given to a number of physical, mental and medical conditions that may be present.⁹⁹

97 Guidance on the Safer Detention and Handling of Persons in Police Custody, produced on behalf of ACPO and the Home Office by the National Centre for Policing Excellence, 2006. See http://police.homeoffice.gov.uk/publications/operational-policing/Safer_Detention_and_Handlin1.pdf?view=Binary.

98 Ibid, p.16.

99 Ibid, p.22.

On arrival in a custody suite “(d)etainees should be asked if they have any disability”.¹⁰⁰ The guidance also includes requirements that anyone detained be asked about medical conditions.¹⁰¹

One senior police officer’s recall of how his force operationalises these requirements suggests that he views the requirements broadly: “Anyone arrested is asked if they are suffering from any condition that might affect their detention”. The guidance notes that where officers are in doubt healthcare professionals should be consulted.¹⁰²

Disability also features in the treatment of buildings and facilities in the guidance. It notes that the needs of all custody users must be considered in order to ensure compliance with the DDA, and refers also to the relevant parts of the Police and Criminal Evidence Codes of Practice. Forces must have a policy on compliance with the DDA, and must use the Home Office Police Custody Buildings Design Guide and the Police Property Service Managers Group Custody Best Practice Document.¹⁰³

The MOJ told this project that implementation of the guidance:

... is monitored by the NPIA Safer Detention Assisted Implementation Team and subject to Peer Reviews to monitor progress and to identify noteworthy practice and share this with guidance providers and policy developers.

In January 2008, a national training programme was issued to accompany the guidance.

Another senior officer this project spoke to, also unaware of the *Price* case, referred to the Home Office Police Custody Buildings Design Guide as the source document that would prevent a similar situation from arising¹⁰⁴. He noted that there are two issues a police force needs to attend to – firstly a minimum that can be implemented within existing facilities – such as having at least one cell suited to wheelchair use, and then, more fundamentally, the requirement that new-builds fully meet the Design Guide.

At national level there are initiatives in place to improve custody. These include a National Custody Forum, the Learning the Lessons Group, and the Forum for Preventing Deaths in Custody. The MOJ described to us the role of these initiatives

100 Ibid, p.66.

101 Ibid, p.22.

102 Ibid, p.66.

103 Ibid, p.118.

104 The MOJ told us that this document refers to both human rights law and discrimination law.

in considering the broader issues of disability and custody, noting that the National Custody Forum:

... enables practitioner-based advice and practical case scenarios to be promoted to a national level for policy and guidance change.

The Learning the Lessons Group considers:

... findings from relevant court cases and advice or guidance from other groups, for example healthcare professionals.

The underlying principle of these initiatives is:

... to recognise that all individuals are vulnerable in custody but that some individuals may have greater need of additional support in view of their physical or mental condition.

As well as relevant national policies police officers told this project about practical ways they would envisage handling the detention of someone with severe disabilities.

One senior police officer, unfamiliar with *Price*, commented that in his force risk assessment procedures would include looking at whether they had a suitable place to detain a person. If they did not, then other options would be pursued – including releasing someone on bail, or using protective custody provided by social services. He notes:

In reality the options are limited – we have to make a professional judgment which could be not to detain them.

In the particular circumstances of *Price* this would not have been an option open to Lincolnshire Police.

Seeking alternatives is referred to in the Safer Detention guidance. It notes that officers must, in consultation with healthcare professionals, determine if an individual is fit to be detained.¹⁰⁵ Alternatives to police detention are to be considered.¹⁰⁶

Another senior officer comments that an option open to the police if faced with a situation such as that which arose in the case of *Price* would be to make the court aware that adequate facilities were not available and enter into a discussion with them – “there may be cases where it’s very clear that we don’t have adequate facilities”.

105 Ibid, p.66.

106 Ibid, p.43.

Looking for alternatives is an option with limited applicability in the prison sector. One NGO analyst that this project spoke to attributes the detention of individuals in unsuitable conditions, at least in part, to the prison “inability to say no”; prisons are not in a position to turn people away.

A senior NOMS policy-maker noted that where there is time – such as between conviction and sentencing – forward planning allows relevant authorities – including prisons – to explore the suitability of available accommodation, or to make appropriate plans for the detention of someone with disabilities. However in the *Price* case this was not an option open to the police or prison authorities – nor would it be if they were placed in the same situation again.

3. The relevance of *Price v UK* and continued concerns for disabled detainees

The argument that the Safer Detention Guidance and the Buildings Design Guide – one dealing largely with process, and another dealing with building design – and the obligations under the DDA would help avoid a situation like *Price* arising is a reasonable one but we cannot explicitly link this policy and legislation to the *Price* case. Neither is it possible to determine the veracity of claims that they would prevent a situation like *Price* arising again. One senior prison policy maker expressed doubt as to the extent the DDA addresses the issues raised by the case of *Price*. This interviewee saw the DDA as primarily setting down parameters that deal with the environment – requirements to put in place ramps and stair lifts, for example. However she argues that the needs of someone as severely disabled as Adele Price cannot be met simply through compliance with the DDA – there are always things specific to the individual that require careful planning. She believes the case raised more fundamental questions than through changes to process and asks whether there is a level of disability that prisons “simply cannot cope with”.

Other actors express ongoing concern about treatment of prisoners with disabilities. The Prison Reform Trust, for example, in a recent report on older prisoners, expresses concerns about ill-adapted cells and lack of access to aids, such as walking sticks.¹⁰⁷ The 2006/07 Annual Report HM Chief Inspector of Prisons notes shortcomings and, while it does not indicate the possibility of conditions of detention reaching the threshold of Article 3, it does note the possibility of DDA-focused litigation:

...the response to the needs of prisoners with disabilities remains reactive, rather than proactive. ... attempts to grapple with the new statutory duties are

107 Prison Reform Trust (2008), *Doing Time: the experiences and needs of older people in prison*, available at: <http://www.prisonreformtrust.org.uk/standard.asp?id=1470>.

*limited and patchy...reasonable adjustments, or thoughtful adaptations, are rarely in place. In one prison, there were insufficient wheelchairs for those who needed them; another had cells adapted for wheelchair users where the toilet grab bars could not easily be reached...There is clearly a considerable amount for prisons to do to comply with their new duties and responsibilities under the Disability Discrimination Act 2005. This is an area where the National Offender Management Service as a whole needs to take a lead in issuing guidance and robust standards, rather than waiting for a tragedy or costly litigation.*¹⁰⁸

Regular, independent inspection of police custody is currently evolving. HMIC and HMIP have developed a joint inspection methodology and published their first joint inspection report in 2008.¹⁰⁹ There is no public commentary on police capacity to meet the requirements of individuals with disabilities. The IPCC however, deals with relevant individual complaints. In June 2007 it concluded an investigation into the treatment of Jonathan Lea, a wheel-chair user, by West Midlands Police. The investigation found shortcomings in policies and procedures for dealing with people with disability and measured these shortcomings in relation to the DDA. A statement on the case noted that the complainant's allegation that police had deprived him of his wheelchair, thereby compromising his human rights, was not upheld: "We found no evidence of...abuse of human rights". The statement goes on to say:

*... it is equally clear that because of the force's failure to make appropriate provision for disabled detainees Mr Lea was discriminated against – that is, he was treated differently and to his detriment because of his disability and the force had no adequate reason or justification for so doing.*¹¹⁰

In this case, curiously, issues of human rights and of discrimination were viewed separately where we would have expected to see clear links between them being drawn.

108 HM Chief Inspector of Prisons for England and Wales, Report 06/07, pp.27-8.

109 Report on an inspection visit to police custody suites in Southwark Basic Command Unit 21 – 22 April 2008 by HM Inspectorate of Prisons and HM Inspectorate of Constabulary, available at: http://inspectors.homeoffice.gov.uk/hmiprison/inspect_reports/553231/southwark-pcs?view=Binary.

110 IPCC: Disability Rights Complaint: allegations of misconduct not upheld - force not meeting access duties, available at: http://www.ipcc.gov.uk/news/pr070607_leaconclusionswmp.htm.

4. Conclusion

Policy documents draw on a variety of sources and driving factors to facilitate better practice. These sources include the DDA which has brought some of the issues referred to in *Price* into sharper focus - but we have not seen evidence of the distinct human rights focus on the issue of disability and detention as a driver for change.

CHAPTER 5

DESTITUTION IN THE ASYLUM SYSTEM: THE CASE OF LIMBUELA

The case of *Limbuela* related to the denial of asylum support to a group of destitute asylum-seekers on the grounds that they had applied for asylum too late. In this chapter, we document the direct impact of the case on reducing destitution within the asylum system. We show that *Limbuela* has been interpreted narrowly by the UK Government to apply only to the specific matrix of factors arising in the case; thus, it has not had an impact on government policy in addressing the rising incidence of destitution among failed asylum-seekers.

We have also interviewed directors, managers and case workers within local authorities about the handling of applications for community care by destitute failed asylum-seekers or other people from abroad with no recourse to public funds. We have found evidence that – contrary to the narrow interpretation of the case by central government - some local authorities have interpreted the **principles** of *Limbuela* as being relevant to this area of their work. However, there is no evidence that the case has had any direct or systematic impact on decision-making by local authorities in relation to destitute claimants.

1. The case and its context

Since April 2000, asylum-seekers have been unable to claim mainstream welfare benefits and instead must apply for asylum support (financial support and/or accommodation provided by the Home Office). The UK Border Agency (UKBA) is now responsible for setting policy and issuing guidance on asylum, including support.

In January 2003, the government introduced section 55 of the Nationality, Immigration and Asylum (NIA) Act 2002.¹¹¹ Section 55 denied access to asylum support to those asylum-seekers who had not applied for asylum “as soon as reasonably practicable” after arriving in the UK.¹¹² This had the effect of singling out late asylum claimants and

111 See Annex 4.

112 A government statement in December 2003 interpreted this as being within three days of arrival. See Inter-Agency Partnership (2006), *Memorandum of Evidence: Joint Committee on Human Rights’ Inquiry into the Treatment of Asylum-seekers*, p.4.

removing them from eligibility for support, at the same time as barring them from working or accessing mainstream benefits.

A survey by refugee agencies of those refused support under section 55 – almost 9,500 individuals in 2003 - found that:

- almost 70 per cent were sleeping rough or faced imminent homelessness
- 70 per cent had difficulty accessing food each day
- almost 60 per cent were experiencing negative health effects.¹¹³

The survey found that “too many decisions under section 55 appear to be arbitrary, contradictory and unsafe”.¹¹⁴ There was no right of appeal against negative decisions, and by October 2003, section 55 cases amounted to a quarter of all the judicial review cases lodged in the High Court.¹¹⁵

In its judgment in *Limbuela* in 2005, the House of Lords dismissed the Home Office’s appeal against an earlier Court of Appeal judgment that the removal of support from three destitute asylum-seekers under section 55 was unlawful as it breached their right not to be subjected to inhuman or degrading treatment under Article 3 ECHR.¹¹⁶

The Law Lords said the Secretary of State had the power under section 55(5) of the NIA Act 2002, and the duty under the HRA, to act to avoid a breach of Convention rights. The judgment set out the minimum standard of severity that treatment must achieve before it would constitute a breach of Article 3.¹¹⁷

113 Inter-Agency Partnership (2004), *The impact of section 55 on the Inter-Agency Partnership and the asylum-seekers it supports*, p.3;
<http://www.refugeecouncil.org.uk/OneStopCMS/Core/CrawlerResourceServer.aspx?resource=2A5E5C6C-F447-4A4A-8DD8-59F5A96390B4&mode=link&guid=58737ff796474a1b87657fc5370787e4>.

114 Ibid, p.6.

115 Joint Committee on Human Rights (2007), *The Treatment of Asylum-seekers*, Tenth Report of Session 2006-7, Volume I, p.30.

116 *R (Limbuela and Others) v S/S for the Home Department* [2005] UKHL 66. Full judgment at: www.publications.parliament.uk/pa/ld200506/ldjudgmt/jd051103/adam-1.htm.

117 In para 8, Lord Bingham notes that the threshold would be crossed when “an individual applicant faces an imminent prospect of serious suffering caused or materially aggravated by denial of shelter, food or the most basic necessities of life. Many factors may affect that judgment, including age, gender, mental and physical health and condition, any facilities or sources of support available to the applicant, the weather and time of year and the period for which the applicant has already suffered or is likely to continue to suffer privation”.

Key principles arising from the case are:

- Treatment is inhuman or degrading if, to a seriously detrimental extent, it denies the most basic needs of any human being.¹¹⁸
- Where the inhuman or degrading treatment or punishment results from acts or omissions for which the state is directly responsible, there is an absolute obligation on the state to refrain from such conduct.¹¹⁹
- It is not just a question of "wait and see". The Secretary of State has the power to avoid the breach.¹²⁰
- The threshold test was whether "the treatment to which the asylum-seeker was being subjected by the entire package of restrictions and deprivations that surrounded him was so severe that it could properly be described as inhuman or degrading treatment within the meaning of [Article 3]".¹²¹

2. The impact of the case

2.1 Impact on the application of section 55

In this section, we examine the impact of *Limbuella* on the application of section 55 and the guidance issued to case workers.

Interviewing and assessments of eligibility under section 55 were suspended on 21 May 2004, following the Court of Appeal's judgment,¹²² and an interim approach to section 55 decision-making was introduced in June 2004.¹²³

Figures show the immediate impact that the Court of Appeal judgment had on the application of section 55. In 2003, around two thirds of asylum-seekers referred for a section 55 decision were denied support;¹²⁴ in 2004, the figure was less than 10 per cent.¹²⁵

118 *R (Limbuella and Others) v S/S for the Home Department* [2005] UKHL 66 at para 7.

119 *R (Limbuella and Others) v S/S for the Home Department* [2005] UKHL 66 at para 53.

120 *R (Limbuella and Others) v S/S for the Home Department* [2005] UKHL 66 at para 62.

121 *R (Limbuella and Others) v S/S for the Home Department* [2005] UKHL 66 at para 58.

122 *The Secretary of State for the Home Department v (1) Wayoka Limbuella (2) Binyam Tefera Tesema (3) Yusif Adam* Case No: C/2004/0383, 2/2004/0384 & C/2004/0277 21 May 2004; full judgment at <http://www.asylumsupport.org.uk/docs/limbuella.pdf>.

123 Home Office (2005), *Asylum Statistics United Kingdom 2004*; <http://www.homeoffice.gov.uk/rds/pdfs05/hosb1305.pdf>.

124 Home Office (2004), *Home Office Statistical Bulletin: Asylum Statistics United Kingdom 2003*; <http://www.homeoffice.gov.uk/rds/pdfs04/hosb1104.pdf>.

125 *Ibid.*

Following the House of Lords judgment in November 2005, there was a further sharp fall both in the number of asylum-seekers being certified as section 55 cases, and in the proportion of those applicants deemed ineligible for support.¹²⁶ The figures for 2006¹²⁷ and 2007¹²⁸ show an increase on 2005, but remain significantly below the pre-*Limbuela* levels.

This table presents available figures from 2003 to 2007.

Year	Number of asylum-seekers referred for section 55 decision	Number of applicants deemed ineligible for support under section 55
2003	14,760	9,410
2004	10,570	1,360
2005	3,780	355
2006	Not available	910
2007	Not available	990129

The impact of the case is clearly visible in revised guidance issued to case owners and policy teams in July 2007.¹³⁰ The guidance explicitly adopts the destitution threshold set out in *Limbuela*: that where an applicant has no alternative means of support, including overnight shelter and basic provisions such as food and access to sanitary facilities,

126 Home Office (2006), *Home Office Statistical Bulletin: Asylum Statistics United Kingdom 2005*; <http://www.homeoffice.gov.uk/rds/pdfs06/hosb1406.pdf>.

127 Home Office (2007), *Home Office Statistical Bulletin: Asylum Statistics United Kingdom 2006*; <http://www.homeoffice.gov.uk/rds/pdfs07/hosb1407.pdf>.

128 Home Office (2008), *Asylum Statistics Fourth Quarter 2007: United Kingdom*, <http://www.homeoffice.gov.uk/rds/pdfs08/asylumq407.pdf>; Home Office (2007) *Asylum Statistics Third Quarter 2007: United Kingdom*, <http://www.homeoffice.gov.uk/rds/pdfs07/asylumq307.pdf>; Home Office (2007) *Asylum Statistics Second Quarter 2007: United Kingdom*, <http://www.homeoffice.gov.uk/rds/pdfs07/asylumq207.pdf>; Home Office (2007) *Asylum Statistics First Quarter 2007: United Kingdom*, <http://www.homeoffice.gov.uk/rds/pdfs07/asylumq107.pdf>.

129 This figure does not include the small number of applicants who were initially refused support under Section 55 but were subsequently granted support following a reconsideration of that decision.

130 Immigration and Nationality Directorate (2007), *Asylum Support Policy Bulletin 75: Section 55 guidance*, p.17; <http://www.ind.homeoffice.gov.uk/sitecontent/documents/policyandlaw/asylum-supportbulletins/accesstosupport/>.

support should be provided to prevent a breach of Article 3, even if the claimant is judged have claimed late.¹³¹ Case owners are advised to be alert to health or other relevant factors. Vulnerabilities may include age and illness, in particular HIV. Applicants who are pregnant should normally be supported.¹³² No asylum applicant should be refused support under section 55 without first being invited to attend an interview.¹³³ Cases involving victims of torture or rape must be treated “with particular care and sensitivity”.¹³⁴

A senior lawyer within UKBA said the agency saw *Limbuella* as being about the detailed application of a known principle: what the judgment did was to take “a different view on how the acts and omissions of the agency actually amount to treatment of an individual in a way that engages Article 3”. The effect was to change “quite markedly” the way the statute was used in practice.

The interviewee said it is challenging in a large and geographically dispersed organisation to ensure that frontline staff are aware of case law. The channels used (intranet postings, email alerts and briefing through line management chains) would depend on how “significant, urgent and wide-ranging” the implications of a particular case were. In doing so, he said, the agency would explain the context of why the change was necessary.¹³⁵

2.2 The narrow interpretation of *Limbuella* by UKBA

2.2.1 The use of section 55 to refuse subsistence only claims

We have seen that *Limbuella* has had a direct and quantifiable impact in reducing the numbers of destitute asylum-seekers refused support under section 55. However, the parliamentary Joint Committee on Human Rights (JCHR) has raised concerns that section 55 is still being used to refuse cash-only support claims from applicants with accommodation.¹³⁶

131 Ibid, p.3; while the pre-*Limbuella* section 55 guidance alerted caseworkers to the risk of breaching Convention rights, and specifically mentioned Articles 3 and 8, it did not give any indication as to how to apply the test in practice. See www.asylumsupport.info/bulletin75.htm.

132 Ibid, p.32.

133 Ibid, p.2.

134 Ibid, p.9.

135 This project has not been able to engage with regional case owners under the UKBA to sample levels of awareness of HRA case law.

136 Such as people staying with friends. See: *The Treatment of Asylum-seekers*, p.31.

The continued use of the section 55 provision to deny support in subsistence-only cases leaves many asylum-seekers reliant on ad hoc charitable support and with no regular means of providing for their basic daily necessities. We believe that this treatment does not comply with the House of Lords Limbuela judgment, and is in clear breach of Article 3 ... We recommend that section 55 be repealed.

This view has been echoed by, among others, the Independent Asylum Commission¹³⁷ and the Inter-Agency Partnership (IAP) of the UK's leading refugee agencies.¹³⁸ The IAP notes that, under section 55, the burden of proof placed on the asylum-seeker is high, and the decision to refuse support heavily influenced by subjective perceptions of the applicant's credibility.¹³⁹ The IAP argues that the charitable sector is not able to provide sustainable support to asylum-seekers and that to require each claimant to prove this places an unnecessary burden on them.¹⁴⁰

One London-based advocacy organisation said even where subsistence-only claimants have serious health issues, refusals of support under section 55 have not been overturned on appeal. This suggests that although the number of cases may be small, the effect for individuals who may be living in insecure accommodation and without the means of subsistence could be severe.¹⁴¹

A senior UKBA official confirmed that repeal of section 55 "will be considered" as part of a wider process of legal simplification of asylum law.¹⁴²

137 Independent Asylum Commission (2008), *Deserving Dignity: The Independent Asylum Commission's Third Report of Conclusions and Recommendation*, p.33; www.independentasylumcommission.org.uk.

138 *Memorandum of Evidence: Joint Committee on Human Rights' Inquiry into the Treatment of Asylum-seekers*, p.5-6.

139 For example, the guidance on section 55 states that the "well-presented and clean shaven" appearance of an applicant might call into question the veracity of his account. The IAP says this ignores the fact that many cultures place a high value on appearance when presenting to authorities.

140 *Ibid*, p.6.

141 We also heard evidence that *Limbuela* has been used by advocacy organisations to press for better housing conditions for asylum-seekers who do qualify for both accommodation and subsistence from UKBA. An interviewee in the Welsh Refugee Council said he had used the case to argue that in some instances requiring asylum-seekers to share accommodation was inhuman or degrading.

142 The draft Immigration and Citizenship Bill was published in July 2008; our interviewee confirmed that asylum support was "in the frame" as part of the reform of the legal framework for immigration, but gave no timeframe.

2.2.2 Destitution among failed asylum-seekers: the use of section 4

There is a significant body of research about the rising incidence of destitution, particularly among failed asylum-seekers.¹⁴³ In this section, we show that *Limbuella* has not been interpreted as applying to failed asylum-seekers either by UKBA or by the Asylum Support Tribunal.¹⁴⁴

Individuals whose asylum claims have been refused can apply to the UKBA for support under section 4 of the NIA Act 2002. To qualify for this support, they must have either signed up to return voluntarily or be unable to leave the UK through no fault of their own.¹⁴⁵ UKBA case owners have been given guidelines to help them assess whether individuals will face destitution if they are denied support under section 4.¹⁴⁶ The guidelines do not expressly refer to *Limbuella*, the ECHR or Article 3.¹⁴⁷

Attempts have been made at the Asylum Support Tribunal to invoke *Limbuella* in support of claimants denied support under section 4. Two “landmark” decisions indicate that the fact of destitution, per se, is not a violation of the Convention and the *Limbuella* judgment is not to be interpreted as such.¹⁴⁸ In these two decisions, appeals for section 4 support by a Palestinian and an Iranian Kurd are rejected because the individuals, though destitute, fail to meet at least one of the other necessary criteria.

143 See for example: Inter-Agency Partnership (2008), *Destitution tally: an indication of the extent of destitution among asylum-seekers and refugees*, http://www.refugeecouncil.org.uk/NR/rdonlyres/D446ACE9-9F10-442D-A1A8-B7D53DD1C3A6/0/IAP_Destitution_Tally_Jan08.pdf; Refugee Action (2006), *The Destitution Trap: Research into destitution amongst refused asylum-seekers in the UK*, http://www.refugee-action.org.uk/campaigns/documents/RA_DestReport_Final_LR.pdf; Amnesty International (2006), *Down and Out in London: The road to destitution for failed asylum-seekers*, http://www.amnesty.org.uk/uploads/documents/doc_17382.pdf; The Joseph Rowntree Charitable Trust (2008), *Not Moving On: Still Destitute in Leeds*, <http://www.jrct.org.uk/text.asp?section=0001000200030006>; *West Midlands No Recourse to Public Funds Conference: focus on asylum-seekers* (2008), <http://www.wmlga.gov.uk/documents/NRPF%20conference%20report%20with%20appendices.pdf>.

144 The body which hears appeals against decisions made by the UKBA.

145 This may be because they are too ill to travel **or** have outstanding representations with the Home Office such as a fresh claim for asylum or a Judicial Review. In addition, women in the late stages of pregnancy or who have babies less than six weeks old qualify for section 4 support. See <http://www.bia.homeoffice.gov.uk/asylum/support/>.

146 Immigration and Nationality Directorate (undated), *Asylum Support Policy Bulletin 4: Determining whether persons who apply for asylum support are destitute*.

147 Note, however, that the threshold for destitution under section 4 is less severe than that in the *Limbuella* judgment and applied under section 55. A claimant is deemed destitute if he **either** does not have adequate accommodation or any means of obtaining it **or** he cannot meet his other essential living needs, allowing the possibility of subsistence only claims.

148 See ASA/06/09/14132 and ASA/06/04/13140; <http://www.asylum-support-tribunal.gov.uk/public/landmarkDecisions.aspx>.

The applicants' destitution was not the consequence of a deliberate administrative act; rather, the solution to their destitution lay in their own hands by voluntarily leaving the UK.¹⁴⁹

By the latest count, there are an estimated 283,000 failed asylum-seekers in the UK.¹⁵⁰ As of December 2007, approximately 9,140 individuals were receiving section 4 support.¹⁵¹ Advocacy organisations and social care directors and managers within local authorities expressed concern about the way section 4 support decisions are made in practice and the impact these decisions are having on levels of destitution among failed asylum-seekers.

These interviewees did **not** suggest that *Limbuela* had found any immediate application in the context of section 4, either in the courts or at a policy level. What emerged strongly in our interviews was that the application of section 4 and destitution among failed asylum-seekers was the "key, live issue" and that the UKBA "might have to consider whether section 4 was adequate", as one local authority strategic manager for asylum put it.

Several interviewees noted that the speeding up of asylum status decisions under the UKBA's New Asylum Model¹⁵² could have the unintended consequence of increasing destitution. As one put it:

*You've got more people processed quicker and refused quicker, and fewer means of support available within the community ... and at that point people go off the radar.*¹⁵³

149 This interpretation was underlined by our interviewee in the UKBA who noted that if a claimant does not qualify to remain in the UK, the fact that they are destitute is "neither here nor there. They can go back and be destitute at home".

150 National Audit Office (2005), *Returning Failed Asylum Applicants*, p.2; http://www.nao.org.uk/publications/nao_reports/05-06/050676.pdf.

151 *Asylum Statistics Fourth Quarter 2007*.

152 The aim of the New Asylum Model is to have individual case workers dealing with a case from start to finish and to conclude it within six months. See http://www.refugee-legal-centre.org.uk/C2B/document_tree/ViewACategory.asp?CategoryID=170.

153 See also West Midlands Strategic Migration (2008), *Maternity, Mortality and Migration: the impact of new communities*, p.22; http://www.wmlga.gov.uk/documents/MMM%20Document_FINAL%20Webversion.pdf.

The Asylum Support Appeals Project (ASAP) has highlighted the problem of destitution among those who are physically unable to leave the UK through no fault of their own, yet have failed to access section 4 support.¹⁵⁴ ASAP concludes that:

*UKBA's narrow criterion places an unrealistic demand on failed asylum-seekers to prove they are taking all reasonable steps to return.*¹⁵⁵

Several interviewees from local authorities and advocacy organisations noted that recent case law has thrown the issue of the UKBA's potential responsibility for the human rights of failed asylum-seekers into sharp relief. In particular, the recent case involving Slough Borough Council is likely to have the effect of narrowing the eligibility of failed asylum-seekers to receive community care support from their local authority and putting the responsibility back onto the UKBA.¹⁵⁶ Advocacy organisations expressed concern that as a result of the case longstanding recipients of community care could have their support terminated, and new applicants be refused. A strategic director for asylum said "the UKBA may have to consider the human rights issues for those people".

2.3 Impact on local authority decision-making

Local authorities are prohibited under section 54 of the NIA Act 2002¹⁵⁷ from assisting failed asylum-seekers, except when doing so would lead to a violation of Convention rights. The term given to these exceptions is "destitute plus" – that is, people who are assessed as having a need for care and attention that does not arise solely from destitution but from an additional reason such as age, illness or disability. We interviewed individuals in local authorities, from directors to case workers, to explore whether – contrary to the narrow interpretation by UKBA - they saw *Limbuela* as relevant to this area of their work.

154 They include, among others, stateless people and those whose nationality is in dispute, those who do not possess any travel or identity documents and those whose safe route home is disputed. See: Asylum Support Appeals Project (2008), *Unreasonably Destitute? A report by ASAP into the difficulties of obtaining Section 4 Support for refused asylum-seekers taking reasonable steps to leave the UK*; http://asaproject.org/web/images/PDFs/news/unreasonably_destitute.pdf.

155 Ibid, p.24.

156 *R (M) v Slough Borough Council* (2008) UKHL 52. This case established that an able-bodied person's need for a refrigerator in which to keep HIV medication did not amount to "need of care and attention" under section 21 of the National Assistance Act 1948 so as to entitle him to residential accommodation from his local authority. "Care and attention" had to mean something more - a need to be "looked after", beyond merely the provision of a home and the means of survival. Only if a person already needed section 21 care and attention under this definition is the local authority responsible – "otherwise the responsibility falls on central government" (para 41). Full judgment at <http://www.parliament.the-stationery-office.co.uk/pa/ld200708/ldjudgmt/jd080730/rmfc-1.htm>.

157 Section 54 removes the rights of European Economic Area nationals and their dependants, failed asylum-seekers and overstayers to community care assistance. See <http://www.islington.gov.uk/Health/ServicesForAdults/nrpf/eligibility.asp>.

2.3.1 Relevance of *Limbuella* to local authorities

In our survey of legal directors in England and Wales, around half of the 25 respondents who answered the relevant question had not heard of *Limbuella* and none had changed policy because of it.¹⁵⁸

Local authority interviewees generally noted that *Limbuella* was not “high on the radar” of local authorities compared to case law more directly concerned with their responsibilities.¹⁵⁹

However, some local authority interviewees said they saw the general principles of the case as being relevant to their work. One director of a large adult social care department said:

Limbuella is very helpful for drawing a bottom line ... Limbuella sets that context where – as it should – the Human Rights Act sets a higher order of things and says ... ‘you cannot be treated lower than this standard’.

He suggested that this principle could be of particular relevance to local authorities with few asylum-seekers who are faced with unfamiliar challenges such as a large influx of migrant workers living in destitute conditions. He said the case could regain prominence in relation to destitution among newer groups of European migrants who have not developed networks of support (and who might, in future, face restrictions on their entitlement to benefits).

One strategic manager for asylum in a metropolitan authority agreed that *Limbuella* was “not a key case” for local authorities. However,

There are interesting messages that come out of Limbuella which ... all public bodies need to be aware of – that it’s not just actions, it can be inactions [that can have an effect].

We interviewed one local authority manager whose team has developed its own human rights assessment form with key cases, including *Limbuella*, on the front sheet.¹⁶⁰ The manager said case law is a “lingua franca” in her team and is routinely referenced in individual assessments to ensure accountability:

158 Six of the 36 legal directors who responded to all or part of the survey said asylum was not a significant issue in their area.

159 An NRPF team manager in a London borough said that for him, *Limbuella* was a “small piece of a bigger picture” and got “mashed up” in the interface between the HRA, community care legislation and immigration law.

160 See Annex 5.

*Our starting point is the difference between a power and duty ... Some local authorities may err on the side of only acting where they have a duty ... and not on a more generous application of utilising their powers. Whereas we as a team will always look at what we **can** do and ask 'where's the case law that backs us up on that?'*

We found some evidence that advocacy organisations rely on *Limbuela* when claimants who are “destitute plus” meet resistance to their community care application. One solicitor for a housing charity said *Limbuela* had “given ... a sense of the line to be drawn, below which people can't be allowed to go”.

2.3.2 Variation in practice between local authorities

There is considerable variation in the way that local authorities discharge their duty to identify and support those who are “destitute plus” to avoid breaches of Convention rights.

A survey of 26 authorities by the No Recourse to Public Funds (NRPf) network in 2006 found that community care, mental health and human rights assessments vary by, and sometimes within, authorities.¹⁶¹ More than half of the respondent authorities had an “ad hoc” approach to assessment, with responsibility split between different service departments.¹⁶²

One interviewee, who co-ordinates a regional group of local authorities, noted that hard-pressed authorities will effectively set the bar higher than those with fewer claims for community care. The director of a large social care department noted that resource pressure has, in some areas, bred “competitive behaviour” between authorities. Interviewees also raised the problem of “advice deserts”, suggesting that case law principles only come into play if claimants have an advisor pressing their case.

There are significant initiatives to bring about greater clarity and consistency among local authorities. Among these are the NRPf network¹⁶³ and the Asylum Task Force¹⁶⁴ of directors of adults' and children's social services.

161 Islington Council (2006), *Destitute People from Abroad with No Recourse to Public Funds: a survey of local authorities*;
http://www.islington.gov.uk/DownloadableDocuments/HealthandSocialCare/Pdf/nrpf_survey_local_authorities.pdf.

162 One local authority, where there appeared to be confusion about NRPf obligations, indicated that women who had been told they were ineligible for support had offered their children up for adoption.

163 The NRPf network, which is partly funded by the UKBA, is chaired by LB Islington and has more than 250 members, mostly other local authorities. See:
http://www.islington.gov.uk/Health/ServicesForAdults/nrpf_network/default.asp.

164 <http://www.adss.org.uk/committee/asylum.shtml>.

The NRPf network has drawn up guidance on assessing and supporting people with no recourse to public funds, including guidance on making human rights assessments.¹⁶⁵ Their assessment form is structured around Articles 3 and 8. *Limbuela* is not cited expressly and nor was it singled out in our interview with a leading member of the network as having influenced the assessment form. The network does not have a formal case law monitoring role; however, one team manager said that “if there have been cases with particular impact the implementers will pick it up and often distribute [it] to other authorities”. Case updates came primarily from the authority’s legal department and not from the Home Office. The interviewee said local authority practitioners who belonged to the network were increasingly aware of their duties in this area “but it hasn’t filtered up to their managers”.

2.3.3 Broader climate of decision-making

Our interviews explored with local authority directors and managers the influence on their decision-making of the broader climate around human rights and asylum.

Some interviewees in English authorities noted that the adversarial climate in which they work produced defensive attitudes to human rights. As one strategic manager for asylum and persons from abroad in a metropolitan authority said:

[Local authorities] are beaten around the head quite substantially by solicitors who seek to challenge virtually every decision we make. That ...is a negative side to human rights – you get into a very defensive position in terms of trying to justify your own decisions rather than looking at how you can use human rights to improve [services].

Most of our local authority interviewees agreed that decision-making about the support due to failed asylum-seekers was made more difficult by the lack of central government reimbursement for NRPf work and the lack of Home Office guidance and regulation.¹⁶⁶ Our interviewee on the Asylum Task Force said that local authorities had been reticent about raising the funding issue publicly because they were:

... cognisant that if they make too much noise, there’s a danger of opening up another, more dangerous political agenda locally ... They are worried about a press debate which feeds the far right ... So there’s a silence on it and a reticence in coming forward and saying ‘there’s a baseline’.

165 http://www.islington.gov.uk/Health/ServicesForAdults/nrpf_network/policy_guidance.asp.

166 In 2006, the NRPf network asked the Home Office to issue interim guidance to and regulations for local authorities, and to establish a shared database on who is getting local authority support in order to minimise fraud and ensure individuals are adequately supported. A leading member of the NRPf network told us this had “come to nothing”. See *Destitute People from Abroad with No Recourse to Public Funds: a survey of local authorities*, p.11.

These comments illustrate how the political climate around an issue can restrain debate, which may in turn influence the context in which case law is considered and acted upon. Our interviewee in the Welsh Refugee Council suggested that the climate there was different. Failed asylum seekers in Wales qualify for free health care, unlike in England, and ministers refer to the HRA in their speeches.

3. Conclusion

We have seen that *Limbuela* has had a direct and quantifiable impact on reducing “beginning of process” destitution by changing the way section 55 is applied in policy and practice.

We have not been able to identify a direct impact of *Limbuela* in reducing “end of process” destitution. Contrary to the position of the UKBA, some of our local authority interviewees **do** see the case as having relevance for their work in setting a baseline of acceptable treatment and reinforcing the principle that omissions as well as actions can breach Convention rights. However, all our local authority interviewees said subsequent case law more directly applicable to local authorities was significantly more influential.

Our interviewees in local authorities and advocacy organisations said that destitution among failed asylum-seekers, and issues surrounding the application of section 4, are now the key challenge. As far as we are aware, a case has not been made in the courts or at a policy level as to whether the matrix of factors causing destitution among failed asylum-seekers (and, through bureaucratic shortcomings, among some people still in the asylum system) might amount to “acts or omissions for which the state is directly responsible” as established in *Limbuela*. What does seem clear is that the emerging context of destitution in the UK presents challenges to the UKBA and to local authorities in which the general principles of the *Limbuela* case might potentially have resonance.

CHAPTER 6

BALANCING RIGHTS: THE CASE OF EAST SUSSEX¹⁶⁷

The *East Sussex* case related to the issue of “no lifting” policies and the need to balance the dignity and integrity of service users with the safety of care staff (section 1). In this chapter, we examine the impact of the case on manual handling policy and practice by public authorities, with a focus on the primacy of individual risk assessment (section 2). We also examine the factors limiting its impact (section 3) and the changing public policy context in which the principles must be implemented in the future (section 4).

1. The case and its context

Two adult sisters, A and B, have profound physical and learning disabilities and are cared for by their mother (X) and stepfather (Y). In order to carry out many daily activities the sisters need to be moved and handled by others. Central to this case was a dispute between the family and East Sussex County Council (ESCC), as to whether moving and handling should always be done using hoisting equipment, as ESCC stipulated on health and safety grounds, or sometimes manually - as X and Y preferred, because the sisters found the hoist painful and distressing. The council had refused to employ care workers in the family home and sought to place the sisters in residential care.¹⁶⁸

Some key principles reinforced by the case are:

- Where there is a blanket ban on manual handling, Article 8 is engaged as it protects the disabled person’s dignity and their physical and psychological integrity, including their right to participate in the community and have access to cultural and recreational activities.¹⁶⁹

167 http://83.137.212.42/sitearchive/DRC/the_law/transcripts_of_key_judgments/a_and_b_v_east_sussex_county.html.

168 For more background on the case, see: http://83.137.212.42/sitearchive/DRC/library/policy/health_and_independent_living/high_court_ruling_on_manual_li.html.

169 R v East Sussex County Council Ex parte A, B, X and Y [2003] EWHC 167 at para 99. The judgment noted that Article 3 could also be engaged where the consequence of failing to lift A or B manually might result in them sitting in bodily waste or on the lavatory for hours. Leaving disabled people as a matter of policy or protocol to drown in the bath or perish in a fire could engage Article 2 (para 114).

- The state has a positive obligation to take appropriate measures designed to ensure as far as possible that a disabled person is not "so circumscribed and so isolated as to be deprived of the possibility of developing his personality".¹⁷⁰
- Individuals like A and B require an enhanced degree of protection under human rights legislation; in order to avoid discriminating it is sometimes necessary to treat people in different circumstances differently.¹⁷¹
- Certain types of manual handling policy are likely to be unlawful. In the context of community care, these are: "no lifting"; no lifting unless life is at risk, and no lifting in every instance where equipment can effect the transfer.¹⁷²
- Care staff also have rights, which must be balanced proportionately with those they care for; moreover, hoisting is not inherently undignified. In each and every case, "individual assessment is all".¹⁷³

Under the Manual Handling Operations Regulations of 1992,¹⁷⁴ employers are required, so far as reasonably practicable, to avoid (but not eliminate) the need for employees to undertake manual handling operations which involve risk of injury.¹⁷⁵ Commentaries on this case say the adoption of "no lifting" policies arose from misunderstandings or over rigid interpretations of these regulations. The Disability Rights Commission (DRC), which intervened in *East Sussex*, singled out Royal College of Nursing (RCN) guidance as particularly unhelpful:

Most of the problems with manually lifting policies have resulted from adherence to the RCN guidance which advises that '...the manual lifting of

170 R v East Sussex County Council Ex parte A, B, X and Y [2003] EWHC 167 at para 99; for an analysis of how Strasbourg jurisprudence (notably *Botta v Italy* [1998] 26 EHRR 241), has interpreted the meaning of Article 8 see paras 67-122.

171 R v East Sussex County Council Ex parte A, B, X and Y [2003] EWHC 167 at para 93. In its submission to this project, the Ministry of Justice said it agreed with this principle, which, it notes, forms the basis of the Disability Discrimination Act (DDA) 1995 duty of reasonable adjustment for providers of services, the first stage of which pre-dated the East Sussex judgment. The DDA 2005 amended the 1995 Act and introduced a range of new duties for public authorities.

172 R v East Sussex County Council Ex parte A, B, X and Y [2003] EWHC 167 at para 154.

173 R v East Sussex County Council Ex parte A, B, X and Y [2003] EWHC 167 at paras 118, 122, 128.

174 http://www.opsi.gov.uk/SI/si1992/Uksi_19922793_en_1.htm.

175 For analysis of how 'reasonably practicable' and 'risk' have been interpreted by the courts, see *R v East Sussex County Council Ex parte A, B, X and Y* [2003] EWHC 167 at paras 49-66

*patients is eliminated in all but exceptional or life threatening situations’.*¹⁷⁶

The *East Sussex* judgment articulated a framework of principles for the interpretation and application of the 1992 Regulations. It said the principles were concerned only with care workers supporting disabled people in their own homes.¹⁷⁷ Accordingly, our interviews have focused primarily on those managing the provision of home care, those training or advising home care staff, and practitioners (such as occupational therapists) providing services in the home. However, there is evidence that some public authorities and advocacy organisations have interpreted the case as being applicable to other care settings such as hospitals and residential homes and where possible our interviews have explored this wider application of the *East Sussex* principles.

2. The impact of the case

In this section, we examine the variability in manual handling policy and practice that existed at the time of the *East Sussex* judgment (section 2.1). We explore different types of impact identified by our interviewees. These include a “bottom up” influence on professional practice and debate (section 2.2) and impacts on policy and guidance (section 2.3), training (section 2.4) and day-to-day service delivery (section 2.5). These are qualitative findings which reflect the experiences of randomly sampled individuals and authorities and may not represent wider trends.

2.1 Manual handling before East Sussex

The DRC said that the *East Sussex* case was:

*... the tip of a ‘no lifting’ iceberg: stories abound of disabled teenagers going to school in nappies because no one is allowed to lift them on to the toilet and of older disabled adults unable to leave their houses because their carers are forced to rely on hoists...*¹⁷⁸

176 http://83.137.212.42/sitearchive/DRC/newsroom/news_releases/2003/no_lifting_bans_on_home_care.html. See Royal College of Nursing (1996), *Code of Practice for Patient Handling*. The *East Sussex* judgment, at para 47, noted that the RCN guidance was “not necessarily an entirely safe guide” to the handling of incapacitated people in their own homes, and that guidance issued in 2002 by the Health and Safety Executive (HSE), in consultation with the DRC and the Department of Health, was the most relevant guide. See Health and Safety Executive (2002), *Handling Home Care: Achieving safe, efficient and positive outcomes for care workers and clients*.

177 *R v East Sussex County Council Ex parte A, B, X and Y* [2003] EWHC 167 at para 124.

178 Human Rights Culture – A Social or Legal Phenomenon? Speech by Bert Massie to the UCL and Bindmans annual debate, 15 May 2007; http://83.137.212.42/sitearchive/DRC/library/drc_speeches/bert_massie_speech_ucl_bindm.html.

By contrast, the Ministry of Justice told this project the case was “very much a ‘one off’ with extreme circumstances”.¹⁷⁹ This apparent discrepancy highlights the difficulty of generalising about manual handling policy and practice, which is diffused across the social care field.

The picture that emerges from our interviews is of a continuum of policy and practice rather than any clear watershed. Several manual handling advisors and service managers said their authorities had previously had policies which, though not blanket policies, were loose enough for prescriptive practices to flourish. An advisor to a range of public authorities said that only in the last five years had it become the norm for public authorities to have manual handling policies at all. Even now, many are “extremely basic” and not individualised to the organisation.

Our interviewees said the principle of balanced decision-making enshrined in *East Sussex* was not **new**: there was some earlier (non HRA) case law¹⁸⁰ and guidance, and debate in professional circles, which promoted the principle, together with the established public law principle of not fettering discretion.

Interviewees who advise a range of public authorities suggested that *East Sussex* has been more influential than these earlier cases. This was partly because, thanks largely to the DRC’s intervention, the case gained a high profile in the specialist and mainstream press, among professional networks and in a speech by the prime minister about a balanced approach to risk.¹⁸¹

In this sense, as one manual handling advisor put it, the case might have accelerated the evolution of manual handling policy without being a revolution.

2.2 “Bottom-up” change

Our interviewees suggested two broad ways in which they considered the case had exerted impact, over and above specific changes to policy and practice which we explore below (sections 2.3-2.5). We characterise this change as “bottom up” in the sense that it is primarily visible in debate and practice among peer practitioners rather than in top down guidance or instruction.

179 Ministry of Justice submission to this project, August 2008 (unpublished).

180 See *King v Sussex Ambulance NHS Trust* [2002] EWCA Civ 953 and *Koonjul v Thameslink Healthcare NHS Trust* [2000] PIQR P123. For a fuller analysis of case law in this area see Mandelstam, M. (2007), Case file: cross-arm lifts, swivel transfers, moving beds, lifting and disability discrimination in school; in *The Column*, journal of the National Back Exchange and Mandelstam, M (2002), *Manual Handling in Health and Social Care: An A-Z of Law and Practice* (London: Jessica Kingsley Publishers).

181 For a useful summary of how the case was publicised see Disability Rights Commission (2005), Disability Rights Commission submission to the Equalities Review, pp.45-7; http://www.leeds.ac.uk/disability-studies/archiveuk/DRC/DRC_final_submission_to_the_equalities_review.pdf.

Manual handling advisors and practitioners told us that one impact of *East Sussex* was to influence the terms in which manual handling issues were debated by professionals. An interviewee recalled one indicator of this shift – a national conference held shortly after the case called ‘Humanising the Load’:

A title like that speaks volumes about [how] professionals had come to regard people as inanimate objects – so East Sussex tipped people to thinking there must be a better balance.

The second was to validate the efforts of practitioners who were seeking to challenge the over-rigid interpretation of manual handling regulations. One local authority manual handling advisor noted that:

*[The judgment] ... gave me license to do what we were doing anyway ... [Previously] we were working **against** our own policy. So the case was like a ray of sunshine that allowed us to do it properly and legitimately.*

Another advisor, herself a physiotherapist, noted that:

*It's not so much that the case has **changed** practice – what it's done is to allow physiotherapists to practice without feeling that they couldn't tell anyone what they were doing.*

These experiences show how human rights cases can impact upon public authorities by reinforcing the efforts of committed professionals seeking to effect change from within. As the head of one disability organisation put it:

*Quite often the impact of legal interventions ... is that, although overtly they are challenging an organisation, what they may be doing is giving support to people **within** that organisation or that sector who want to progress in that direction. Understanding that dynamic and working with those ‘champions within’ is very important.*

2.3 Impact on policy and guidance

One immediate impact of the case was that the DRC and the parties agreed the wording of a model manual handling policy which was adopted by ESCC and which the DRC promoted to public authorities and care providers.¹⁸²

182 As far as we are aware, there was no follow up to this promotion, and none of the public authorities we interviewed on this case said they had developed policy through this route. See http://83.137.212.42/sitearchive/DRC/the_law/drc_legal_cases/interventions/r_v_east_sussex_county_council.html.

The imprint of the case is clearly visible in what is commonly described as the “gold standard” guidance, *The Guide to the Handling of People*, published in 2005.¹⁸³ The editor told us that the *East Sussex* judgment was one influencing factor in her

decision to commission a chapter on manual handling in social care, which previous editions had lacked. In addition, it had a “reinforcing effect” to be able to cite a legal judgment in support of arguments that had previously been made by often isolated practitioners. She emphasises that the guidance differs from pre-*East Sussex* editions in that it is “not prescriptive; it’s about equipping people to make balanced judgments”.

Some interviewees told us the case had influenced the development of manual handling policy or procedure in their authority. For example, a disability services manager in an English city council said the case was one of the drivers behind a joint policy for moving and handling agreed by the social services department and NHS Trusts in the city.¹⁸⁴

A manual handling co-ordinator in another English city council said the case had changed the way risk assessments were explained to staff. She was developing the council’s first corporate policy on the moving and handling of people; existing policies deal primarily with inanimate loads.

The manual handling co-ordinator for a Welsh county borough council said she had revised manual handling policy because of the case.¹⁸⁵ This interviewee noted that among the 22 authorities grouped in the Welsh Local Government Association Manual Handling Forum “there’s plenty of evidence that they all provide a balanced assessment process”. She said the forum was planning to replicate guidelines developed (with explicit reference to *East Sussex*) by Scotland’s Commissioner for

183 Smith, J (ed) (2005), *The Guide to the Handling of People*, 5th Edition (London: Back Care). This guidance was produced in collaboration with the Royal College of Nursing, the National Back Exchange, the Chartered Society of Physiotherapy and the College of Occupational Therapists.

184 With reference to *East Sussex*, the policy states that the authorities “recognise and accept that it may be unlawful to fetter the discretion of those undertaking moving and handling risk assessments by adopting restrictive or blanket policies or protocols. To that end this policy requires that designated risk assessors adopt a balanced decision-making approach in full consultation as appropriate with the person being assessed, their family, involved professionals, carers and contracted parties”.

185 The relevant section now reads: “...handling that involves manually lifting the whole or large part of a person’s weight is eliminated wherever possible. However, where this is considered necessary due to considerations affecting the client’s well being, the decision to lift clients must be made on a multi-disciplinary basis. A balanced risk assessment must be completed which considers both staff and client needs, and reduces risks to the lowest practicable level.”

Children and Young People for the moving and handling of children and young people with disabilities.¹⁸⁶

The College of Occupational Therapists (COT) has incorporated elements of *East Sussex* into its manual handling guidance, with express reference to the case and the HRA.¹⁸⁷ An interviewee from the COT said the case had brought welcome clarity to divergent professional practice: “it was a real landmark to have a case that set out some principles”.

2.4 Impact on training

All the manual handling trainers or advisors we interviewed said the principles of the *East Sussex* case were embedded in the training or advice they deliver, with or without express reference to the case. Given their specialist role, one would expect these individuals to have a greater awareness of the case than other practitioners. As one noted:

Since the case I've changed the way I ... teach ... I don't think there would be a single manual handling advisor that would not be aware of the case – but I do know there are many other professionals to whom it's relevant [who] ... may well not be aware.

One city council we interviewed used the case as the basis for problem-solving exercises, alongside broader discussion about the ECHR. This authority also used the case as a framework within which to discuss issues such as for how long it was acceptable to leave a service user lying in urine or faeces.

The disability service manager in another city council said care staff had had training on Articles 3 and 8, and that the case was raised during this discussion.

2.5 Impact on day-to-day service delivery

Identifying the case's impact on routine practice is uncertain. Our interviews suggest that policy and practice don't run on straight lines: a policy that reflects the case doesn't necessarily lead to good practice if it is not operationalised, while experienced care staff may provide a good service even with a restrictive policy.

186 Scotland's Commissioner for Children and Young People (2008), *Handle with Care: a report on the moving and handling of children and young people with disabilities*; http://sccyp.org.uk/admin/04policy/files/spo_271200Handle%20With%20Care%20Young%20Persons%20for%20Web%20200802.pdf.

187 College of Occupational Therapists (2006), *Manual Handling*, pp.15-16; http://www.cot.org.uk/members/publications/list/manualhandling/pdf/COT-Manual_Handling-text.pdf.

Some operational managers and practitioners said they couldn't disentangle their knowledge of *East Sussex* from other professional values and legislation which influenced their behaviour. As one occupational therapist in a London borough noted:

It's inherent in what we've been doing for years, way before it was called human rights. It's second nature. With a case like [East Sussex] ... you might use it as ammunition to back up your argument, but the thinking goes to our core.

Nevertheless, some interviewees identified positive impacts on their practice which they attributed at least in part to their knowledge of the case.

2.5.1 Improved transparency and accountability

Most of our interviewees stressed that *East Sussex* was primarily about the need for individualised risk assessment, not about the need for more manual handling per se. For some service users in some circumstances, the use of equipment can be more dignified than cruder manual techniques. In other instances, a risk assessment may conclude, against the wishes of a service user or carer, that it is not safe for care staff to carry out a manual handling procedure. However, our interviewees recalled instances where, in either scenario, the process of risk assessment had afforded a degree of transparency and accountability and achieved a consensual outcome based on negotiation and compromise. As one manual handling advisor said, "even if the service user doesn't get what they want, at least they're not completely disempowered".

The occupational therapists in a London borough we interviewed acknowledged that the process of risk assessment was potentially challenging to practitioners:

It complicates things. It takes you out of your comfort zone. If you've got a nice blanket policy, you don't have to start questioning your own value judgments.

Nevertheless, none of the practitioners we interviewed identified the process of risk assessment as anything other than beneficial.

2.5.2 Improved health and safety for staff

Interviewees said that the promotion of balanced decision-making was beneficial to staff, because where prescriptive policies had existed they would do lifting "on the quiet" and without protection or supervision. Several interviewees noted that a well-managed higher risk procedure was generally less hazardous to staff than a poorly

managed lower risk one.¹⁸⁸ One manual handling advisor in a local authority gave the example of administering rescue medication to a person having an epileptic fit, which involves getting the person out of a chair:

*If they were trained to deliver rescue medication, they couldn't be expected to stand by and **not** deliver it, if someone was in distress or choking ... But at least now we can do it in a co-ordinated and planned way.*

2.5.3 Enriching the concept of dignity

Some manual handling advisors and practitioners noted that parts of the *East Sussex* judgment relating to dignity and integrity were ground breaking. Practitioners gave examples of where dignity considerations had been paramount in decisions about risk assessment. Among these was the case of a morbidly obese man who had to be admitted to hospital. Previously he had been dragged out onto the street on a canvas sheet. The advisor did a risk assessment and found a way of using a hoist and trolley to wheel him out of his house with more dignity.¹⁸⁹ However, interviewees noted that central and local government initiatives to promote dignity in care meant the particular impact of *East Sussex* was hard to pinpoint.

3. Limits to impact

Our interviewees caution against overstating the overall impact “on the ground” of *East Sussex*, so far as it can be ascertained through anecdotal evidence. Our surveys of English and Welsh local authorities also suggest grounds for caution.

Our interviewees who advise a range of authorities and care providers suggest the case may have had a greater impact among specialist professionals whose practice is centrally concerned with rehabilitation (such as physiotherapists and occupational therapists) than among council home care staff, agency staff and nurses.¹⁹⁰ One interviewee with substantial experience across different care settings also noted “a much greater readiness to write older people off” compared to manual handling

188 See also Mandelstam, M (2005), 'Manual Handling in Social Care: Law, Practice and Balanced Decision Making' in *The Guide to the Handling of People*, Ch.2, p.28.

189 For more on this case, see Cookson, K (2007), *Large but Unseen: bariatric patients and manual handling* in *Cardiometabolic Risk and Weight Management* Vol 2, Issue 1.

190 After the *East Sussex* judgment, articles in some specialist nursing publications argued that the hazards of working in the community environment had generally been better addressed as part of the assessment for and delivery of individual care packages than the hazards facing nursing staff in hospitals. One noted that: “As a result of the revised interpretation of reasonably practicable by the courts, NHS trusts will need to review their no-lift policies to ensure they are not unlawful. The manual handling of patients will be more common. Nurses will be obliged to put themselves at risk of back injury and the incidence of such injuries in health care is likely to rise”. See Griffiths, R and Stevens, M (2004), *Manual handling and the lawfulness of no-lift policies*, *Nursing Standard*, Vol 18, No 21, pp.39-43.

provision for children and young people. These generalisations remind us that the impact of case law may not be uniform between sectors and different types of service user.

We identified four broad areas which, in the view of our interviewees, might limit the impact of *East Sussex* in those authorities or care providers where policy or practice is not necessarily compliant.

3.1 Lack of systematic policy review and guidance

None of our interviewees working as service managers or frontline practitioners in public authorities recalled getting specific guidance on the case through their authority. They had generally heard about the case in the media and/or sought guidance from professional associations and networks or specialist journals.¹⁹¹ Some had subsequently encountered the case in manual handling training provided by their employer, and several advisors responsible for delivering training said this was a good way to introduce frontline staff to the issue.

Manual handling advisors noted that communication channels do exist to disseminate key messages about policy and practice (for example, email lists for medical device alerts). However, as one advisor in an NHS Trust put it:

Nobody comes and puts something on my desk and says 'that's about human rights and it's relevant to you' ... From consultants to porters to everyone in between ... there's very, very few that have heard of [East Sussex] ... there's no method to cascade case law down to the relevant people.

In our survey of directors of legal services in England and Wales, a third of the 23 respondents who answered the relevant question said their authority had examined its policies in the light of *East Sussex*. Three respondents said their authority had changed its policies, while 18 per cent said their authority had issued guidance to ensure staff were aware of lessons for their everyday practice.¹⁹²

191 Practitioners and manual handling advisors we spoke to said the National Back Exchange was especially influential as an arena for debate and information; <http://www.nationalbackexchange.org/>.

192 Note that nine out of the 35 respondents who filled in all or part of the survey said their authority did not have a social services function. By way of comparison, a survey by Scotland's Commissioner for Children and Young People of Scottish local authorities' manual handling policy and practice found that none had "no lifting" policies, but some implied that equipment must be used in every situation and many "struggled to distinguish between moving and handling inanimate objects and people". The survey found that there is often wide variation in moving and handling practice and that practice does not always accurately reflect law or national policy.

These findings point to the difficulties of disseminating changes to policy or practice based on case law within large and complex organisations and to a range of different practitioners. Our interviews suggest consistency is not always achieved within a single authority, less still between authorities.

3.2 Persistence of blanket policy or practice and restrictive working cultures

It is beyond our scope to quantify the impact of *East Sussex* in terms of the continued prevalence of potentially unlawful restrictive policies. We have not found evidence of complaints about manual handling being taken to either the Parliamentary and Health Service Ombudsman or the Local Government Ombudsman. The three national disability organisations we interviewed reported few complaints about manual handling to their helplines.¹⁹³ However, we found anecdotal evidence of restrictive or “no lifting” policies both within public authorities and private providers.

One interviewee with wide experience of advising councils and care providers had encountered “shocking” practice, including authorities or care agencies who tell staff “we don’t do stairs” or “we don’t do legs” – even when the intervention would involve minimal risk (such as a verbal reminder to a stroke patient to move their hand up a stair rail).

As this interviewee put it:

Far too often, you still come across the two extremes – the extreme where people’s needs, independence and human rights are being forgotten in blind protection of staff or the other extreme where staff are inadequately protected [and] end up taking risks they ought not to.

A director of adult social care in a metropolitan authority reported investigating a complaint in which care had been delivered according to the “snooker table test”:

If you couldn’t care for the person by keeping one foot on the floor we were going to withdraw services. It was a blanket policy – and it was being done with good intent, for the safety of the workforce, but it was complete nonsense.

The occupational therapists we spoke to said “no lifting” policies persist among private care agencies they work with:

Scottish authorities also expressed a need for more guidelines and best practice models. See *Handle with Care*, pp.47-67.

193 One director of a large disability organisation noted that the low volume of complaints did not necessarily indicate that there were no problems with manual handling, but rather that those affected tended to have other priorities or be so marginalised that they had no contact with advocates or disability organisations.

You hear it from care agencies all the time ... they call us in because moving and handling isn't something they're prepared to do ... It's all driven by people being sued and care staff going off sick and claiming compensation.

Interviewees recalled instances where risk managers or health and safety officers overruled experienced manual handling advisors, including in cases where a service user's rehabilitation could be affected by the decision.¹⁹⁴

A manual handling advisor who works in a range of care settings said “blanket policies are rare on paper now” but resource constraints have the same effect of limiting practitioners' ability to make balanced decisions.

In a care setting, you will get people at the sharp end who are trying to make that judgment, but without the resources to support rehabilitation, dignity, or quality of life ... and big organisations turn their head to what's going on because they're quite happy to let staff take some risks and ... get away without having to put in place some of that more expensive provision.

Our interviewee in the COT had encountered prescriptive policies in some local authorities, including authorities who fetter their discretion by not providing, for example, stair lifts for people with MS or epilepsy, or bathing equipment.

They know people are entitled to risk assessment but they stop people coming in the front door by saying 'we don't provide that' ... custom and practice becomes hardened into policy.

She described these as “pockets of bad practice”, caused by a combination of resource constraints, poor management and supervision, limited understanding of the law and excessive risk-aversion. However, none of the practitioners or service managers we interviewed cited resource constraints as a significant obstacle to implementing the *East Sussex* principles.

3.3 Divergent perceptions of human rights

Some manual handling advisors noted that “sensationalised” media coverage had created received wisdom about the *East Sussex* case which sometimes prompted

194 We found examples of such policies, including an ambulance service protocol which notes (with express reference to *East Sussex*) that some care home staff “have in effect a no lifting policy and have been advised by their managers not to lift patients from the floor” but instead dial 999. See East Midlands Ambulance Service NHS Trust (2007), *Safer Manual Handling Policy*, www.emas.nhs.uk/EasysiteWeb/getresource.axd?AssetID=625&type=Full&servicetype=Attachment. We were also contacted by a training agency which promotes to public authorities “the need for a no-lifting approach to patient care” on the grounds that “people cannot safely lift people”. See <http://www.handlingpeople.co.uk/>.

negative reactions among staff (“before we couldn’t lift and now we have to”; “what about our rights?”) However, the interviewees suggested that these perceptions could be addressed through discussion.

Several noted that labelling manual handling guidance as derived from human rights principles could be counter-productive. One advisor said that, while the *East Sussex* principles are embedded in his core training, he doesn’t “wave a big flag” to highlight their human rights origin.

A group of occupational therapists employed by a London borough said *East Sussex* was not signposted as being derived from human rights principles in their training and it would “put people off” if it was. Their unanimously positive view of the case co-existed with a generally negative view of human rights and the HRA. As one put it:

I think there’s a lot of fear about it ... These rulings ... are fantastic in an ideal world but how do they transfer into reality where there isn’t a bottomless pit of resources?

By contrast, one manual handling co-ordinator noted that in her local authority, *East Sussex* is signposted as a human rights case in training and she had not encountered negative reactions. She added that “if anything it becomes **more** empowering for care assistants because they ... get a better understanding of the context in which decisions are made” and of how they can use the case to protect their own safety. This suggests the way the case is presented – as being about balancing the rights of care staff and service users – can help allay potential resistance to its human rights dimension.

3.4 Contracting out

The contracting out of services can, interviewees noted, dilute the impact of local authority manual handling policies that enshrine the importance of individual risk assessment. One interviewee who has advised many public authorities said:

Local authorities want to pay care agencies as little as possible, care agencies and care homes can’t retain staff – so where are you going to develop this body of expertise? ... People adopt the lowest common denominator approach and reach for the rigid policy because it’s easier and quicker ... That’s a huge, huge barrier.

In our survey of local authority legal directors, only 14 per cent of respondents said their authority had a mechanism to ensure that sub-contracted agencies are aware of policy in this area.¹⁹⁵

We found a variety of approaches in the authorities we interviewed. One city council required providers to have manual handling policies that are not in conflict with the council's policy. In another authority, a manual handling advisor had been asked by contract compliance officers to assess the manual handling policies of private agencies; however, she doubted the effectiveness of enforcement measures since "the money factor always wins". A director of social care in a metropolitan authority acknowledged that:

In areas like home care, we require them to have [manual handling] policies but it's incredibly hard for us to check how that feeds through ... The driver in community care has been ... almost exclusively cost.

A representative of the National Care Homes Association said she would not expect care homes in the association to have "no lifting" policies; however, she did not indicate that practice in this area was monitored. She added that, in her view, neither *East Sussex* nor the HRA had had any impact on practice in care homes.

The case was a nonsense ... We have huge chunks of legislation around abuse, and if people aren't implementing the legislation properly, it's not going to be made any better because of ... human rights legislation.

Asked whether local authority manual handling policies were built into contracting arrangements, she said:

There's a breakdown in communication in relation to commissioning and contracting and therefore these really important points ... aren't necessarily being discussed.

4. Issues for the future

The context in which manual handling is taking place is complex and changing, with significant implications for implementation.

4.1 Direct payments and personalised care

¹⁹⁵ Another interviewee who advises a range of care providers noted that domiciliary care agencies are sometimes restricted in their practice by insurance companies who stipulate, for example, that care agency employees cannot work alongside informal carers, regardless of the outcome of an individual risk assessment.

Several interviewees raised the issue of direct payments¹⁹⁶ as presenting new challenges in relation to manual handling practice. Local authority staff are unsure how far their authority can or should promote good manual handling practice to care

workers who are employed by direct payment recipients.¹⁹⁷ All our local authority interviewees said this was an area of concern; at best, they had been able to supply ad hoc manual handling training or advice to care workers employed via a direct payment, but with little or no follow up. The Welsh Manual Handling Forum has tabled the issue of direct payments for discussion because “we’re all waiting for it to be tested in the courts and we hope it won’t get tested with us”.

However, some interviewees also said the broader policy trend towards personalised care created a positive dynamic in relation to *East Sussex*. One who heads adult social care in a metropolitan authority said he saw the case as “feeding into the personalisation agenda”. A manual handling advisor in an English city council noted that:

East Sussex has gone down incredibly well because it fits in with a lot of agendas such as person-centred care. So the implications of the case and the tone it set have had a ripple effect going outwards which has been in line with ripple effects coming out of other influences on our work.

This interviewee noted the impact of case law generally can be cyclical: case law can encourage a direction of policy change, and policy change can make authorities more responsive to the lessons of case law.

4.2 Promoting compliance

Inspectorate bodies, advocacy organisations, and professional associations or networks all have a role to play in promoting compliance with human rights principles.

196 Direct payments are cash payments made to individuals who have been assessed as needing services, in lieu of social service provisions.

197 Department of Health guidance notes that: “As a general principle, local councils should avoid laying down health and safety policies for individual direct payment recipients”. See Department of Health (2003), *Direct payment guidance: community care, services for carers and children’s services*, p.26; http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4096246.

Some interviewees suggested that manual handling does not readily fall within the structure of inspections and that some inspectors may lack the knowledge and understanding to pick up prescriptive practices.¹⁹⁸

There is some evidence that, at a policy level, disability organisations have promoted the *East Sussex* principles.¹⁹⁹ However, disability organisations we interviewed suggested that disabled people and advocacy groups do not frame issues in human rights terms. As one director of a disability organisation noted:

That's not the sort of language [disability groups] are talking in and nor necessarily are the specific implications of [human rights] judgments being picked up ... I think there's a big question about how legal cases and interventions get disseminated, picked up and used.

This suggests potential to develop the “demand side” of human rights compliance by equipping service users to follow through on case law and its implications for service delivery.

5. Conclusion

We have seen that *East Sussex* has had a discernable impact on some policy and guidance within public authorities and professional associations. Manual handling advisors and practitioners have described the beneficial impact of the case on their practice. However, anecdotal evidence suggests that the impact of the case across public authorities and care providers is variable and uncertain.

Professional associations and networks have played a significant role – often informally - in disseminating information about the *East Sussex* case and debating its implications for practice.²⁰⁰ Our interviews highlight the strong potential that these informal channels have for translating and disseminating the lessons of case law for everyday practice.

198 The Commission for Social Care Inspection's guidance to inspectors on how to interpret regulations and national minimum standards for home care notes the need for risk assessment in relation to manual handling, and refers to the 1992 Manual Handling Operations Regulations, but not the Human Rights Act. See Commission for Social Care Inspection (2007), *Domiciliary Care Agencies Guidance Log*; http://www.csci.org.uk/professional/care_providers/all_services/guidance/guidance_log_domiciliary_care.aspx.

199 See for example, Mencap (2007), *Moving and Handling*; www.mencap.org.uk/displaypagedoc.asp?id=314.

200 Several manual handling advisors suggested that, were a similar case to occur in the future, they would expect to find out about it via the National Back Exchange, which has an active network of local groups and an online forum for debate.

CHAPTER 7

THE POSITIVE OBLIGATION TO SECURE DIGNITY AND INTEGRITY: THE CASE OF *BERNARD*

The *Bernard* case is widely cited in literature on the Human Rights Act (HRA) as illustrating the potential of human rights to improve public service delivery.²⁰¹ Our findings suggest this potential has not been fulfilled. According to our interviewees, the case has made little or no impact on local authority policy and practice or at a national policy level. Our research has focused on exploring why the case has largely failed to “bite” – either in the local authority concerned (section 2.1) or in other public authorities (section 2.2).

1. The case and its context

Enfield Council social services department had assessed the needs of a severely disabled woman, Mrs Bernard, who used a wheelchair and suffered from incontinence and diabetes. Her care plan stated that she needed to move to a suitably adapted property with urgency, but the council’s housing department failed to take action even after the court had ordered it to re-house her, and offered no apology or explanation. For 20 months, Mrs Bernard was almost confined to her home and forced to spend much of her time in a shower chair which caused her pain. She had no privacy and soiled herself several times each day.

The High Court decided that the council’s failure to act showed a “singular lack of respect” for the claimant’s private and family life, amounting to a breach of Article 8,

201 See for example: Age Concern (2006), *Rights for Real: Older People, Human Rights and the CEHR*, p.52; http://ageconcern.org.uk/AgeConcern/Documents/0406_Rights_for_Real_Report.pdf. Audit Commission (2003), *Human Rights: Improving public services delivery*, p.6; http://www.audit-commission.gov.uk/Products/NATIONAL-REPORT/FDE9C6A9-7DAF-4cd3-B21E-21E9E13E1D43/HumanRights-briefing_1.pdf. Joint Committee on Human Rights (2007), *The Human Rights of Older People in Healthcare*, Eighteenth Report of Session 2006-07, Vol I, p.83; <http://www.publications.parliament.uk/pa/jt200607/jtselect/jtrights/156/156i.pdf>. Social Care Institute for Excellence (2008), *Dignity in Care: Adults’ Services Practice Guide*, p.175; <http://www.scie.org.uk/publications/practiceguides/practiceguide09/files/pg09.pdf>.

and awarded £10,000 damages. However, the humiliation experienced was not severe enough to amount to inhuman or degrading treatment under Article 3.²⁰²

Key principles reinforced by the case are:

- Users of public services needing particular assistance should not experience undue delay in having those needs met.
- The local authority was under an obligation to take positive steps to enable the disabled person and her family to live as normal a family life as possible. These positive steps included the provision of suitably adapted accommodation, which would have secured her physical and psychological integrity and restored her dignity as a human being.²⁰³
- Gross acts of maladministration, with grave consequences, may merit a substantial award.²⁰⁴

In 2004, 1.5 million people were in need of accessible accommodation, with 329,000 living in completely unsuitable housing.²⁰⁵ A survey of physically disabled people by the John Grooms charity found that:

*Many local authorities don't know what accessible housing stock is available or the needs and characteristics of disabled people locally. As a result there are thousands of disabled people who wait years before finding a house suitable for their needs.*²⁰⁶

At least two cases referred to the Local Government Ombudsman (LGO) since the *Bernard* judgment involved similar circumstances. In one, an elderly, disabled woman lived in unsuitable accommodation for at least five years longer than necessary because the London Borough of Havering failed to consider her housing needs and

202 R (Bernard) v Enfield LBC [2003] HRLR 4 at paras 28-9; the judgment cited as an important consideration the fact that the claimants' suffering was due to corporate neglect and not an intention to humiliate or debase.

203 R (Bernard) v Enfield LBC [2003] HRLR 4 at para 33.

204 R (Bernard) v Enfield LBC [2003] HRLR 4 at para 36.

205 Disability Rights Commission in association with Habinteg (2006), *Housing and the Disability Equality Duty: A guide to the Disability Equality Duty and Disability Discrimination Act 2005 for the social housing sector*, p.5; <http://www.dotheduty.org/files/Housing.pdf>

206 John Grooms (2005), *Response to the PM Strategy Paper "Improving the Life Chances of Disabled People"*; p.9; http://www.cabinetoffice.gov.uk/strategy/work_areas/disability/~/_media/assets/www.cabinetoffice.gov.uk/strategy/john_grooms%20pdf.ashx.

her human rights.²⁰⁷ In another, a seriously ill and profoundly disabled woman was confined to bed in one room of her house for two years longer than necessary because Leeds City Council failed to recognise its legal duties to the woman and mishandled her disabled facilities grant.²⁰⁸

The Leeds case illustrates the constraints that some local authorities face in providing suitable accommodation for disabled people. The LGO found no fault by the council in handling the claimants' re-housing applications and commented that:

It is some measure of the extreme pressure on social housing, especially properties adapted to be wheelchair accessible, that all the higher priority cases were in even more difficult situations than the complainant and his wife...

The LGO decisions, and the broader context of deficient housing provision for disabled people, indicate the wide range of policies and practice for which *Bernard* might hold lessons: liaison and dispute resolution between housing and social care departments; decision-making around housing allocation and adaptations, and processes to ensure that accessible housing stock is matched without undue delay to those that need it.

2. The impact of the case

2.1 Impact on the London Borough of Enfield

The *Bernard* judgment said the claimants' case had "fallen into an administrative void" between Enfield's social services and housing departments.²⁰⁹ At the time of the judgment, there was "nothing to indicate that the defendant's procedures have been improved so that the same kind of mistake ... is less likely to occur in the future".²¹⁰

In July 2003, Enfield's Homelessness Review²¹¹ drew two learning points from the case:

207 London Borough of Havering (06/A/10428); <http://www.lgo.org.uk/socserv.htm>.

208 Leeds City Council (05/C/13157); <http://www.lgo.org.uk/socserv.htm>.

209 *R (Bernard) v Enfield LBC* [2003] HRLR 4 at para 29.

210 Indeed, the Housing Department had compounded the effects of its inaction by threatening to evict the claimants; the threat was withdrawn, but should never have been made had there been proper liaison between the two departments (para 41).

211 Enfield Council (2003), *Homelessness Review*; <http://www.enfield.gov.uk/112/Homelessness%20Review.pdf>.

- Staff compiling occupational therapy and other assessment reports should be familiar with the relevant legislation.
- Different council departments should work closely together and co-ordinate activity and share information.

A senior housing manager in LB Enfield (not in post at the time of the case) outlined a number of changes to organisational structure and practice that had been made since the judgment. She emphasised that none was a **direct** result of the case. Instead, *Bernard* was a subsidiary element in a continuum of other developments, notably the government's drive for greater personalisation of care.

Services relating to housing need in LB Enfield are now part of the adult health and social care department, under unified leadership. Cases involving complex needs are now addressed in multi-disciplinary meetings to avoid "battles over what's expected and what's deliverable". Issues of need are now looked at "in the round", with service users playing some role in designing their own solutions, whether from the council's own stock or from the private sector.

Asked to explain where the *Bernard* case fits alongside other drivers of policy and practice, she said:

Reputationally, no authority would wish to be in the position [of] Enfield ... with regards to this case. So ... the council has taken it very seriously. However, as time moves on, the issues that were raised within the case are overtaken by government agendas ... [and] become embedded in the organisation as a result of many different drivers ... What [the case] does do is sharpen the mind as to what's acceptable and what's not acceptable and that is sharpened even further by the priorities that the government has set for local authorities.

Asked whether the case had changed the council's approach to human rights, she added:

I don't see it as something we would be fearful of - I see it as part of the jigsaw in terms of the context when you're making a decision ...

There was no indication that the case had featured prominently in staff training: the interviewee said she thought understanding of human rights came more from "copious" general briefings on the HRA than from *Bernard*. The interviewee praised the department for Communities and Local Government (CLG) for its email alerts on case law. Operational managers are expected to keep abreast of case law and "translate" the lessons for frontline staff. The interviewee acknowledged that "the

closer you get to the frontline the more diluted it becomes”, partly due to staff turnover.

The interviewee was confident that the concept of positive obligations was understood by those staff that needed to know. She gave the example of a case conference which “pulled out all the stops” to house a severely disabled child having identified a right to life issue after a consultant said the child was at risk of catching an infection in hospital.

We try to work proactively where ... we recognise that there is a risk to someone and a risk to the authority's reputation – to ensure that that person's needs are met, most definitely. It's part of the system.

The interviewee did not know whether the £10,000 financial penalty had made a difference to the council's response to the case, but doubted whether a sum of this size would have a “major impact” as a driver of policy.

Asked whether a similar case could arise again, she acknowledged that in a large, complex organisation, individuals can always “slip through the net”. However, she considered that the authority has enough checks and balances to make it extremely unlikely, including a complaints procedure that acted as an early warning and mechanisms to involve service users in finding solutions.

2.2 Impact on other public authorities

In this section we examine how far local authorities reviewed or changed policy in the light of the *Bernard* case. According to our interviewees and survey respondents, this did not happen to any significant extent (section 2.2.1). We examine the issue of resource and capacity constraints as a barrier to impact (section 2.2.2); the multiple drivers for change identified by our interviewees, in which *Bernard* and human rights case law generally are seen as subsidiary to other factors (section 2.2.3) and the impact of financial penalties attached to legal judgments (section 2.2.4).

2.2.1 Policy review and revision

In our survey of 36 directors of legal services in England and Wales, around two thirds of respondents who answered the relevant question had heard of the case; less than one third said their authority had examined policies because of the case, and one individual said their authority had changed policy.²¹² About ten per cent said their authority had issued guidance to ensure that staff were aware of the implications for their practice. Comments suggest the case is not regarded as holding relevant lessons:

212 Note that five out of 36 respondents said that their council did not have a housing and/or a social services function.

This was a pretty basic case ... It did not add anything new.

This case was so extreme it would have been in contradiction of our understanding of our statutory position and our policies and guidance as to how we treat our clients.

Of 25 directors of housing in England and Wales we surveyed, fewer than half of respondents who answered the relevant question had heard of the case; just over a third said their authority had examined policies in the light of it, and one respondent said their authority had changed policy. However, more than 90 per cent said they knew where to go for relevant guidance.²¹³

One respondent said they had cited *Bernard* to put pressure on another local authority to change a housing allocation for a homeless family referred to it. This is one instance where a public authority has used human rights arguments to seek to secure a better outcome for service users.

2.2.2 Constraints on resource and capacity

Comments by housing directors in our survey indicate that they see financial restraints and the shortage of accessible housing as barriers to implementation of the *Bernard* principles:

[The case] has increased the gap between the legal obligations on adaptations for disabled people and the funds available to deliver those adaptations.

The case has highlighted an issue that should have been addressed in any reasonable LA - however with the lack of accessible housing available it may occur again ... Whatever is available is better than the street...

A divergence of experience emerged in our interviews. A director of housing in a local council suggested that central London boroughs and other authorities with scarce accommodation always operated “on the edge of the law”. In authorities where there was less pressure on housing stock, “we rarely encroach on any case law, human rights or otherwise”. One housing advisor in East Cambridgeshire District Council (who had not heard of *Bernard*) noted that her council had more adapted housing stock than neighbouring authorities and so rarely made adverse decisions requiring consideration of case law. By contrast, a disability housing

213 In another survey of 13 local authority and housing association personnel (via the Chartered Institute of Housing), some two-thirds said they considered the case relevant to the work they did; none said their organisation had reviewed policy in the light of the case.

advisor in Hull said he handled some 400 cases a year relating to adaptations and re-housing, many in circumstances comparable to *Bernard*:

And that's the tip of the iceberg ... I haven't been able to use [Bernard] partly because there are so many people that I think I could apply it to every case.

2.2.3 Multiple drivers for change

Interviewees working at a national policy level said that *Bernard* is viewed as peripheral by those directing and managing housing-related services both in local authorities and housing associations.

A policy officer in the Local Government Association said that, in her view, *Bernard* was “extreme”; she could not recall it ever being discussed with senior officers in local authorities on matters of housing policy or implementation. She did not consider the HRA and human rights case law to be significant drivers of policy or practice:

Authorities are structured in a way that mean [housing] legislation and statutory duties are the primary concern. Any case law is going to be open to interpretation and sometimes ... contradictory.

An interviewee in the Housing Corporation, which regulates housing associations, said the regulatory code setting out the expectations of housing associations²¹⁴ was, in his view, a much more significant driver of policy and practice than the HRA or case law.²¹⁵

[Bernard was the] exception rather than the rule – it just shouldn't have happened. There are enough guidelines and expectations without the HRA for that to be something that is unacceptable.

Interviewees in the Chartered Institute of Housing (CIH) reiterated this view. One professional practice officer noted that the case had not gained prominence as a “landmark case” in the housing sector. This interviewee said that the human rights or equality related cases which had gained a higher profile were those which appeared to expose a “systemic failure” which placed authorities at risk of breaching the law, or

214 <http://www.housingcorp.gov.uk/upload/pdf/RegulatoryCode.pdf>.

215 He added, however, that human rights considerations might come into sharper focus for housing associations given the recent ruling in *R (Weaver) v London and Quadrant Housing Trust* [2008] EWHC 1377 (Admin); [2008] WLR (D) 207, which held that the management and allocation of housing stock by a registered social landlord was a function of a public nature, so that it was amenable to judicial review and regarded as a public authority for the purposes of the HRA.

those which “go to the very core of the mechanics of how tenancies work”.²¹⁶ By contrast, *Bernard* tended to provoke the reaction from local authorities: “it couldn’t happen here”.

She added that some local authorities were taking steps to improve the supply and profiling of accessible housing stock (for example through the development of Accessible Housing Registers). This “slow burn” process was driven by a variety of factors, including legislation and a council’s motivation to be designated as high-performing; no single case like *Bernard* could be identified as a driver.

A senior figure in the CIH did not think the HRA or human rights case law were pushed with similar levels of leadership as the “huge amount of work” around equality and diversity: “human rights considerations appear on a case-by-case basis, not as standard”.

One operational housing manager in a London borough noted that *Bernard*, and HRA cases generally, were viewed as less significant and immediate than case law under the Housing Act 1996 or the Disability Discrimination Act (DDA) 2005 - especially the general Disability Equality Duty.²¹⁷

This manager said *Bernard* was not incorporated into training, partly because the principles it raises have stronger drivers from other routes. For example, the principle of “no undue delay” is embedded in performance indicators and the Homelessness Code of Guidance.²¹⁸ Other “hard targets” – such as those contained in Local Area Agreements, CLG targets and Best Value Performance Indicators – were all stronger drivers of practice than, as he put it, “airy fairy” human rights standards. The manager said that court judgments could only be enacted if the necessary housing stock existed and suggested operational managers became case-hardened:

There’s so much case law around and it’s sometimes contradictory – so

216 Housing cases with a human rights or equality dimension which our interviewees regarded as more significant were: *Lewisham London Borough Council v Malcolm* [2008] UKHL 43; [2008] WLR (D) 205, which held that a landlord’s claim for a possession order against a disabled tenant who sublet the premises in breach of the tenancy agreement did not amount to unlawful discrimination for a reason which related to the tenant’s disability. Also, *Ghaidan v Mendoza* [2004] UKHL 30, in which the Law Lords ruled that a homosexual man whose partner had died should succeed to the tenancy of their shared flat because the relevant provision of the Rent Act relating to the surviving ‘spouse’ fell within the ambit of Mr. Ghaidan’s Article 8 right to respect for his home and therefore also engaged his Article 14 right against discrimination.

217 The Disability Equality Duty requires public authorities to promote equality of opportunity for disabled people when developing their policies and delivery procedures, and new duties requiring both private and social landlords to make reasonable adjustments for disabled people. In its submission to this project, the Ministry of Justice referred to the duties on local authorities under the DDA 2005, suggesting that it considers the principles of the *Bernard* case to have been met or superseded by this legislation.

218 <http://www.communities.gov.uk/documents/housing/pdf/152056.pdf>.

issues of natural justice won't be the prime driver in the way we make our decisions.

We also interviewed a service manager and a director of service in Leeds City Council, with reference to the LGO case cited in section 1. The service manager noted that the external challenge from the LGO case had “given an extra edge” to changes already under way to improve the interface between housing and social care.²¹⁹ Both

interviewees confirmed that the *Bernard* case did not figure in discussions either within the council or between the council and the Ombudsman (though the HRA was raised retrospectively as having been relevant). The service manager noted that the HRA is “a bit peripheral in people’s thinking” and tends to get squeezed out amidst the “raft of legislation” that informs decision-making. However, she did recall *Bernard* being raised in discussions with the council’s complaints officer regarding provision to meet housing need.

An interviewee from Shelter reiterated that *Bernard* had made little impact, “maybe because it is easily marginalised as being on rather extreme facts”. He welcomed the fact that the Court of Appeal had, in this case, interpreted Articles 3 and 8 in a positive way rather than as merely a negative restraint. But in his experience, “there’s never any mention of human rights as being any element of the decision-making process [in the housing sector] ... nothing proactive”.

2.2.4 The role of financial penalties

Directors and managers of housing services said that financial penalties could not be ignored; they consumed public money that could be used to provide services. But none considered the £10,000 penalty in *Bernard* to be significant in the context of authorities with multi-million pound budgets. One director of housing in a Welsh county borough council said a fine of this order “was not much of a threat” compared to an industrial tribunal with unlimited damages. It is not known how much Enfield spent defending the *Bernard* case; one housing manager in another London borough said his authority was in the process of spending some £100,000 fighting a case relating to the housing needs of a divorced couple.

From the service user perspective, the disability housing advisor we interviewed said financial penalties were important for claimants to compensate for the stress of pursuing a case.

219 These changes included the introduction of a multi-disciplinary case management approach to address complex housing needs and an appeals process to resolve disputes about what adaptations are required to meet a disabled person’s needs.

3. Conclusion

Our interviewees offer a variety of opinions as to why they think the *Bernard* case has achieved so little traction in the housing and social care sectors, including a proliferation of legislation and case law; restraints on resources and capacity, and a tendency to view the case as an aberration. It may be that the sheer breadth of areas the case holds lessons for means any potential impact is lost amid a raft of other, more tangible drivers.

In areas where there is sufficient capacity to meet the basic level of decent treatment set by *Bernard*, our interviewees suggest that the case is seen as having few generalisable implications. For example, the principle of no undue delay was seen as being enshrined in performance targets and codes of practice more central to everyday decision-making.

In circumstances of extreme pressure on housing stock, our interviewees did not see *Bernard* as pertinent to the hard decisions that must be made in conditions of scarcity. What emerged from the interviews was a lack of “fit” between a case which set a **minimum threshold** of acceptable treatment and a system in which much existing legislation and guidance is about the equitable and transparent **rationing** of resources.

These observations do not necessarily rule out the potential significance of the case in highlighting unacceptable professional practice which cannot be excused by resource and capacity constraints (the “corporate negligence” of which LB Enfield was accused). However, again, the majority of our interviewees pointed to other drivers that they would expect to prevent such egregious practice from occurring.

Our findings suggest that the potential of the HRA to drive improvements in public services has been particularly under-explored in relation to housing. The tendency to view the HRA as peripheral to other drivers, including equalities legislation, was a strong theme of our interviews. It might be argued that this perspective neglects the role played by the HRA as an overarching piece of legislation which renders visible groups that fall outside the incomplete patchwork of anti-discrimination legislation and gives them a voice and a channel for legal redress. This suggests further potential to develop and model integrated human rights and equality approaches within public authorities.

CHAPTER 8

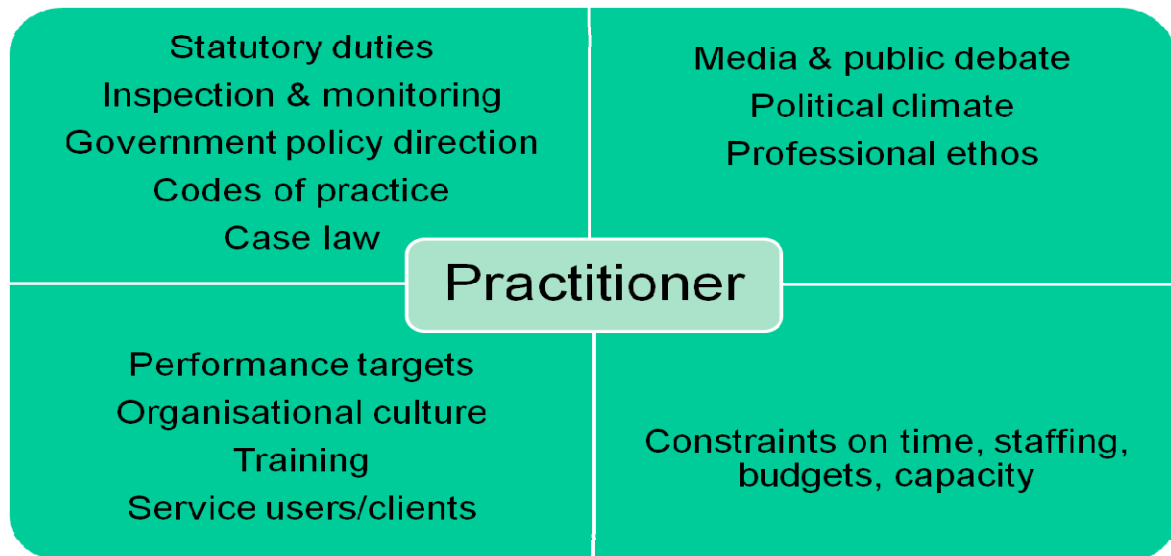
CONCLUSION

In this chapter, we analyse the themes that emerge from our qualitative research on the impact of selected cases. These insights point to some of the inherent limitations of any exercise to determine the impact of human rights case law (section 1). They reveal some of the barriers which might prevent principles established by particular cases from changing policy or practice in public authorities which are not compliant (section 2). More positively, they provide snapshots of how the lessons of human rights case law have been put into practice and ways of communicating human rights to gain consent (section 3).

1. Limits to assessing impact

1.1 Multiple drivers for change

At an institutional level, the HRA and human rights cases are rarely the sole or principal driver for change within public authorities. Our interviewees identified a range of other drivers and influences on practitioners. As illustrated here, these include externally imposed standards and broader government policy directions; organisational targets and working cultures; cultural and social factors such as media coverage, and constraints on capacity and resources.



The limits to assessing impact are not uniform. Where a case has direct implications for policy and guidance set nationally (as in *Limbuela*), the impact is visible and even quantifiable. Impact is harder to ascertain where cases have implications for diverse practice across a range of public authorities, or where they involve complex circumstances from which it appears hard to generalise.

As individual practitioners, interviewees frequently struggled to disentangle their knowledge of case law from other factors (such as their professional ethos and training) as an influence on specific decisions or habitual behaviour. The exception appears to be the *Osman* case. Police officers were able to identify ways in which the case has influenced policy and practice; however, their awareness of the details of the case was lower, which might have implications for applying the principles of the case to a range of situations.

1.2 The passage of time

The time lag between an incident, a legal judgment, and resulting policy changes reaching operational staff can make it difficult to determine what is attributable to case law and what relates to the evolution of good practice; for example, prevention of suicide within the Prison Service or the evolution of manual handling practice. Policy changes may be made in response to an incident review ahead of any legal case; they may also be made in response to inquiries that stem from the legal case (as in the case of *Zahid Mubarek*). In each instance, determining the impact of the case itself is uncertain.

1.3 Media coverage and advocacy

In some cases, there has been high profile media reporting of a judgment and/or subsequent inquiries, or vocal campaigns by relatives and advocacy organisations to challenge poor practice. Arguably, the HRA underpins any resulting changes to

policy and practice; however, a note of caution is needed when assessing the impact of the case on its own.

2. Potential barriers to impact

2.1 Divergent perceptions of human rights

We found both positive and negative views about human rights and the HRA at different levels of seniority in public authorities.

Some service directors and managers had experienced human rights as a “stick to beat us with”, a “line of attack” or as the basis for unrealistic or unfounded claims to services. This had led to what one London housing manager described as a case-hardened attitude to the HRA. Some said human rights were debated in an

oppositional manner, making it harder to win consent to change (“what about my rights?”). Others spoke of the HRA as being “almost taboo”, an object of derision or something threatening, in contrast to the Disability Discrimination Act which was viewed positively by all those who referred to it.

However, other interviewees emphasised that such views are neither universal nor insurmountable. Practitioners spoke about learning from human rights cases to approach seemingly intractable problems (such as the moving and handling of morbidly obese patients) and as a framework within which to resolve competing interests. Service directors spoke positively about human rights as a set of underpinning principles for their work and a constructive challenge function. One director said:

I think it's quite appropriate that I'm given organisational headaches, to ensure that I and other senior managers think about the human rights implications of what we're doing.

In the area of prisons, several interviewees said the principles of human rights are readily embraced by staff, but recognition that these principles reflect human rights law is low. Stephen Shaw, Prisons and Probation Ombudsman, said:

If you say to prison officers 'do you believe in treating prisoners with decency?' then I think you would get a very high ... and genuine sign up ... If you asked the question 'is it important that the Human Rights Act is followed in the treatment of prisoners?', there I think you would get a much more varied response.

Our findings suggest that generalisations about perceptions of human rights are hard to sustain: opinions in a single public authority can differ markedly. As one snapshot,

a frontline police officer told this project the *Osman* case had contributed to a “bureaucratic nightmare with frontline officers bearing the brunt” while another from the same force said *Osman* was “another example of how the Police are becoming more professional/accountable”.²²⁰

2.2 Resources and capacity: an issue of supply and demand

Interviewees said a significant barrier to applying the lessons of case law systematically is the need for additional resources (for example, the cost of a social care budget) or additional capacity (for example, accessible prison space or housing stock).²²¹ It is rarely as straightforward as a public authority saying it cannot afford to implement case law; rather, limitations on resources and capacity create different dynamics in relation to case law.

In some cases, public authorities appear to develop ways of interpreting the obligations they might be expected to take on as a result of case law to fit within available resources. For example, a regional asylum policy officer told us that hard-pressed local authorities with large numbers of destitute failed asylum seekers effectively apply a higher threshold for community care than neighbouring authorities with fewer claimants.

In other instances, case law concerned with a minimum level of decency and respect for a claimant’s human rights can struggle to gain purchase in a system which is primarily about the equitable and transparent rationing of resources. A case like *Bernard* may be a salient reminder of the “bottom line” but does not, some interviewees said, assist an authority to make hard decisions about allocating scarce housing stock.²²²

On the “demand” side, our interviewees suggest that variations in the availability of legal representation or advocacy can create something akin to a “post code lottery” (for example, in relation to access to community care). Interviewees spoke of “advice deserts” and of applicants struggling to make headway through the system without representation. Disability organisations suggested that demands by service users to

220 These views were obtained via an anonymous questionnaire of detective constables and police inspectors in the same force.

221 This is not to suggest that implementing the principles of case law necessarily costs more than not doing so. Indeed, it may be that following through the lessons of case law could encourage a more rational use of resources (such as, in the case of *Bernard*, the development of Accessible Housing Registers to match adapted housing stock to those that need it).

222 In such cases, the primary lead on following through the implications of case law may need to come from central government.

operationalise case law were patchy and certainly had not achieved a sufficient critical mass to drive change.

The *Middleton* case has implications for the nature of coroners' investigations and has in many cases facilitated an improved role for families in inquests – but some interviewees noted that families seeking legal representation still face considerable hurdles.

2.3 Variable mechanisms to monitor case law and review policy against it

Our findings suggest that monitoring arrangements are variable and often highly specific to each public authority. In local authorities differing perceptions may exist between legal staff and service departments as to the adequacy of those arrangements.

In our survey of legal directors, more than half of the 32 respondents who answered the relevant question said their authority had systematic arrangements in place to monitor human rights case law regularly, while 40 per cent said their authority did so on an ad hoc basis. When asked the same question, directors of service departments appeared less confident; 22 per cent of housing directors and a third of directors of social services who responded said their authority had systematic monitoring arrangements.

A significant number of interviewees within local authorities said mechanisms to review policy and guidance in the light of case law are haphazard and overly dependent upon personal initiative. Service directors or managers said they generally rely on legal colleagues to flag relevant case law that might affect policy, or wait to be alerted to it through external channels.

A director of social care in a London borough said:

I wouldn't feel assured that important case law was coming through from the legal department ... I've got nobody scanning the system for the impact on policy issues.

However, other interviewees (both in local and national government and in police forces) were more confident. A senior legal officer in the UK Border Agency (UKBA) said operational policy teams in the UKBA's regional structure pick up relevant principles from specific asylum cases and feed these up to ministers. In turn, policy changes are fed back to the operational policy teams to generate new guidance or instructions when required. The National Offender Management Service (NOMS) said this role is served by having a legal adviser sitting on its board to inform it of the implications of upcoming and recent changes. Police officers from four out of the five police forces we interviewed were able to outline internal mechanisms for monitoring

case law and disseminating relevant points, and noted that the National Policing Improvement Agency (NPIA) fulfils this role at a national level.

In one snapshot of local authority procedure, a director of adult social care in a metropolitan authority said the authority's legal department collates cases of interest roughly every two months and flags them to relevant departments, with additional interpretation and guidelines: "this works well as a system to keep intelligence flowing".

2.4 Variable mechanisms to disseminate the lessons of case law

We encountered variable experience in the public authorities we interviewed and surveyed, both as to the perceived effectiveness of how the lessons of case law are disseminated and whether policy responses are signposted as being derived from human rights judgments (especially to those on the "frontline" of service delivery).

The dissemination of the lessons of case law – whether or not they come with a human rights label - depends upon channels of communication reaching all those that need to know. This is particularly challenging in public authorities that are large and/or geographically dispersed.

Anecdotally, the service managers and practitioners we interviewed could not recall getting guidance about *East Sussex* or *Bernard* (or any resulting policy changes) automatically through their authority. Some had pro-actively sought information from their legal department or other sources (including specialist legal websites or alert services, specialist journals and professional associations or networks).

In our survey of directors of social services, a quarter of respondents who answered the relevant question said they felt they received sufficient guidance about human rights case law. About one third thought the guidance was timely and accessible (in the sense of being written so that they understand the lessons of the case and can put them into practice). When asked whether they thought operational managers and frontline staff in their department received sufficient, timely and accessible guidance, the figures were the same or lower. The responses of housing directors to the same questions were broadly in line with these figures.

In our survey of legal directors, 80 per cent thought operational managers in their authority received sufficient guidance, more than 70 per cent considered it timely and more than 60 per cent considered it accessible. The figures relating to their perception of the guidance given to frontline workers were lower (between 30 and 46 per cent). These findings indicate that the perception of legal directors as to what constitutes sufficient, timely and accessible guidance may differ in some instances from that of directors of service departments. Notably, fewer than half of **all** these

director-level respondents consider that frontline staff in their authorities receive sufficient, timely or accessible guidance about the lessons of case law.

There is debate about how far down an organisation it is helpful to label a policy change or guidance as being based on human rights. Some said this can be off-putting

or unnecessarily legalistic.²²³ However, several practitioners told us that, in some instances, they **do** find it helpful to understand the human rights origin of a change to guidance or policy. In the case of *East Sussex*, it helped frontline staff to know that changes were not arbitrary and involved a balancing of rights, including their own.

For example, some interviewees in NHS Trusts or other agencies responsible for healthcare in prisons articulated a need for more explicit advice on human rights case law. One said he would like to see this framed as “positive guidance ... based on sound, reasoned judgment ... so it’s not just about risk aversion”. A medical director working across a cluster of prisons said he needed to know about case law developments for his patients’ benefit and his own protection:

[T]here needs to be a way of distilling that case law, the wisdom of it and the instruction of it in a way that is recognisable by doctors and the [primary care trusts] that employ those doctors.

An interviewee in the NOMS security policy unit said explicit references to human rights cases in policy documents can prevent staff from becoming too “cellular” and remind them that experiences in other prisons are relevant to them.

We have also found evidence of local authorities articulating a need for central government guidance on the provision of support to people with no recourse to public funds, which would include the application of human rights assessments to determine potential breaches of Articles 3 and 8.

Amid such variable experience, it is unsafe to draw conclusions about the most commonly used – or most effective – way of disseminating the implications of case law. What is clear is that we cannot always be sure whether, even in instances where case law has had a demonstrable impact, frontline staff necessarily know that human rights principles underpinned changes to their practice.

223 In its unpublished submission to this project in August 2008, the Ministry of Justice said: “It would ... be rare ... for a public authority to disseminate guidance about changes in case law, except between those who would actually need to understand such points of legal detail ... Instead, if as a result of case law a public authority decides that it should change its practices or policies, it would disseminate guidance about that specific change; this guidance may not necessarily need to refer to the underlying reasoning or case law.”

3. Human rights as a driver for change

This section looks at some of the broader issues of human rights as a driver for change, as they have arisen in the course of our research into the impact of selected cases. As noted earlier, case law is only one way in which human rights influences change.

3.1 A principles based approach

Legal judgments are generally specific interpretations of the law applied to a particular set of circumstances: this is what a legal case requires and judges may be understandably reluctant to articulate broader frameworks of principles (though the *East Sussex* judgment is an interesting exception **and the *Osman* judgment also articulates a principle intended to be broadly applicable**).

This in turn can discourage any culture within public authorities of identifying generalisable principles arising from case law – and create a tendency for authorities to await further legal challenges in order to determine the application of established principles to new situations. Similarly, individual professionals may distinguish specific situations that face them on the facts, if they do not have the knowledge or understanding to apply a broader human rights framework. Moreover, our interviews suggest a generic tendency to view some human rights case law as arising from extreme or aberrant circumstances.

Some service directors acknowledged that, even where staff are aware of human rights principles, they are not always confident in applying them to individual cases or particular populations. One director of housing and social care in a London borough, who is active in the disability network of the Association of Directors of Adult Social Services (ADASS), said:

What we'd like to know is: what is generalisable, what does this [case law] suggest should be ... the broad policy positions that we promote? ... That's the area that needs to be developed from ADASS's perspective.

As one example of this broader application, a chief officer for housing and social care in a Welsh county borough council said human rights principles had been one driver behind a decision to stop applying a blanket policy around intentional homelessness because it was disadvantaging vulnerable children. In other examples, local authority

interviewees referred to cases concerning the need to investigate the effects of care home closures on residents as having produced tangible changes to policy and procedure, even where their own authority had faced no legal challenge.²²⁴ The director of social care in one metropolitan authority said case law in this area had helped drive a “pro-active approach” characterised by open consultation, transparent decision-making and service user involvement.

However, we found relatively few examples of this kind, and interviewees across the public service areas we explored suggest the need to equip service directors and managers to apply human rights principles across a range of circumstances.

Professor Francesca Klug has called this process “smart compliance”: that is, providing guidance to public authorities on the implications of human rights case law which extend beyond the public authority and specific facts raised by a particular case in ways that may not be immediately apparent.²²⁵ The absence until 2007 of a commission charged with this role of promoting human rights and “translating” the lessons of law into effective practice may well, our interviews suggest, have led to the HRA being under-sold and under-exploited.²²⁶

3.2 Promoting “smart compliance” through formal and informal networks

Our findings suggest that there are different dynamics by which case law can exert impact. Sometimes the lever is top down: for example, instructing case workers to process asylum support applications differently. Impact can also be achieved from the bottom up: in the case of *East Sussex*, our findings suggest that change occurred through non mechanistic routes, by validating the efforts of committed professionals.

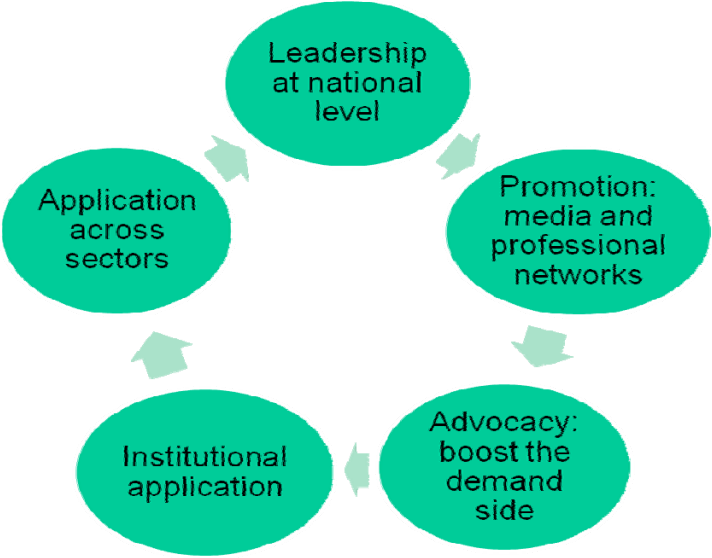
One director of a national disability organisation said legal interventions should be viewed as part of a longer-term process involving promotion and implementation, harnessing multiple formal and informal channels. Our interviews suggest several

224 See *Cowl et al v Plymouth City Council* [2001] EWCA Civ 1935; *R (Madden) v Bury MBC* [2002] EWHC 1882 and *R v North & East Devon Health Authority, ex p Coughlan* [1999] Lloyds L Rep (Med) 306.

225 Klug, F (2004), *Establishment of the Commission for Equality and Human Rights: implications for the public sector: Westminster Explained 36: An assessment of the impact of the HRA*, pp.3-4; http://www.lse.ac.uk/collections/humanRights/articlesAndTranscripts/Westminster_explained.pdf.

226 The role played by the Ministry of Justice to ensure correct application of the HRA and improve public confidence in it is set out in Equality and Human Rights Commission (2008), *Human rights in Britain since the Human Rights Act 1998: a critical review*, forthcoming, pp.18-20. In its unpublished submission to this project, the Ministry of Justice sets out its view of the Government’s role in relation to promoting human rights. It notes that: “The Human Rights Act is not a form of regulation that is enforced by the Government. Instead, each person subject to the Act is responsible in their own right as a public authority for their compliance with the Act, and is susceptible to challenge before the courts. It is therefore for each public authority to ensure the compliance of their own actions and policies with the Act, rather than for Government to issue directions and intervene if they are not observed.”

levers for promoting the implications of human rights case law to public authorities, which we show here as a cycle.



Our interviews suggest the potential for **national leadership** to promote the principles of human rights case law – in particular from central government policy departments and national associations such as ADASS, together with the Equality and Human Rights Commission. One professional practice officer in the Chartered Institute of Housing noted that:

Where cases have an impact it's because they have this joint momentum behind them ... Housing managers may still hear of a case ... but it's unlikely to have the same impact unless there is a joint partnership to get the message out.

Our interviewee in the College of Occupational Therapists (COT) offered the “spectacular” roll out of the Mental Capacity Act as a model for how to get a co-ordinated message across to those delivering public services. It is worth noting, however, that while legislative changes are planned, public authorities’ responses to legal cases are invariably reactive. This can create a tendency to “bolt on” the response, rather than assess whether human rights principles might demand a more fundamental shift in thinking.

Promotion via the media, including trade publications, is an effective way to reach practitioners, particularly given the patchy institutional application of case law. In some instances, interviewees had first encountered a human rights case in the media. One service manager said legal officers were more likely to examine policies

where a case was seen as a “live issue” posing greater reputational risk for an authority. Our findings also suggest the potential to promote human rights principles through professional associations and networks, and using new technology such as online forums. The engagement of those who can act as “multipliers” is critical (such as manual handling co-ordinators in the case of *East Sussex*).

Advocacy - both legal representation and campaigning advocacy – can boost the “demand side” in relation to human rights cases. In the case of *Bernard*, our interviews suggest that the £10,000 penalty was not a sufficient incentive for change. A greater awareness among service users and advocacy organisations might increase the potential leverage of future cases.²²⁷

Effective **institutional application** involves monitoring, review and “lessons learned” mechanisms, dissemination, training and the translation of principles into messages that make sense to practitioners’ everyday roles. The evidence we have found suggests that these systems vary considerably between authorities and in particular that the lessons of case law may not always filter down to those on the frontline. Dissemination is likely to be much more effective if the principles are set out in a context that is amenable to discussion in team meetings or training sessions and by managers who are not specialists.

Application across sectors: The principles arising from legal cases, and the implications for practice, are not always immediately transparent to practitioners and are sometimes disputed. This brings us back to the role of national leadership to identify and champion key principles and lessons to a wider range of sectors and circumstances than might be suggested by the facts of the individual case.

3.3 Communicating human rights

Our interviews suggest that, in order to become more embedded in public services, human rights principles need to be communicated to professionals within those services (the “supply” side) and to those using services and to the wider public (the “demand” side).

Our interviews with those delivering public services suggest several strategies for communicating rights in a way which taps into existing organisational cultures.

In some cases, practitioners are already delivering services in a way which meets human rights standards, sometimes whilst under pressure to cut costs. Guidance that suggests they can have confidence in their judgments is seen by our interviewees as

227 We heard anecdotally from the College of Occupational Therapists of practitioners feeding information to local service user organisations because they considered this the most effective route to challenge restrictive practices in their authority.

a useful validation. Indicating that changes based on case law can increase transparency and increase confidence in a service, particularly if things go wrong, is also constructive.

Our interviews on *East Sussex* suggest that, where there are rights to be balanced, setting out guidance in a way which makes the resolution of competing interests clear can help gain consent. Where an absolute right is engaged, and where legal obligations are strong because someone is in the state's care, interviewees (especially those new to detention settings) articulated a need to have these obligations explained explicitly and in a way that makes sense to their job.

Where we encountered negative perceptions of human rights, this was in part based on a sense of them being burdensome. However, some interviewees working in housing and social care emphasised that the time invested in considering every aspect of a person's needs – and involving service users and carers in devising solutions – can effect a qualitative change in the relationship between those who use and deliver public services.

Human rights and the HRA are viewed as one among many drivers of policy and practice in public authorities. In local government, as one senior interviewee in the Improvement and Development Agency put it:

... equalities is seen as a 'home' issue – I don't think human rights is an 'owned' issue in the same way ... It's not in the DNA.

This suggests potential to develop integrated equality and human rights approaches which build consensus around the HRA as a means to extend existing approaches to inequality and set a threshold of treatment to secure dignity and respect for those in vulnerable situations.

Our findings suggest that the effective promotion of “smart compliance” requires a pragmatic understanding of the complex legal and policy environment in which new principles need to be applied and a readiness to work with the grain of organisational cultures that may not readily embrace the language and principles of human rights. Equally, we have detected an appetite among some of our interviewees to operationalise the lessons of case law based upon a more confident understanding of how human rights principles can be applied across public services, thus promoting both the transformative and remedial roles the HRA was anticipated as playing a decade ago.

ANNEX 1

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ANNEX 4

NATIONALITY, IMMIGRATION AND ASYLUM ACT 2002 SECTION 55 LATE CLAIM FOR ASYLUM: REFUSAL OF SUPPORT

(1) The Secretary of State may not provide or arrange for the provision of support to a person under a provision mentioned in subsection (2) if -

(a) the person makes a claim for asylum which is recorded by the Secretary of State, and

(b) the Secretary of State is not satisfied that the claim was made as soon as reasonably practicable after the person's arrival in the United Kingdom.

(2) The provisions are -

(a) sections 4, 95 and 98 of the Immigration and Asylum Act [1999 \(c. 33\)](#) (support for asylum-seeker, &c.), and

(b) sections 17 and 24 of this Act (accommodation centre).

(3) An authority may not provide or arrange for the provision of support to a person under a provision mentioned in subsection (4) if -

(a) the person has made a claim for asylum, and

(b) the Secretary of State is not satisfied that the claim was made as soon as reasonably practicable after the person's arrival in the United Kingdom.

(4) The provisions are -

(a) section 29(1)(b) of the Housing (Scotland) Act 1987 (c. 26) (accommodation pending review),

(b) section 188(3) or 204(4) of the Housing Act [1996 \(c. 52\)](#) (accommodation pending review or appeal), and

(c) section 2 of the Local Government Act [2000 \(c. 22\)](#) (promotion of well-being).

(5) This section shall not prevent –

(a) the exercise of a power by the Secretary of State to the extent necessary for the purpose of avoiding a breach of a person's Convention rights (within the meaning of the Human Rights Act [1998 \(c. 42\)](#)),

(b) the provision of support under section 95 of the Immigration and Asylum Act [1999](#) [\(c. 33\)](#) or section 17 of this Act in accordance with section 122 of that Act (children),
or

(c) the provision of support under section 98 of the Immigration and Asylum Act 1999 or section 24 of this Act (provisional support) to a person under the age of 18 and the household of which he forms part.

(6) An authority which proposes to provide or arrange for the provision of support to a person under a provision mentioned in subsection (4) -

(a) must inform the Secretary of State if the authority believes that the person has made a claim for asylum,

(b) must act in accordance with any guidance issued by the Secretary of State to determine whether subsection (3) applies, and

(c) shall not be prohibited from providing or arranging for the provision of support if the authority has complied with paragraph (a) and (b) and concluded that subsection (3) does not apply.

(7) The Secretary of State may by order -

(a) add, remove or amend an entry in the list in subsection (4);

(b) provide for subsection (3) not to have effect in specified cases or circumstances.

(8) An order under subsection (7) -

(a) may include transitional, consequential or incidental provision,

(b) must be made by statutory instrument, and

(c) may not be made unless a draft has been laid before and approved by resolution of each House of Parliament.

(9) For the purposes of this section “claim for asylum” has the same meaning as in section 18.

(10) A decision of the Secretary of State that this section prevents him from providing or arranging for the provision of support to a person is not a decision that the person does not qualify for support for the purpose of section 103 of the Immigration and Asylum Act 1999 (appeals).

(11) This section does not prevent a person’s compliance with a residence restriction imposed in reliance on section 70 (induction).

ANNEX 5

A SAMPLE HUMAN RIGHTS ASSESSMENT FORM FROM XXXX COUNCIL'S UNACCOMPANIED ASYLUM SEEKING CHILDREN AND PERSONS FROM ABROAD TEAM

Human Rights Assessment

Kimani v Lambeth LBC [2004] 1 WLR 272, “...that whether or not a refusal to support will cause a breach of Convention rights must be assessed with regard to all the circumstances, including the position in which the claimant will find themselves if they return to the country from which they came.”

Pretty v UK (2003) 35 EHRR 1, in which the EctHR defined human and degrading treatment in the following terms: “ill-treatment’ that attains a minimum level of severity and involves actual bodily injury or intense physical or mental suffering. Where treatment humiliates or debases an individual showing a lack of respect for, or diminishing, his or her human dignity or arouses feelings of fear, anguish or inferiority capable of breaking and individual’s moral and physical resistance, it may be characterised as degrading and also fall within the prohibition of article 3...”

In R (Q) v SSHD [2003] 3 WLR 365, Subsequently applied to Limbuela – Limbuela, Tesema and Adam. “Putting someone out on the streets will not in itself suffice, in the absence of special considerations, such as age, infirmity or other special vulnerability. However, an Article 3 claim could arise subsequently if , for example , there is some illness or accident. Which materially affected the individual’s ability to fend for himself , or there were a demonstrated inability, over time, to find food and other basic amenities...”

Ullah v Special Adjudicator [2004] UKHL 26. That is, that a claimant who contends that they will suffer a breach of Convention rights if they are removed to another jurisdiction must show: “...a very strong case”, amounting to “strong grounds for believing” that the person, if returned, faces a real risk of suffering a “flagrant violation” of their Convention rights, that is, that the right in question “would be completely denied or nullified in the destination country.”

Mrs S

Person Basic Details

CF Number; 123456

DOB: 25-5-1972

Current Address: XXXX

Country of Origin: India

Religion: Hinduism

Date of Entry to UK: 21-08-2004

Legal Status: Lawfully present, subject to immigration control

Current Application: ILR application made under domestic violence concession.

Date made: 20-07-2006

Marriage Status: Separated

Current Basis of Support: Section 21 (1A) of the National Assistance Act 1948

Summary of Background to case

Mrs S is an Indian woman who came to the UK on a marriage visa on 21-08-2004, having been married to her British born husband in India earlier that year. Her religion is Hinduism. Her first language is Gujarati, although Mrs S speaks and understands some English. She is currently in her second trimester of pregnancy.

Mrs S states that she has been subjected to physical, emotional and financial abuse from her husband and his family with whom they lived. She left her husband and his home on 09-07-2006 after he punched her in the face. Mrs S says she called the Police who took her to the police station where she made a statement. The Police subsequently took her to XXXX Royal Infirmary where she was admitted. Mrs S subsequently made the decision not to return to her husband. She was without income to support herself and without anywhere to live, and is reported as depressed. Her case was referred by hospital ward staff to the Children and Maternity Social Work team at XXXX Royal Infirmary. This team arranged for Mrs S to be accommodated in a hotel pending further assessment. Her case was

subsequently transferred to the Persons from Abroad team for further assessments to take place.

Mrs S's marriage visa expired on 22-07-06. Assistance was given to her to apply for indefinite leave to remain (ILR) under the domestic violence concession. This was sent by recorded delivery on 20-07-06. Solicitor DM at Immigration Law Centre is now involved, and confirmed it would appear that the application was received in time at the Home Office.

Mrs S was until recently, employed by an agency and was working in a biscuit factory. However, her employers stated that Mrs S had a lot of time off sick, and they terminated her employment when her marriage visa expired.

Mrs S has no income or savings.

Support Networks

Mrs S's views of support available

Mrs S states it is not an option for her to return to India, as she would not receive any support there. She states her family have rejected her, as culturally it is not acceptable to them that she has left her husband, in spite of the circumstances surrounding this. Mrs S states that her family in India consists of her mother, three brothers and her eldest brother's wife. She states that the family live in a very small two roomed house, and that whilst she was living there and being supported financially by her eldest brother while she was living in India, there was a clear expectation in the family that when she married she was leaving the family to be part of her husband's family, and subsequently she cannot return to her family home. Mrs S states her mother told her "you live with your husband, you die with your husband". Mrs S states her mother refused to speak with her when she rang her family home recently, and says this was particularly hurtful to her.

Mrs S states that her father died about five years ago. The head of the family is now her eldest brother Mr B. Mrs S states she did not work when she was in India, except for work experience placements as she studied and obtained academic qualifications in accounts and business studies, and vocational qualifications in garment making and beauty therapy. She states that whilst her brother Mr B supported her when she was living in India, he earns a low wage as a maintenance person, and he could not afford to provide any financial support to her either in this country or in India, as he is financially providing support to his wife, and the rest of the family also.

Mrs S states that she has no one who is able to provide financial support or accommodation to her in the UK. She says the people she knows in the UK are able to provide moral and emotional support to her only.

Mrs S states that she wants to make a home for her and her baby in the UK and to be able to support herself when this is viable.

The following people were contacted with regards to exploration of support to Mrs S :

Mrs S's brother Mr B

Mr B was contacted by telephone. It was explained that Mrs S was without a home and I was contacting him as part of my assessment. He confirmed that culturally it was not acceptable to him and the family that Mrs S returns to live in their home after a failed marriage. He advised that he only earns a small wage, which has to support his wife and extended family, and therefore cannot offer any financial support to Mrs S either in India or in the UK. I asked whether he knew of anyone else who could offer support either in the form of accommodation or financially to Mrs S either in India or in the UK. He said he did not know of anyone else who could offer such support.

Ms J, friend

Ms J states she does not really know Mrs S all that well, but feels she is able to offer her moral and emotional support. Ms J has been accompanying Mrs S to appointments and allowed Mrs S to stay at her house on one occasion after she had presented ill at hospital, and it had been recommended that she did not spend the night alone. Ms J says she offered a bed to Mrs S on this occasion on a one off emergency basis, but it meant her daughter had to give up her bed to Mrs S for the night, and Ms J was clear she couldn't offer ongoing support with accommodation or financial support. I asked Ms J if she knew of anyone else who could offer accommodation or financial support to Mrs S. She stated she did not.

Contact with Indian Embassy

A Persons from Abroad team colleague has recently contacted the Indian Embassy and spoke with a Mr C, Consular, to check what support would be available to someone who was in very similar circumstances to Mrs S. Mr C was clear that there are no provisions available in the UK or in India from the Indian Government in the way of shelter or food. Mr C's advice for securing support in such circumstances is to file a case in court for compensation and maintenance from the husband. The Embassy would not accept getting involved in this.

Domestic Abuse

Mrs S's views

Mrs S says she has been left very depressed by the domestic abuse she was subjected to by her husband and his family. She states she was subjected to physical, emotional, sexual and financial abuse by her husband, and emotional abuse by his

family. She states her husband threatened the life of her and their baby, and on one occasion kicked her in the stomach. Mrs S states she made the decision to leave her husband when he punched her in the face. She subsequently telephoned the police who took her to the police station to make a statement, and then onto hospital.

Police Feedback

Mrs S advised me that a PC MW was the investigating officer when she contacted the Police after her husband punched her. She was able to give me an incident reference number, but did not know if her husband was to be arrested or charged with an offence or not. Mrs S's solicitor DM at the Immigration Law Centre has requested police feedback in order to provide supporting evidence for Mrs S's ILR application to the Home Office.

GP feedback

Mrs S's GP Dr P has provided information on Mrs S's presentation to him, which supports her report of domestic abuse. See 'health needs' section.

Hospital feedback

The referral made by hospital ward staff to this department confirmed police involvement with Mrs S and gave details of the crime reference number. The referral also confirmed that Mrs S presented to hospital with facial bruising.

Health Needs

Mrs S's views on her health

Mrs S says she feels very depressed and at times suicidal. However, she says she will not give in to such feelings, as she will not put her baby at risk. She says she feels at her worst at nighttime when she starts to think about what has happened to her. She says this makes her feel very tired the following day and affects her functioning ability. She has been having aches and pains recently which feel to her like pulled muscles. She has presented to hospital with these pains but was not

admitted. Mrs S says she experiences hay fever sometimes, but apart from this her physical health is usually good.

Dr P, GP Feedback

Dr P, GP, states that Mrs S has presented to him several times before she left her husband feeling very depressed and anxious, which seemed to be precipitated by the domestic abuse she was subjected to. He advised she also presented with bruising to her thigh after she claimed her husband threw a hairbrush at her. He confirmed that she remains very distressed and presents with anxiety and depression. Dr P advised that he is unable to prescribe medication to relieve Mrs S's symptoms because of her pregnancy, and has referred her to a counsellor. Although Mrs S has not found this service helpful to her so far, she plans to continue to attend the counselling sessions for the time being.

Dr P states that he has no concerns about Mrs S's pregnancy or physical health.

Midwives' Feedback

TR, Consultant Midwife at XXXX Royal Infirmary, states she is involved with providing follow up care to Mrs S because of concerns raised following Mrs S's emotional presentation at hospital ante natal appointments, as she was mentally very agitated and spoke of suicide. TR states physically there are no concerns with the pregnancy, but said Mrs S presents as visibly upset and anxious.

DL is Mrs S's community midwife and confirmed that she does not have concerns about Mrs S's physical health or pregnancy, but states that Mrs S continues to be very upset by the abuse subjected on her.

SR Women's Aid Worker Feedback

SR states that Mrs S was referred to Women's Aid as hospital staff felt she needed support because of her emotional state. SR confirms that in her opinion Mrs S is socially very isolated and depressed, and states that although she can give her emotional and practical support in terms of accompanying her to appointments and making telephone calls on her behalf, she feels that Mrs S needs counselling to help her come to terms with her situation.

Presentation

Mrs S presents as very tearful at times particularly when talking about her past experiences, and her family's rejection of her. She also presents as very anxious about most aspects of her life, and has evidenced this in telephone calls to myself where she shared her concerns about her visa and employment termination. During a recent visit she had been followed by her husband from the bus station to XXXX (witnessed by SR, Women's Aid Worker). Mrs S was clearly very distressed by the

incident, and took a long time to recover before she felt able to leave the building. This incident appears to clearly have knocked her confidence also. Mrs S also appears very fatigued whenever I have seen her, and low in mood. She has shared her past thoughts of suicide with me, but also is clear that she will not act positively on these feelings because of her baby.

Evaluation

Mrs S originally came to the UK on a marriage visa. She has been subjected to physical, emotional, financial, and sexual abuse throughout her marriage. She left her husband after he assaulted her on 09-07-2006. She had contacted the police who subsequently took her to hospital.

Mrs S's visa expired on 22-07-06, and she submitted an in time application to the Home Office for ILR under the domestic violence concession.

Mrs S is in her second trimester of pregnancy. She has been experiencing some aches and pains. However, she has presented at hospital with these and hospital staff have not felt a need to admit her. There are no concerns about Mrs S's physical health, but the professionals involved in her care confirm that she is experiencing anxiety and depression at present. She has also expressed suicidal thoughts in the recent past, and is currently receiving counselling for her mental health. Her mental state appears to be reactive to her situation and the abuse she has experienced.

Mrs S has no income or savings, and has no recourse to public funds under the terms of her visa. All possible options of support have been pursued on Mrs S's behalf, and it would seem her family have turned their backs on her, as it is not acceptable to them culturally for Mrs S to have left her husband. Her brother who is head of the family states that it is not possible for him to financially support her or offer her accommodation, and says he does not know of anyone else who could provide such support. There does not appear to be anything in India in the way of governmental or charitable support that could provide for Mrs S and her baby, when it is born. Mrs S has a friend in the UK who is able to offer moral support, but cannot offer financial support or accommodation.

Whilst Mrs S has a right to work, and indeed has worked in the past, she is not well enough to work at the moment, her mental state and stage of pregnancy leaving her very fatigued. Her stage of pregnancy will also affect her employability. When Mrs S has her baby, her chances of finding work, which will also offer child care or pay enough to employ child care services, are likely to be slim.

Mrs S appears mentally quite fragile and requires a lot of emotional support, as her coping mechanisms are limited. Based on the information gathered in the course of

the community care and human rights assessments, the reality is that Mrs S, (and her baby when it is born), would experience inhumane and degrading treatment if they were to return to India, as they would not have access to any support, and would be without automatic access to food or shelter. Indeed, the situation would be the same in the UK as Mrs S has no means of informal support or recourse to public funds in this country either, and if it were not for the current level of support given to her, she would be without food and shelter and at risk of nutritional neglect. This would put Mrs S's health at risk of further deterioration, and her pregnancy would be put at risk. I therefore feel Mrs S's basic human rights under Article 3 of the Human Rights Act 1998 would be violated if support with shelter and food and other basic essentials were withdrawn from her.

Conclusion and Recommendation

I recommend that the Department continues to support Mrs S under Section 21 (1A) of the National Assistance Act 1948 on the basis that at this time, Mrs S is physically and emotionally vulnerable due to her pregnancy, the effects of the domestic abuse she experienced, and that she is destitute without means to support herself in the UK or secure travel back to India.

This assessment will need to be reviewed on a three monthly basis, and re-evaluated by reference to a number of factors, including the progress of her domestic violence concession application and any adjudicator's decision in respect of this, by Mrs S's ability and willingness to continue to pursue other avenues of support for herself including a legal right to seek support from her husband, and a re-assessment of her fitness to travel to India after the birth of her baby, and any risks she may be exposed if she were to return to India following this.

21-08-2006

ANNEX 6

ANONYMISED LIST OF PARTICIPANTS

Limbuela

National level officer	UK Border Agency
Manager for asylum and persons from abroad; Strategic director, social care and health (2)	English metropolitan authority
Manager, Unaccompanied Asylum Seeking Children and Persons from Abroad team	English city council
Manager, adult social care	Outer London borough
No Recourse to Public Funds team: head of refugee and migrant service; team manager and 2 x caseworkers (4)	Inner London borough
Policy officer	Regional multi-agency Strategic Migration Partnership
Project worker	British Red Cross
National officer	Welsh Refugee Council
Policy officer	Refugee Council
Legal advisor	Asylum Support Appeals Project
Solicitor	Shelter

East Sussex

Manual handling advisor	NHS Foundation Trust
Manual handling co-ordinator	English city council
Director of housing and social care, manager of adult social care, manual handling co-ordinator and 7 x occupational therapists (10)	Outer London borough
Strategic director, social care and health	English metropolitan authority
Manual handling co-ordinator	Welsh county borough council
Disability services manager, deputy director of social services (2)	English city council
Director of housing and social care	Welsh county borough council
National officer	Radar
National officer	National Centre for Independent Living
National officer	PMLD Network/Mencap
National officer	National Care Homes Association
National officer	College of Occupational Therapists
Independent advisor to public authorities and care providers on manual handling and social care law	
Independent advisor on manual handling	
Lecturer, nursing (and Royal College of Nursing safety rep)	University of Northumbria

Bernard

Senior housing officer (and background conversation with former housing manager) (2)	LB Enfield
Disability services manager; deputy director of social services (2)	English city council
Director of housing and social care; housing manager; social services manager (3)	Outer London borough
Strategic director, social care and health	English metropolitan authority
Housing advisor	English district council
Director of housing and social care	Welsh county borough council
Disability housing advisor	Habinteg housing association
National officers (2)	Chartered Institute of Housing
Policy officer	Housing Corporation
Policy officer	Local Government Association
Solicitor	Shelter

Osman, Detainees, Price

Coroners (2)	2 English cities
Police officers – various ranks (9)	5 forces
Prison health managers (3)	3 PCTs
Prison health practitioners (5)	5 prison clusters
Prison health adviser	London PCT
Regional prison health adviser	Health and Social Care in Criminal Justice
Government prison policy advisers (2)	Central government
Prison health policy advisers (2)	Central government
Prisons and Probation Ombudsman	-
Independent prison monitor	Independent Monitoring Board
Senior director	NOMS
Prison training director	Newbold Revel Prison Service College
Professor of Prison Studies	London university
Director	Prison NGO
Analyst/researcher	Prison NGO

ANNEX 7

EXAMPLE OF AN 'OSMAN WARNING'



Northamptonshire Police

Notice of Threat to Personal Safety

Mr/Mrs/Miss

I am in receipt of the following information, which suggests that your personal safety is now in danger.

I stress that I will not under any circumstances disclose to you the identity of the source of this information and whilst I cannot comment on the reliability or otherwise of the source or the content of this information, I have no reason to disbelieve the account as provided.

Insert here details of the threat

Although Northamptonshire Police will take what steps it can to minimise the risk, the Police cannot protect you from this threat on a day-by-day, hour-by-hour basis.

I also stress that the passing of this information by me in no way authorises you to take any action which would place you in contravention of the law (e.g. carrying weapons for defence, assault on others, breaches of public order) and should you be found to be so committing you will be dealt with accordingly.

I therefore suggest that you take such remedial action as you see fit to increase your own safety measures e.g. house burglar alarms, change of daily routines, always walk with an associate, carry a mobile phone, install a domestic CCTV door guard system, increase house security measures e.g. locks and bolts. It may even be that you decide that it is more appropriate for you to leave the area for the foreseeable future. That is a matter for you to decide.

If you wish to provide me with full details of the address at which you will be resident I will ensure that the necessary surveys can be undertaken by police staff to advise you regarding the above safety measures.

I would also ask that you contact the Police regarding any suspicious incidents associated with this threat.

Iacknowledge that athours on2008, the above notice was read out to me

by of the Northamptonshire Police.

Signed

Date of Birth

Address
.....
.....
.....

Signed by Officer reading notice to

.....Time/Date.....

Signed by Officer witnessing reading

.....Time/Date.....

ANNEX 8

GLOSSARY

ACCT	Assessment, Care in Custody & Teamwork
ACPO	Association of Chief Police Officers
ADASS	Association of Directors of Adult Social Services
ASAP	Asylum Support Appeals Project
CIH	Chartered Institute of Housing
CLG	Communities and Local Government
COT	College of Occupational Therapists
DDA	Discrimination and Disability Act (2005)
DRC	Disability Rights Commission
ECHR	European Convention on Human Rights
ECtHR	European Court of Human Rights
ESCC	East Sussex County Council
HMIC	Her Majesty's Inspectorate of Constabulary
HMIP	Her Majesty's Inspectorate of Prisons
HMP	Her Majesty's Prison
HRA	Human Rights Act (1998)
HSE	Health and Safety Executive
IAP	Inter-Agency Partnership
IPCC	Independent Police Complaints Commission
JCHR	Joint Committee on Human Rights
LB	London Borough
LGA	Local Government Association
LGO	Local Government Ombudsman
MOJ	Ministry of Justice
NASS	National Asylum Support Service
NHS	National Health Service
NIA Act	Nationality, Immigration & Asylum Act (2002)
NOMS	National Offender Management Service
NPIA	National Policing Improvement Agency
NRPF	No Recourse to Public Funds
PACE	Police and Criminal Evidence Codes of Practice
PCT	Primary Care Trust
PER	Prisoner Escort Records
PPO	Prison and Probation Ombudsman
PSI	Prison Service Instruction
PSO	Prison Service Order
RCN	Royal College of Nursing
UKBA	United Kingdom Border Agency

ANNEX 9

BRIEFING FOR INTERVIEWEES

Research project for the Equality and Human Rights Commission (EHRC): Evaluating the impact of selected cases under the Human Rights Act on public service provision

Thank you for participating in this project which is being conducted by Professor Philip Leach of the Human Rights and Social Justice Research Institute at London Metropolitan University and Alice Donald, Elizabeth Mottershaw and Jenny Watson of Global Partners and Associates.

1. Aims of the project

This project is part of the EHRC's ongoing independent inquiry into human rights in Britain (launched in April 2008). The project will:

explore the impact of a number of strategic legal cases brought under the Human Rights Act (or the European Convention on Human Rights) on a range of public authorities;

- explore with service providers from different sectors whether and how the principles established in these cases have been incorporated into policy and practice;
- explore the positive impact within these sectors of implementing human rights principles;
- identify the barriers that prevent or obstruct the use of human rights principles in these sectors.

2. Interviews

We are conducting semi-structured interviews with key stakeholders who have particular experience and expertise in the implementation of human rights standards in Britain and whose organisations have a role to play in the creation of a human rights culture. The general questions we will explore are:

- a. What are the mechanisms for monitoring case law and disseminating guidance on the principles and implications of case law that you are aware of – and, in your view, how effective are they?

- b. If you are working in a public authority, are you able to access guidance about the lessons of case law that makes sense for the work you do?
- c. In your experience, do mechanisms exist for the key principles of case law to be incorporated effectively into policy and practice? If so, how does this happen (e.g. through training, written guidance, policy reviews, top-down briefings)?
- d. In your organisation or sector, can you point to any aspect of everyday practice which you think has changed because lessons have been learnt from human rights cases?
- e. What are the barriers to implementing the lessons of human rights cases and how do you think they could be tackled?
- f. In your experience, are there positive benefits within your sector or organisation that can be identified as having flowed directly from the implementation of HRA case law?
- g. What factors, from your experience, make the difference between “risk proofing” in response to legal judgments and cases being seen as a positive way of achieving better outcomes for staff and service users?
- h. In general, do you see human rights law as imposing lines that cannot be crossed or as a (potential) driver of good practice? Put another way, does it make you think “what can’t I do?” or “what should I do?”

3. Selected cases

We have chosen a number of cases which have significant implications for policy and practice in a range of public authorities. As a means of focusing the general questions above, we would like to explore with you, as appropriate to your sector and your own experience, the impact of one or more of the following. We stress that we are focusing on the general principles raised by these cases and their lessons for policy and practice, rather than a detailed consideration of the legal judgments.

Cases involving Article 2: right to life

Cases illustrating key principles concerning the circumstances in which preventative measures should be taken in order to avert a risk to life; the nature of such measures, and the holding of effective investigations where there has been loss of life.

Osman v UK, No. 23452/94, Judgment of 28 October 1998 / Osman v UK (2000) 29 EHRR 245

Keenan v UK (2001) 33 EHRR 38

R (on the application of Wright) v S/S for the Home Department [2001] 1 Lloyd's Rep Med 478

Edwards v UK (2002) 35 EHRR 19

R (on the application of Amin) v S/S for the Home Department [2004] 1 AC 653; [2001] EWHC Admin 520; 2001 WL 606447

R (on the application of Middleton) v Coroner for the Western District of Somerset [2004] 2 AC 182

The Limbuela case

This case concerned a group of asylum seekers and established that where inhuman or degrading treatment or punishment results from acts or omissions for which the state is directly responsible, there is an absolute obligation on states to refrain from such conduct. In addition, it established that treatment was inhuman or degrading if, to a seriously detrimental extent, it denied the most basic needs of any human being. The test for whether the margin was crossed was whether the treatment to which the asylum seeker was being subjected by the entire package of restrictions and deprivations that surrounded him was so severe that it could properly be described as inhuman or degrading treatment within the meaning of Article 3.

R [Limbuela and Ors] v Secretary of State for the Home Department [2005] UKHL 66, 3 November 2005

Cases involving principles relating to balancing rights and the application of blanket policies

The "East Sussex manual handling case" concerned the family of two adult sisters with profound physical and learning disabilities who challenged the council's blanket application of a policy prohibiting manual handling by care workers. In the "prison baby case" the court held that a policy of only allowing babies to remain with their mothers in prison until they were 18 months old had to be applied flexibly, bearing in mind the individual circumstances. These cases enshrine principles involving the application of a blanket policy or the rigid application of a policy without consideration of individual circumstances, as well as the way in which the HRA provides a framework for balancing competing rights.

R v East Sussex County Council Ex parte A, B, X and Y [2003] EWHC 167

R [on the application of P and Q] v S/S for the Home Department [2001] EWCA Civ 1151

Cases involving positive obligations relating to disability and Articles 3 & 8:

In *Bernard v Enfield* a disabled woman was knowingly placed in unsuitable council accommodation, in breach of her Article 8 right to a private and family life. In *Price v UK* a disabled woman was detained in a cell not adapted to her needs, amounting to inhuman or degrading treatment under Article 3. These cases both relate to the principle of positive obligations in relation to disability – that is, the proactive steps that public authorities must take to protect and promote the rights of disabled people. *Bernard v Enfield* also established the need to provide a service free from unnecessary delay for service users who need particular assistance.

Bernard v Enfield LBC [2003] HRLR 4

Price v UK [2001] 34 EHRR 128

ANNEX 10

HUMAN RIGHTS SURVEY - THE OSMAN CASE

Human Rights Survey - the Osman case

Survey for the Equality and Human Rights Commission

This survey is part of a research project for the Equality and Human Rights Commission to explore the impact of selected legal cases on public service delivery in England and Wales. The project is part of the Commission's inquiry into how human rights work in Britain.

This survey comprises a small number of questions about a case called Osman v UK and police policies and practices that are relevant to the case. It should take no more than 10 minutes to complete. All questions are optional, but it would help us if you could complete as many as possible.

Please reply by Monday 1st September.

All responses are anonymous. Our small research team from Global Partners and Associates and London Metropolitan University will not be able to identify any responses by name. Additionally the overall anonymous results will be used without any reference to particular police forces.

Survey for the Equality and Human Rights Commission

1. We're interested first of all to know about levels of awareness of the case of Osman v UK.

	Yes	No	Don't know	Not applicable
I have heard of the case but I do not know any details about it.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have heard of the case and I understand some of its implications for my work.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am very familiar with the case and confident that I understand its implications for my work.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have not heard of the case.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Survey for the Equality and Human Rights Commission

Human Rights Survey - the Osman case

2. The case of Osman v UK was about a teacher who developed an obsession with a pupil. The teacher killed the pupil's father. The European Court of Human Rights found that authorities would be in breach of human rights law if they knew or should have known of a risk to life and failed to take measures within their powers to avert that risk. We are interested to know if you think this principle is reflected in your practice, policies, training or other documents that guide your work.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
I recognise this principle as something that guides my work.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I recognise this principle as something reflected in policies that guide my work.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I recognise this principle from training I have received.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I recognise this principle as something reflected in other documents that guide in my work.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I do not recognise this principle as something relevant to my work.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Survey for the Equality and Human Rights Commission

3. We would like to know more about any policies you believe reflect this principle and the areas of work they cover. [The principle is that that there would be a breach of human rights law if authorities knew or should have known of a risk to life and failed to take measures within their powers to avert that risk.]

Please use the boxes below to tell us the names of any policies or similar that reflect this principle, and/or the issue they cover; and/or, if known, the source – are they issued by your local police force or by another, possibly national, body?

- 1a) Name of policy/issue covered:
- 1b) Organisation issuing the policy:
- 2a) Name of policy/issue covered:
- 2b) Organisation issuing the policy:
- 3a) Name of policy/issue covered:
- 3b) Organisation issuing the policy:
- 4a) Name of policy/issue covered:
- 4b) Organisation issuing the policy:
- 5a) Name of policy/issue covered:

Human Rights Survey - the Osman case

covered:

5b) Organisation issuing
the policy:

Survey for the Equality and Human Rights Commission

4. We would like to know your opinions on the usefulness of any such policies.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
Policies I am aware of that reflect the Osman principle are clear and easily understood.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Policies I am aware of that reflect this principle are disseminated to all relevant people within the force.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Policies I am aware of that reflect this principle are easy to put into practice.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Implementation of such policies is routinely monitored.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Survey for the Equality and Human Rights Commission

5. We would like to know more about your understanding of "known or should have known" and when it might affect your work.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
I am confident that I understand what "known or should have known" means in practice.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I know where to go for guidance on what this principle means in practice.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am confident that my police force has in place mechanisms for sharing information to ensure the right people are aware of risks to life of someone in the community.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Survey for the Equality and Human Rights Commission

6. Can you recall an instance when you or a colleague had cause to discuss or put into practice the Osman principle in relation to a risk to life of someone in the community? If so, please use this box to describe briefly what happened.

Survey for the Equality and Human Rights Commission

Human Rights Survey - the Osman case

7. We are interested in any additional thoughts you have about the case of Osman and the way in which it impacts on your work. Please use this box to add any further comments.

Survey for the Equality and Human Rights Commission

The Survey is now complete - many thanks for your time and co-operation.

ANNEX 11

HUMAN RIGHTS SURVEY – LEGAL DIRECTORS

Human Rights Survey - Legal Directors

Survey for the Equality and Human Rights Commission

This survey is being sent to directors of legal services in England and Wales and is one of a set of surveys that will give us preliminary information about the impact of human rights case law in a range of sectors.

The survey should take no more than 10 minutes to complete. Please reply by Monday 21st July. Please note that any information from this survey that we incorporate in our final report will be unattributed. However, as you will see in question 15, we are inviting local authorities to participate further in the project by means of a short telephone interview, and comments made in that interview might be attributed with your permission.

Survey for the Equality and Human Rights Commission

1. Please tell us which local authority you work in (you do not have to fill in this box and if you do, your comments will not be attributed to you).

Survey for the Equality and Human Rights Commission

2. We are interested to know whether, in your authority, responsibility for monitoring human rights case law is a centralised function or one that takes place within different service departments.

- Monitoring is done by legal officers within the chief executive's office
- Monitoring is done by a separate legal department
- Monitoring is done by legal advisers to separate service departments

Other (please specify)

Survey for the Equality and Human Rights Commission

Human Rights Survey - Legal Directors

3. We are interested to know what mechanisms exist in your local authority to monitor human rights case law.

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree
My local authority has systematic arrangements in place to monitor human rights case law on a regular basis.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My local authority has an appropriate lead officer with specific responsibility for monitoring human rights case law.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My local authority has no systematic arrangements in place to monitor human rights case law, but does so on an ad hoc basis.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I don't know if my local authority has systematic arrangements in place to monitor human rights case law.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4. Does your authority have any other arrangements for monitoring human rights developments, other the options suggested above?

Survey for the Equality and Human Rights Commission

5. Do you receive any guidance or advice on human rights case law from sources external to your authority, and if so where does it come from?

Survey for the Equality and Human Rights Commission

Human Rights Survey - Legal Directors

6. We are interested to know whether, in your view, operational managers in your local authority receive sufficient, timely and accessible guidance about the lessons of relevant human rights case law for their work.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
Operational managers receive sufficient guidance.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Operational managers receive guidance reasonably soon after the case in question.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Operational managers receive guidance that is written so that they understand the lessons of the case for their day-to-day work and are able to put them into practice.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When operational managers receive guidance on case law, it is explicitly 'labelled' as human rights guidance and includes an explanation of the case in question.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Operational managers have to seek out guidance - it doesn't come to them automatically.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Operational managers never receive guidance.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I don't know what relevant guidance operational managers receive.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Survey for the Equality and Human Rights Commission

Human Rights Survey - Legal Directors

7. We are interested to know whether, in your view, frontline staff in your local authority who deliver services day to day receive sufficient, timely and appropriate guidance about the implications of relevant human rights case for their work.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree
Frontline staff receive sufficient guidance.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Frontline staff receive guidance reasonably soon after the case in question.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Frontline staff receive guidance that is written so that they understand the lessons of the case for their day-to-day work and are able to put them into practice.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When frontline staff receive guidance on case law, it is explicitly 'labelled' as human rights guidance and includes an explanation of the case in question.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Frontline staff have to seek out guidance - it doesn't come to them automatically.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Frontline staff never receive guidance.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I don't know what relevant guidance frontline staff receive.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Survey for the Equality and Human Rights Commission

8. Please use this box to explain briefly how your authority disseminates the lessons of human rights cases to those staff that need to know them.

Survey for the Equality and Human Rights Commission

Human Rights Survey - Legal Directors

9. We would like to ask you about three human rights cases which have significant implications for the policy and practice of local authorities. The first is Bernard v Enfield LBC [2003] HRLR 4. A woman who used a wheelchair and suffered from incontinence and diabetes was left by the council in unadapted accommodation for 20 months, confined to one room and unable to use the toilet, even though her care plan stated that she urgently needed to move to a suitable property. The High Court held that the council's failure to act showed a "singular lack of respect" for the claimant's private and family life, in breach of Article 8 of the ECHR, and awarded £10,000 damages. The court held that the council was under a positive obligation to take steps, without undue delay, to restore the claimant's dignity as a human being - including the provision of suitably adapted accommodation.

	Yes	No	Don't Know
I am aware of this case and the principles it raised.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My authority examined its policies in the light of this case to establish whether the policies were compatible.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My authority changed its policies in the light of this case.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My authority has issued guidance to ensure that all relevant staff are aware of the principles raised in this case and the lessons for everyday practice.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My authority has a mechanism to ensure that all agencies that are contracted to deliver services on behalf of the local authority are aware of policy in this area.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10. Please use this box to add any further information about what, in your assessment, has been the impact of the Bernard v Enfield case and its implications for service delivery.

Human Rights Survey - Legal Directors

11. The second case we would like to ask you about is R v East Sussex County Council Ex parte A, B, X and Y [2003] EWHC 167 which involved a challenge by the family of two adult sisters with profound physical and learning disabilities to the council's blanket application of a policy prohibiting manual handling by care workers. The High Court provided a framework for local authorities to balance the potentially conflicting interests of the disabled individual with the health and safety of employees.

	Yes	No	Don't Know
I am aware of this case and the principles it raised.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My authority examined its policies in the light of this case to establish whether the policies were compatible.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My authority changed its policies in the light of this case.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My authority has issued guidance to ensure that all relevant staff are aware of the principles raised in this case and the lessons for everyday practice.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My authority has a mechanism to ensure that all agencies that are contracted to deliver services on behalf of the local authority are aware of policy in this area.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

12. Please use this box to add any further information about what, in your assessment, has been the impact of the East Sussex case and its implications for service delivery.

Human Rights Survey - Legal Directors

13. The third case we would like to ask you about is R [Limbuela and Ors] v Secretary of State for the Home Department [2005] UKHL 66, 3 November 2005. This case concerned a group of asylum seekers and established that where inhuman or degrading treatment or punishment results from acts or omissions for which the state is directly responsible, there is an absolute obligation on states to refrain from such conduct. The test for whether the margin was crossed was whether the treatment to which the asylum seeker was being subjected by the entire package of restrictions and deprivations that surrounded him was so severe that it could properly be described as inhuman or degrading treatment within the meaning of Article 3.

	Yes	No	Don't Know
I am aware of this case and the principles it raised.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My authority examined its policies in the light of this case to establish whether the policies were compatible.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My authority changed its policies in the light of this case.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My authority has issued guidance to ensure that all relevant staff are aware of the principles raised in this case and the lessons for everyday practice.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My authority has a mechanism to ensure that all agencies that are contracted to deliver services on behalf of the local authority are aware of policy in this area.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

14. Please use this box to add any further information about what, in your assessment, has been the impact of the Limbuela case and its implications for service delivery.

Survey for the Equality and Human Rights Commission

15. This project is interested to follow up, by means of a short telephone interview, examples of good practice that relate to the translation of the principles of human rights cases into policy and practice. If you would like to participate in this way, please give brief details here, along with the contact name and email of the person whom we should contact - this could be you or a colleague.

Survey for the Equality and Human Rights Commission

Human Rights Survey - Legal Directors

The Survey is now complete - many thanks for your time and co-operation.

www.equalityhumanrights.com