Neutral Citation Number: [2024] EWHC 2682 (Admin)

Case No: AC-2024-LON-002779

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 23/10/2024

Before:

MR JUSTICE MACDONALD

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Between:

R (ON THE APPLICATION OF A, BY HIS LITIGATION FRIEND, B)	**Claimant**
- and -	
NORTH CENTRAL LONDON INTEGRATED CARE BOARD	**Defendant**
-and-	
LONDON BOROUGH OF HARINGEY	**Interested Party**

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Mr Ian Wise KC and Mr Ollie Persey (instructed by **Miles & Partners LLP**) for the **Claimant**
Mr David Lawson and Mr Jake Rylatt (instructed by **Hill Dickinson LLP**) for the **Defendant**
Ms Fiona Munro (instructed by **LB of Haringey**) for the **Interested Party**

Hearing date: 20 September 2024

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Approved Judgment

This judgment was handed down remotely at 10.30am on 23 October 2024 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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MR JUSTICE MACDONALD

Mr Justice MacDonald:

INTRODUCTION

1. This is an application for judicial review that concerns the provision of continuing healthcare for the Claimant, A. A is a severely disabled 11-year-old boy born in October 2012. The Claimant has a rare SLC13A5 Citrate Transporter Disorder that is, sadly, life threatening and life limiting. As a result of his condition, the Claimant has severe epilepsy that places him at risk of Sudden Death in Epilepsy (hereafter 'SUDEP'), episodes of atonia that place him at risk of suffocation and a severe learning disability, communication and mobility disabilities. The Claimant is represented by Mr Ian Wise of King's Counsel and Mr Ollie Persey of counsel. There is an anonymity order in force.

2. The Claimant is eligible for NHS Children and Young People's Continuing Care (a package of care provided by the NHS by reason of the intensity of a child's health needs, hereafter 'Continuing Care') and has been in receipt of such care since 25 June 2015. The Defendant is the North Central London Integrated Care Board (hereafter 'ICB') and is the responsible commissioner. Its Childrens Complex Care Team commissions individualised care for children with complex health needs that cannot be met by the NHS's universal, and specialist commissioned services. In this case, clinical case management is provided through the Whittington Health Continuing Care Clinical Team of Whittington Health NHS Trust. The Defendant is represented by Mr David Lawson of counsel and Mr Jake Rylatt of counsel.

3. The Claimant's application for judicial review has been listed on an expedited basis for a rolled up hearing. The Claimant pleads three grounds (although the third ground is more accurately described as a remedy):

    i) The Defendant is in ongoing breach of its duty to ensure that the Claimant has a lawful health care plan (at other points in the documents the term "care plan" is used, but the Claim Form uses the term "health care plan").

    ii) The Defendant's decision to terminate the then current registered care provider's contract on 9 July 2024 and to proceed to replace them with a new registered care provider on 10 July 2024 was irrational.

    iii) The Claimant's parents are paying for his healthcare package at a cost of c. £10,000 a week because the Defendant has failed to arrange a lawful healthcare package for the Claimant and the Claimant's family are thereby entitled to restitution on the ground of unjust enrichment.

4. The Claimant also has an Education, Health and Care Plan (hereafter 'EHC plan'), which is maintained by the London Borough of Haringey. The London Borough Haringey is an Interested Party in these proceedings, represented by Ms Fiona Mullin of counsel. The Interested Party has issued care proceedings in respect of A. The application for a care order is allocated to me in the Family Court and the Interested Party is now seeking permission to withdraw those proceedings. That application will be determined following the determination of these judicial review proceedings.

5. In determining this matter, I have had the benefit of reading the bundle and supplementary bundle prepared for this hearing, together with the comprehensive and helpful Skeleton Arguments of Mr Wise and Mr Persey and Mr Lawson and Mr Rylatt. Mr Wise and Mr Lawson also made oral submissions. I reserved judgment and now set out my decision and the reasons for it.

RELEVANT BACKGROUND AND EVIDENCE

6. The relevant background and evidence requires to be set out in a little detail. As I have noted, A was born in October 2012 and thereafter diagnosed with a rare SLC13A5 Citrate Transporter Disorder. A is currently under the care of consultants at Great Ormond Street Hospital and UCL Hospital. The following relevant matters concerning A's medical condition and its consequences can be drawn from the evidence before the court, including a report dated 6 March 2023 from Dr Christina Petropoulos, Consultant Paediatrician at UCL Hospital's Children and Young People's Seizure Clinic, who has been caring for A since infancy when he presented with neonatal seizures:

    i) The SLC13A5 deficiency has resulted in A suffering early infantile epileptic encephalopathy and multifocal epilepsy. His seizures are refractory (i.e. not controlled by anti-epileptic medication) and he has had convulsive status epilepticus since birth with a history of sub clinical non convulsive status epilepticus. A exhibits all seizure types, with the majority being tonic-clonic seizures. Due to the severity and length of the latter, there is an emergency plan requiring the administration of emergency Buccal Midazolam as there is a significant health and mortality risk to A if his seizures are not managed. He is at high risk of SUDEP. The Defendant accepts that A is at high risk of SUDEP.

    ii) A's seizures have multiple triggers, including illness, tiredness, temperature, pain, sensory and environmental factors and certain foods. Following prolonged seizures, A experiences a loss of his already limited skills for days, weeks, months and, in the case of extended status epilepticus, permanently. The areas affected include his sleep, tone, coordination, gross and fine motor skills, communication, eating and drinking, sensory and emotional/ behavioural regulation/modulation. Dr Petropoulos considers A's seizure disorder to be "severe and unpredictable", life limiting and life threatening. To manage the severity of his seizures, A is described as requiring close contact care day and night.

    iii) A also has gross and fine motor disorders and cannot stand or walk independently. He exhibits dystonia and muscle weakness. A can exhibit weakness and loss of muscle tone lasting several minutes to hours. The onset of muscle weakness can cause A to collapse suddenly during the day and at night when asleep, he can sink face down into the pillow or mattress, risking suffocation. A also suffers from hypotonia and has a diagnosis of oropharyngeal dysphagia, placing him at increased risk of choking and aspiration. A has hypermobile joints and reduced feeling in his body. There is concern about subluxation of his hips and out-turning of the left leg. He has significant ankle pronation. A has amelogenesis imperfecta and teething pain exacerbate his seizure frequency. He suffers from pain dysregulation and does

not show pain in the usual way. He is doubly incontinent and is not consistently aware that he has wet or soiled his pad.

iv) A also has significant developmental needs as a result of his condition. A exhibits global developmental delay and has a diagnosis of Severe Intellectual Learning Disability and Severe Language and Communication Disorder. He has significant difficulties with executive functioning and has no consistent or reliable form of communication. He cannot consistently express his basic needs. A demonstrates some autistic features. He struggles with everyday transitions. A also has significant sensory and emotional regulation and modulation difficulties and significant behavioural difficulties. He has food intolerances and allergies and he has difficulties with constipation managed with a daily plan of diet, mobility exercises, mobilisation and massage. A is unable himself to undertake any basic self-care needs and cannot self-feed, dress, wash, brush his teeth, comb his hair, blow or wipe his nose.

7. It is important to state that A is, of course, much more than the sum of his disabilities. In her first statement, the mother describes A as having a smile that draws people to him, the most infectious laugh and a cheeky sense of humour. When well, his mother describes him as engaged with everything and everyone around him and that he shows a strength of character that is admirable and, at times, challenging. A loves music, with tastes that are described as eclectic. When supported effectively, A is a happy child, proud of his advances and achievements.

8. The court has before it a number of documents that deal with A's needs arising from the foregoing matters. Specifically the report of Dr Petropoulos dated 6 March 2023, a letter from Dr Robert Robinson, Consultant Paediatric Neurologist at Great Ormond Street Hospital dated 14 August 2024, Nursing Clinical Judgment Statements dated 8 August 2024 and 20 August 2024, a further report from Dr Petropoulos dated 3 September 2024 and a report from Nerys Hughes, Occupational Therapist, highlighting the following:

i) Many of his seizure triggers are very particular to the Claimant and require specific training from existing care staff, professionals and parents.

ii) The Claimant requires two people to keep him in a position of physical safety when he has an aggressive tonic-clonic seizure. His oral secretions pool in his mouth and can require suction to minimise the risk of choking and aspiration.

iii) In circumstances where A's dystonia and muscle weakness/loss of tone can cause him pain, which is a significant seizure trigger, the episodes require immediate identification and management to prevent such an escalation.

iv) The Claimant has poor balance and requires assistance when moving from one position to another or walking to prevent falls/ head injury and pain which can lead to a life threatening seizure.

v) It is essential to prioritise consistency of the Claimant's care routine. Maintaining stability is crucial to prevent any destabilisation, which could lead to adverse effects on his health and well-being.

vi) A's physical presentation varies in response to both medication and seizure patterns, making his presentation unpredictable and requiring adaptive input when engaging with his needs by well-trained and supportive carers.

vii) It is imperative that comprehensive training and orientation is in place for new care personnel. New personnel must be equipped with in-depth knowledge of the Claimant's specific medical conditions, seizure triggers, communication strategies, and daily care routines in order to ensure that the quality of care remains uninterrupted and that any potential disruptions are minimised.

viii) As the condition under which A labours is rare, there is a limited evidence base specific to his condition and no defined care pathway and training for carers. In the circumstances, training must be delivered by the clinical team working with A who know him well in order that his very specific and rare needs can be met.

ix) Any changes to the Claimant's care package should only be made after careful evaluation and after discussion with those who have a good understanding of his requirements, including his parents.

x) When introducing new caregivers, a carefully structured and phased transition plan should be implemented. If there is a need to change carers there should be a clear handover period, health care plan in place, and appropriate training for any carers who are appointed to understand the Claimant's specific needs.

9. In her first statement, the mother avers that it has been a "never ending struggle" to obtain from the Defendant, the Continuing Care team, the Interested Party, and specifically its Special Educational Needs and Disability 'SEND' team, the services that A requires as a result of his complex needs.

10. As a result of his medical condition and the needs that arise from it, A has been in receipt of Continuing Care since 25 June 2015. The Defendant has been the responsible commissioner for that care since July 2022. As I have noted, clinical case management is provided by Whittington Health NHS Trust's Children's Continuing Care team. That team is responsible for conducting A's annual NHS Continuing Care review in line with the NHS National Framework for Children and Young People's Continuing Care 2016 (hereafter 'the National Framework') and the Defendant's Children's Continuing Care Policy.

11. Between 2017 and 2024 A's care was provided by Enviva, a CQC-registered care agency. In her statement of evidence the Defendant's Assistant Director of Children's Complex Care, Kathryn Collin, states that the Defendant expects that all care agencies providing care to children having Continuing Care will deliver care in line with a health care plan. Ms Collin further states that the care agency is responsible for developing the health care plan in collaboration with the family and the professional team around the child. She avers that the health care plan must be kept up to date at all times by the care agency and, in this case, shared with the Defendant and the Children's Continuing Care team at Whittington Health NHS Trust.

12. Enviva produced a document entitled "Care Plan" dated 13 June 2023. In her second statement, Ms Collin contends that this was a health care plan and was the document

sent to the mother on 22 July 2024 when the mother requested a copy of the health care plan. The information contained in that document can be summarised as follows, the plan being divided into a number of sections:

i) History, Social and Communication.

a) This section details A's medical conditions, including his epilepsy, the fact that his seizures are refractory and not controlled by medication, that there is a significant health risk and risk of mortality if his seizures are not managed with immediate and effective clinical input and that A is at high risk of SUDEP. The section details that A has multiple seizure triggers. It details A's developmental delay. It also details his hypertonia.

b) The section provides A's weekly timetable of activities and services and details certain of the activities he enjoys.

c) The behavioural regulation and modulation section refers to the educational psychology report and warns that A engages in extremely challenge behaviours that require hourly support. The section sets out the action a carer should take when A hits himself and the need for two people to manage him, including his everyday care needs. The section highlights that A requires consideration time to transition from one activity to another. The section makes clear that A should not be told off and his head should not be stroked. It highlights that pain from hitting himself is a trigger for seizures.

d) The emotional regulation and modulation section highlights that A has significant and severe emotional regulation and emotional modulation issue and that concerns in this regard must be reported and the strategies outlined in the behavioural regulation and modulation section deployed and that in addition A must be made to feel safe, secure, stable and reassured. The section states that A responds to verbal reassurance and physical comfort. It highlights that emotional dysregulation and anxiety are seizure triggers and must be closely monitored and reported.

e) The sensory section refers to the Occupational Therapy report for detail of A's sensory processing issues. It warns carers that whilst A gains sensory unput from appliances, he may become overwhelmed, risking the trigger of a seizure, and that carers must recognise this and give him time to calm down. The section specifies the environmental factors that can overwhelm A and the signs that he is becoming overwhelmed. The section indicates that these are signs that his seizure threshold is lowering and immediate intervention is required.

f) The communication section sets out A's communication difficulties arising from his severe learning disability and that, in circumstances where A becomes frustrated if his needs cannot be guessed correctly, carers need to take time to get to know A and his communication methods. The section sets out the methods that assist A's

communication and warns that if A is unresponsive, this may indicate a seizure.

ii) Health

a) The health section of the plan details A's medical condition and the fact that he has frequent and unpredictable seizures requiring constant supervision and care to ensure his safety. It directs carers to read and understand A's seizure management plan. It advises carers not to give medication without consultation with the parents. The section particularises the types of seizures A experiences, the presentation he exhibits during seizures and the triggers for seizures. The plan highlights the course of action that must be taken if A has a seizure, including the actions to be taken if he has a prolonged seizure. The section states that A may require suctioning if he has a seizure or is unwell and the method for undertaking this. It likewise highlights he has oxygen available in case of emergency or a seizure. It sets out the method for assessing A's respiratory status and the observation ranges.

b) The health section requires any concerns regarding A's health to be reported to the parents and instructs carers to dial 999 in case of an emergency.

iii) Nutrition

a) The nutrition section details that A has dysphasia and that his drinking and swallowing skills can be variable and dependent on health and seizure activity. It requires carers to supervise A at mealtimes to ensure his safety. The section specifies A's diet. It details the course to be taken with respect to food and drink if A refuses to eat, particularly following a seizure and the manner in which A is to be fed and given drink.

iv) Personal Care

a) The personal care section set outs the regime for managing A's toileting (including the provision of pads), baths (including temperature, the need for two carers and supervision at all times), dressing (including the need to be vigilant due to the hypermobility of A's joints, A's inability to regulate his temperature as a seizure risk and the need for two carers), oral care (including the need for two carers), constipation (including signs that A might be constipated, the action to be taken if he is, the method of supporting A to have a bowel motion and the need to escalate any concerns to a nurse manager) and skin (including the need to complete body maps for every shift). It specifies that two people must be present to ensure A is comfortable and safe during his personal care and that one person must support his left leg. The plan requires the second carer to engage with A and keep him calm and stipulates that carers must communication to A what is about to happen.

v) Mobility, Moving and Handling

a) The mobility, moving and handling section of the plan highlights the factors that affect A's mobility, including that he does not perceive danger and has hypermobile joints. It specifies that A requires careful and mindful supervision at all times and two carers for all transfers. It details the manner in which A should be supported by two carers to use his walker and knee supports. The section deals with the consequences of A's shortened left Achilles tendon.

vi) Daytime and Sleep Routine

a) The day routine section specifies A's daytime routine from rising between 5.30am and 7.30am to going to bed at approximately 8.00pm, including his mealtimes and naptimes.

b) The night routine section specifies the need for A to be continuously supervised for seizure activity and maintenance of his airway in the context of A becoming more dystonic at night. The section makes clear that in ensuring that A is not in pain or discomfort to minimise seizures, carers must have regard to A's hypermobility and loss of tone and the risk of him having his face in his pillow,

vii) Appendix

a) The appendices to the plan comprise the Seizure Management Plan, the Seizure Description document, TESS research on SLC13A5, the Eating and Drinking Meal Mat, the Suction Machine Manual, the Handwashing guidelines, the Skin poster, the Play Specialist report, the Educational Psychologist report, the Bristol Stool chart, the Neurology report, the Occupational Therapy report, the medical report of Dr Robinson of 9 October 2022, the Seizure Clinic review report from Dr Petropoulos dated 6 March 2023 and the Ambulance protocol.

13. On 12 June 2023, an NHS Continuing Care review commenced to assess A's need for Continuing Care. On 15 June 2023, the Children's Continuing Care Assessment and Decision Support Tool (hereafter 'DST') report was completed. The DST report assessed A's care needs under the domains of 'Education and Learning' (including consideration of A's EHC plan, then dated 9 March 2023), 'Team around the child' (including consideration of A's medical history and a privately commissioned care and support needs assessment of A's care needs), and the care domains of 'Breathing', 'Eating and Drinking' (including consideration of a privately commissioned speech and language therapy report), 'Mobility' (including consideration of a physiotherapy report and occupational therapy assessment), 'Continence or Elimination' (including consideration of a pad assessment), 'Personal Care', 'Skin and Tissue Viability', 'Communication', 'Drug Therapies and Medication', 'Psychological and Emotional' (including consideration of a Behavioural Rating Inventory and a behavioural support document), 'Seizures' (including an urgent care plan in case of prolonged seizures) and 'Challenging Behaviour'. As a result of the completion of the DST, the recommendation was that A's then current care package of 61 hours via a personal healthcare budget (hereafter

'PHB') be maintained. At that time the parents reported that they had in place a consistent team of "Band 4" carers and nurses from Enviva.

14. The Defendant's Continuing Care Panel met on 21 June 2023, where the Children's Continuing Care Assessment and DST report of 15 June 2023 was presented. The aim of the meeting was expressed to be "to discuss the Continuing Care and social care assessments and consider relevant holistic evidence to decide on [the Claimant's] Continuing Care package from health, the social care package and the education offer." The decision of the Panel in that regard was that:

    i) The healthcare package for A would comprise a PHB of 63 hours per week of one to one care, with a second carer to support the care provided by health care assistants, amounting to a total of 126 hours (the report noting that reference to Band 4 and Band 3 did not apply to Enviva care agency staff as they were not on NHS Agenda for Change Contracts).

    ii) The social care package would comprise 14 hours per week of one to one support and the social care team would liaise with the parents to gather any further evidence required to consider an increase to two carers.

    iii) The education package would be an Education Otherwise Than At School (EOTAS) package.

15. Within the foregoing context, the minutes of the Defendant's Continuing Care Panel of 21 June 2023 record that "Parents will need to work in partnership with the ICB through a detailed care and support planning process which will finalise how the agreed hours will be used flexibly across the week and year" and that "PHB audits will need to be up to date and care and support plan will be finalised". Finally, the report further noted that "A timetable mapping all recommended hours across all three agencies will need to be completed for the care and support plan".

16. The Defendant communicated the NHS Children's Continuing Care Eligibility and Package Decision to the parents on 28 June 2023. The Continuing Care Eligibility and Package Decision was thereafter considered by the First Tier Tribunal (SEND) within the context of the parents' appeal under s. 51 of the Children and Families Act 2014 against the contents of the EHC plan made by the Interested Party and first issued on 9 March 2023. The appeal was allowed by the Tribunal in a decision dated 11 July 2023.

17. With respect to health and social care provision (in respect of which the Tribunal may make non-binding recommendations) the Tribunal recommended two to one commissioned care at all times by Band 4 carers (who the Tribunal considered were carers who have a high level of experience and existing knowledge of complex seizures and challenging behaviours), including 13 hours of Band 4 care during the six week summer holiday period. With respect to social care, the Tribunal recommended that a total of 14 hours per week homecare social support to be provided by two carers at all times.

18. On 24 July 2023 and 8 August 2023, the Defendant's Continuing Care Panel met to discuss the decision of the Tribunal and it's health and social care recommendations. The panel concluded that it would depart from the non-binding recommendations for

the health care package with respect to the continuing care hours, and reiterated the decision of the Continuing Care Panel of 21 June 2023, on the grounds that there were no clinically assessed needs that supported an increase in health hours to the level recommended by the First Tier Tribunal. The record of the meeting of 8 August 2023 noted that the package would need reviewing 3 months after implementation. This outcome was confirmed by the Defendant on 15 August 2023.

19. An amended EHC plan was issued by the Interested Party on 23 November 2023. Section C of the EHC plan deals with health needs and details the nature and extent of A's condition. Section E details desired outcomes. Section G deals with health provision and provides that A will need (a) ongoing review, monitoring and assessment from the Claimant's Multi-Disciplinary Team, (b) yearly blood test to monitor impact of anti-epileptic medications on his liver, (c) bi-annual review of orthotics, (d) provision of equipment, (e) two people to manage his seizures, (f) an 'Urgent Care Plan' for prolonged seizures, (g) and the provision of medication. In Section G it states that the Claimant "will be provided with a health care plan." In her second statement, Ms Collin avers that when the Defendant agreed to the insertion of the "health care plan" in Section G of the EHC plan, the Defendant's understanding was that this was a reference to the care plan developed by the commissioned care provider, which at that time was Enviva.

20. Prior to the outcome of the Continuing Care review process in June 2023, Enviva had been providing A with 61 hours of care. As set out above, the Continuing Care review process resulted in the care package increasing to 126 hours, based on A requiring one to one carer support at all times with a second carer available to assist with seizures, manual handling and behaviour that challenges. Enviva sought to find additional carers for the increased care package but struggled to do so, resulting in the mother having to cover significant periods of care.

21. The mother reported difficulties in Enviva sourcing carers in early August 2023 and those difficulties continued. On 17 September 2023 the mother emailed to request an urgent discussion with the Defendant in circumstances where the family was being "messed around so badly by Enviva that [the family] just can't cope anymore". In two further emails on 18 September 2023, the mother particularised her concerns regarding Enviva, stating that Enviva had failed to provide carers for years and were continuing to fail in that regard. The mother further asserted that there was a lack of nurse management despite the care package being in a state of "crisis". In her emails of 18 September 2023, the mother spoke of putting Enviva "on notice".

22. Within the foregoing context, and by a process no longer adopted by the Defendant in circumstances I shall come to, in September 2023 the Defendant identified Practical Staffing (hereafter 'PS') as an appropriate provider of nursing care to cover gaps in carer provision provided by Enviva. PS is not registered and cannot be registered with the CQC. In her statement, Ms Collin avers that the initial plan was for PS to provide, as a temporary arrangement, nurse cover for the weekend of 23 September 2023 and that PS were sent the health care plan prepared by Enviva on 22 September 2023. The mother accepted PS commencing the care of A the day after they had received the Enviva health care plan. The Defendant commissioned PS directly in circumstances where the mother had not provided audit information on the PHB.

23. The difficulties with Enviva covering the care package continued. On 28 September 2023, the mother emailed the Defendant to highlight that Enviva required constant chasing by reason of disorganisation and poor communication. She requested an additional care provider. On 5 October 2023, the mother informed the Defendant that "Enviva aren't going to sort themselves out anytime soon. I'm (*sic*) fact things are only getting worse. Our current team is frustrated with them too and so they would be interested in going over to a new agency." Other emails in the bundle from this period demonstrate the anxiety caused to the mother by Enviva's inability to staff the care package adequately. A two-month Service User Placement Agreement was entered into by the Defendant with PS as an interim measure for October and November 2023. The mother agreed that the Defendant could source another care agency to replace Enviva. Thereafter, the Defendant spent a number of months seeking to investigate alternative providers and to transition the package of care from Enviva.

24. In her statement, Ms Collin outlines what she describes as "a serious incident" on 26 November 2023 whilst another child was receiving Continuing Care commissioned by the Defendant, involving a staffing provider that was not registered with the CQC. Following this incident, the Defendant reviewed its approach to using staffing agencies to support care provision, as it had been doing with PS under the Service User Placement Agreement described above. With respect to the serious incident in November 2023, the Defendant concluded that it should have acted much sooner to address that situation. As a result, the Defendant decided no longer to commission staffing agencies directly to support care or fill gaps in registered care provider rotas. Instead, the Defendant required the CQC registered care provider to meet the assessed Continuing Care needs with their own staff, with any reliance on staffing providers, apart from on an emergency short-term basis and to be investigated with the care provider by the Defendant. Ms Collin avers that the incident, and the subsequent learning by the Defendant, was of significance in this case where staff from PS, an unregistered staffing provider, were undertaking an ever increasing proportion of care due to difficulties in Enviva, the registered care provider, providing care staff of its own. A decision was taken to make an immediate request to PS to stop recruiting carers for A's care package.

25. In figures not disputed by the Claimant, by December 2023, Enviva were covering seven shifts per week and PS three to four shifts per week. On 11 January 2024, the parents were provided with four alternative CQC registered agencies to consider. At a meeting on 24 January 2024, the mother agreed to Voyage Care and REACH being explored as potential options. In circumstances where Voyage Care could not meet A's needs, on 23 February 2024 the mother provided her consent to the Defendant progressing matters with REACH. In her statement, the mother states that she agreed to REACH "being commissioned to fill the then gaps in the package in February". The mother further contends that the Defendant did not take timely and appropriate steps in managing REACH to commence working on A's package.

26. By March 2024, Enviva were covering between one and three shifts per week and PS were covering seven shifts per week. Nurses from PS were beginning to work without Enviva carers present in circumstances where no Enviva carers were available, notwithstanding that A's care package required carers. On 6 March 2024, the mother reported an incident with an Enviva carer that had taken place in February 2024. It

took Enviva until 24 April 2024 to provide a written explanation of how it had responded to the incident, despite repeated requests from the Defendant. At this point the unregistered staffing provider was providing more care for A than the CQC registered care provider. In the circumstances, the Defendant sought to progress REACH replacing Enviva as the CQC registered agency. The mother met with REACH on 14 March 2024 and shared with them the Enviva health care plan and consultant reports. She was not, however, able to give REACH a date for their assessment of A. A home visit on 26 March 2024 was cancelled as A was unwell.

27. Up to 1 April 2024, and subject to the Service User Placement Agreement with PS, A's Continuing Care package was commissioned by the mother under the PHB. On 1 April 2024 the Defendant took over the Enviva contract in full, moving from the PHB to a "notional" budget, whereby the Defendant directly commissioned the care package. At this point Enviva informed the Defendant that it had not invoiced the mother since June 2023. It further became apparent to the Defendant that PS were providing nursing hours above the Defendant's commissioned care package and that PS were providing two nurses on an increasing number of A's care shifts rather than a nurse and a carer. The Defendant was concerned that PS was, in effect, now leading the care package. On 18 April 2024 the Defendant requested that Enviva subcontract PS in order to ensure some governance was in place pending REACH taking over the care package. Enviva agreed to the sub-contracting arrangement proposed by the Defendant.

28. On 24 April 2024 REACH undertook a home visit to A. The intention of the Defendant at this point was for REACH to start introducing carers, working with PS nurses, in May 2024.

29. On 3 May 2024, in circumstances where PS had first agreed then refused to allow its nurses to work with trained carers from another CQC provider, where PS were now covering thirteen shifts and Enviva only one shift, where Enviva confirmed to the Defendant that it was unable to staff A's care package with either carers or nurses and in the context of the incident that had occurred on 26 November 2023, the Defendant concluded that Enviva were not able to provide safe and effective care for A and that PS was working beyond its role as a staffing provider. On 3 May 2024 the Defendant served notice of termination of contract by email to Enviva and expressed its expectation that REACH would fully take over the package of care on 27 May 2024. The notice was served following a conversation earlier that day in which Enviva confirmed it would work with REACH to transition care.

30. At a multi-agency meeting on 9 May 2024, it was agreed that the care package should be increased to 168 hours per week as an integrated care package between the Interested Party and the Defendant in order to cover 12 hour day shifts requested by the parents, with the Defendant as the lead commissioner. The minutes of the meeting on 9 May 2024 record that the Defendant was to arrange a meeting between health, education, and social care and REACH, to discuss the entirety of care plan. It was further recorded that Dr Petropoulos was to meet with Dr Robinson regarding medical plans for A. The Defendant met with REACH, Enviva and PS in May 2024 to discuss the transition plan and the Defendant set up weekly transition meetings.

31. During this period, the Defendant had sought an updated health care plan from Enviva. On 1 May 2024, the Nurse Manager for Enviva stated that she was updating

the health care plan but wished to achieve clarity with respect to roles and responsibilities as nurses were then delivering A's care. On 3 May 2024, the Nurse Manager expressed to the Defendant that she was uncomfortable updating the Enviva health care plan because Enviva was providing a carer and the package was being provided by nurses.

32. As at 27 May 2024 the Enviva package remained in place. At a transition planning meeting on 30 May 2024, the mother stated that she had never agreed to REACH being the sole care provider and was concerned that having a sole provider would again lead to staffing gaps in the care package. At the meeting, Enviva agreed to share an updated working document of its existing 13 June 2023 health care plan, with the intention that a transitional health care plan would be developed by Enviva, PS and REACH.

33. A further transition planning meeting was held on 10 June 2024. The mother reiterated that she did not want A's care package delivered by a sole provider and that she did not want REACH nurses in the package but PS nurses. Later that day, the Defendant secured an agreement from REACH to subcontract with PS nursing staff for a short period to ensure minimal disruption for A during transition. At the transition meeting on 10 June 2024, Enviva stated that it could introduce nurses and carers notwithstanding not being in a position to do so for an extended period of time and at this point were only providing 11 hours out of the 168 hour care package. The mother requested that the notice terminating Enviva's contract be rescinded. In default of that course, Enviva stated that it would hand over the care plan on 12 June 2024. The minutes of the meeting of 10 June 2024 note under the title "Forward Plan" that:

> "Care Plan – [Enviva] raises concerns that if Enviva is pulled from package, care plan cannot be used. [Defendant] notes that all agencies will make their own care plans, and that [Enviva's Nurse Manager] agreed to support the transition and formulation of care plan with new provider in the MDT meeting. The plan is to handover to the Reach Health Care and care plan to be on Reach template"

And

> "[Enviva's Nurse Manager] confirmed that handover would happen with Reach Health Care and care plan would be on Reach Template".

34. On 11 June 2024, the Defendant made a decision to maintain its termination of Enviva's contract and wrote to the mother outlining its reasons and confirming the Enviva contract would end, now on 9 July 2024.

35. On 12 June 2024, REACH provided the mother with profiles of four paediatric nurses and five carers. In her first statement, the mother contends that there had been a significant delay in providing this information. On 14 June 2024 the mother questioned the suitability of the carers on the grounds they were not "highly skilled". The Defendant avers the carers had the relevant experience but concedes that they would require further training to meet A's needs, which would be provided by a registered nurse from REACH. The Defendant further contends that this is to be expected when a care package is transitioned. The Defendant informed the mother

that A's staffing would not change on transition in the short term given the agreement from REACH to subcontract with PS staff for a short period to ensure minimal disruption for A during the transition period.

36. On 21 June 2024, the mother notified the Defendant that she was no longer willing to work with REACH, stating that the family no longer had "confidence, trust or faith in REACH's ability to meet [A's] needs". At this time, the Defendant also received a number of emails from professionals involved in A's care raising concerns regarding the mother's physical and emotional health and requesting, on behalf of the parents, a two week pause in all email communication and meetings with the parents.

37. In her first statement Ms Collin contends that, faced with the withdrawal of the mother's consent to REACH three weeks prior to Enviva's end date and the request for a pause in email communication and meetings, the Defendant had no option but to seek to identify a registered care provider who could provide A's care package from 10 July 2024. The Defendant identified Nursing Direct, which the Defendant contends provides its most complex care packages. Nursing Direct confirmed on 25 June 2024 that it would have availability to mobilise the Claimant's package of care immediately.

38. The Defendant wrote to the mother on 26 June 2024 asking whether she would agree to meet with Nursing Direct. The mother agreed to a meeting with the Defendant on 2 July 2024. The minutes of a strategy meeting held on 28 June 2024 record as follows with respect to the approach the Defendant proposed to take at the meeting with the mother on 2 July 2024:

> "02.07.2024, at 9.00AM – Pooja and Olivia are going to meet with Mum on Teams to discuss ICB Plans and outline the further details on the reason they are unable to keep Enviva as their provider for the foreseeable future. It will be reiterated to Mum that if she continues to refuse providers into her home/refuses to work with both providers offered to her, [A] will be vulnerable and out of care."

39. At the meeting held on 2 July 2024 the Defendant requested that the mother meet with Nursing Direct. That request was followed up in writing on the same day. That communication explained that the intention was for PS nurses to work with Nursing Direct during the transition. The father replied that the mother was too unwell to respond. On 3 July 2024 the Defendant wrote to the father to ask if he was willing to meet Nursing Direct. Again, the email explained that the intention was for PS nurses to work with Nursing Direct during the transition. On 4 July 2024 the mother emailed the Defendant with what is described in the statement of Ms Collin as "a very long, highly emotive and accusatory email which caused significant distress with the Defendant's complex care team, impacting on the team's health and wellbeing". A copy of that email is in the supplementary court bundle. In that email the mother confirmed that she did not provide her consent for the Defendant to progress A's care package with Nursing Direct and again requested the notice to Enviva be rescinded.

40. The statement of Ms Collin avers that, in the foregoing circumstances, the Defendant considered itself at this point to be in a difficult position in circumstances where it was not clear how the parents were planning to meet A's needs following the end of the contract with Enviva and where the Defendant could not contract with a suitable

provider without the parents' consent. A strategy meeting was convened by the Interested Party at 4pm on 5 July 2024, including the Defendant's Director of Safeguarding, Assistant Director for Complex Care, and the Interested Party's Assistant Director of Children's Social Care. A joint decision was taken that, because of the quality and governance concerns about Enviva, because the care was almost entirely delivered by an unregistered staffing provider and because of the lessons learnt from the incident with an unregistered staff provider on 26 November 2023, it remained not possible to rescind the notice to Enviva or extend the contract further. The meeting further noted that an up to date health care plan still had not been provided by Enviva. It was agreed that information should be shared with Nursing Direct in A's best interests. The Defendant asked Nursing Direct to mobilise the package on 9 July 2024 so that a registered nurse and skilled carer could attend the family home on 10 July 2024. An offer by the Defendant to meet the parents to discuss how A's needs would be met after 9 July was not taken up by them. The Interested Party issued care proceedings under Part IV of the Children Act 1989 on 8 July 2024.

41. On 10 July 2024, a nurse and carer from Nursing Direct arrived at the family home. In her first statement the mother avers that the staff from Nursing Direct were not aware of A's name, that Nursing Direct had not provided their staff with the Enviva's care plan and therefore "knew nothing of [A's] care needs". The mother further contends that this was in the context of Nursing Direct having not liaised with Enviva or PS with respect to a handover. On 11 July 2024, the mother notified the Defendant that the family would be privately contracting with Enviva and PS to maintain A's care package and that Nursing Direct should stop attending their house. The Defendant therefore instructed Nursing Direct to stop sending staff for the Claimant until further notice. The parents aver that they have since been funding A's care package at a cost of c.£10,000 per week.

LEGAL FRAMEWORK

42. Section 37(1) of the Children and Families Act 2014 (hereafter 'the 2014 Act') provides as follows with respect to the provision of EHC plans by local authorities:

> "**37 Education, health and care plans**
>
> (1) Where, in the light of an EHC needs assessment, it is necessary for special educational provision to be made for a child or young person in accordance with an EHC plan—
>
> (a) the local authority must secure that an EHC plan is prepared for the child or young person, and
>
> (b) once an EHC plan has been prepared, it must maintain the plan.
>
> (2) For the purposes of this Part, an EHC plan is a plan specifying—
>
> (a) the child's or young person's special educational needs;
>
> (b) the outcomes sought for him or her;
>
> (c) the special educational provision required by him or her;

(d) any health care provision reasonably required by the learning difficulties and disabilities which result in him or her having special educational needs;

(e) in the case of a child or a young person aged under 18, any social care provision which must be made for him or her by the local authority as a result of section 2 of the Chronically Sick and Disabled Persons Act 1970;

(f) any social care provision reasonably required by the learning difficulties and disabilities which result in the child or young person having special educational needs, to the extent that the provision is not already specified in the plan under paragraph (e).

(3) An EHC plan may also specify other health care and social care provision reasonably required by the child or young person.

(4) Regulations may make provision about the preparation, content, maintenance, amendment and disclosure of EHC plans.

(5) Regulations under subsection (4) about amendments of EHC plans must include provision applying section 33 (mainstream education for children and young people with EHC plans) to a case where an EHC plan is to be amended under those regulations."

43. The Special Educational Needs and Disability Regulations 2014 r.12(1)(g) requires the EHC plan to set out in Section G any health care provision reasonably required by the learning difficulties or disabilities which result in the child or young person having special educational needs. Pursuant to r.12(2) of the 2014 Regulations, the health care provision specified in the EHC plan must be agreed by the responsible commissioning body, in this case the Defendant.

44. With respect to the provision of education and healthcare under the EHC plan, s.42 of the 2014 Act provides as follows:

"**42 Duty to secure special educational provision and health care provision in accordance with EHC Plan**

(1) This section applies where a local authority maintains an EHC plan for a child or young person.

(2) The local authority must secure the specified special educational provision for the child or young person.

(3) If the plan specifies health care provision, the responsible commissioning body must arrange the specified health care provision for the child or young person.

(4) "The responsible commissioning body", in relation to any specified health care provision, means the body (or each body) that is under a duty to arrange health care provision of that kind in respect of the child or young person.

> (5) Subsections (2) and (3) do not apply if the child's parent or the young person has made suitable alternative arrangements.
>
> (6) "Specified", in relation to an EHC plan, means specified in the plan."

45. Section 42(3) places a mandatory duty on the responsible commissioning body to arrange the healthcare provision specified in Section G the EHC plan, the responsible commissioning body being, pursuant to s.42(4), the body that is under a duty to arrange health care provision of that kind in respect of a child or young person.

46. Pursuant to s.2(2) of the National Health Service Act 2006 (hereafter 'the 2006 Act'), NHS England or an ICB may do anything which is calculated to facilitate, or is conducive or incidental to, the discharge of any of its functions. Section 3 of the 2006 Act sets out the duties of ICBs as to commissioning certain health services. This includes, pursuant to s.3(1) of the 2006 Act, the duty to arrange for the provision to such extent as it considers necessary to meet the reasonable requirements of the people for whom it has responsibility. Section 3A of the 2006 Act gives ICBs the power to commission certain health services by arranging for the provision of such services.

47. Within the foregoing context, the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 r.21 places a duty on the ICB to assess and provide NHS Continuing Healthcare in respect of a person. NHS Continuing Healthcare is defined by r.20(1) of the 2012 Regulations as a package of care arranged and funded solely by the health service in England for a person aged 18 or over to meet physical or mental health needs which have arisen as a result of disability, accident or illness. In the circumstances, children are not eligible for NHS Continuing Healthcare. Rather, Children and Young People's Continuing Care constitutes separate provision delivered under the auspices of non-statutory guidance in the form of the National Framework.

48. Finally with respect to the legal framework, pursuant to s.10(1) of the Health and Social Care Act 2008, any person who carries on a regulated activity, being an activity which involves, or is connected with, the provision of health or social care and does not involve carrying on any establishment or agency within the meaning of the Care Standards Act 2002, without being registered is guilty of an offence. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 do not provide expressly for the provision by a registered provider of a health care plan. Regulation 9(3)(a) and (b) do, however, require that a registered person must carry out, collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user and design care or treatment with a view to achieving the service users' preferences and ensuring their needs are met.

DISCUSSION

49. Having considered carefully the evidence and the submissions of the parties, I am satisfied that Ground 1 is arguable and that permission should be granted. I am further satisfied that the claim succeeds in respect of Ground 1. Whilst I am also satisfied that permission should be granted in respect of Ground 2, I am not satisfied that Ground 2 is made out. With respect to Ground 3, I am not satisfied that the

Claimant is entitled within these judicial review proceedings to the remedy of restitution on the grounds of unjust enrichment. My reasons for so deciding are as follows.

Ground 1

50. By Ground 1 the Claimant contends that the Defendant is in ongoing breach of its duty to ensure that the Claimant has a lawful health care plan. The Claimant contends that, pursuant to s. 42(3) of the 2014 Act, the Defendant is under "an absolute and non-delegable duty" to provide the Claimant with a health care plan as such a plan is stipulated by Section G of A's EHC plan. The Claimant further contends that, whilst neither document refers to a health care plan, the need for a health care plan is also obvious from the National Framework and the Defendant's own policy reflecting the National Framework, in circumstances where both documents identify the need for continuity of care and the effective implementation of the care planning process, central to which is a care plan. Mr Wise and Mr Persey concede that the drafting of a health care plan can be undertaken by the registered care provider, but submit the Defendant is not thereby excused from the duty to ensure that a lawful health care plan is in place.

51. Within this context, the Claimant contends that the Defendant failed to arrange any health care plan following the conclusion of the review process that led to the EHC plan dated 23 November 2023, the existing care plan produced by Enviva *pre-dating* the conclusion of that process by some five months. Mr Wise and Mr Persey further submit that the 13 June 2023 document produced by Enviva, on which the Defendant relies as meeting its duty in circumstances where it repeatedly requested an updated plan from Enviva, does not meet the basic requirements of a lawful health care plan. In articulating the requirements for a lawful health care plan, the Claimant relies, by parity of reasoning, on the judgment regarding the provision of mental health aftercare under s. 117 Mental Health Act 1983 for a vulnerable child in *R(AK, a child by her mother and litigation friend GK) v The London Borough of Islington and North Central London Clinical Commissioning Group* [2021] EWHC 301 (Admin); (2021) 24 C.C.L. Rep. 31. Mr Wise and Mr Persey submit that *R(AK, a child by her mother and litigation friend GK)* is the culmination of a long line of case law concerning care plans for disabled children, including *R (G) v Nottingham City Council and Nottingham University Hospital* [2008] EWHC 400 (Admin) and *R (J and L) v London Borough of Hillingdon* [2017] EWHC 3411 (Admin). For reasons I shall come to however, it is not necessary to examine in detail the submissions as to the adequacy of the content of the care plan dated 13 June 2023 when determining Ground 1 of the claim.

52. The Defendant accepts that it is under a duty to "arrange" for a health care plan by operation of s. 42(3) of the 2014 Act, in circumstances where the requirement for a health care plan is stated in Section G of A's EHC plan.

53. The Defendant contends that it was entitled to, and did, leave the creation of the health care plan to Enviva. In this regard, the Defendant relies on the evidence of Ms Collin that the Defendant does not develop care plans for children in receipt of Continuing Care funding but commissions provider organisations to do so. Mr Lawson and Mr Rylatt submit that this position is consistent with the Defendant's duty under s.42(3) of the 2014 Act being to "arrange" the specified health care

provision, the section envisaging that, as commissioning bodies, ICBs will not themselves be delivering the provision. Mr Lawson and Mr Rylatt contend that the Defendant's position is further consistent with the Defendant's NHS Standard Contract, which makes it a condition that the provider will develop a care plan in accordance with r.9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Finally, Mr Lawson and Mr Rylatt submit that there is nothing in the National Framework or the Defendant's own policy to suggest that a health care plan must be produced by the Defendant, or which precludes such a document being produced by a contracted registered care provider. As I have noted, Mr Wise and Mr Persey concede on behalf of the Claimant that the drafting of a health care plan can be undertaken by the registered care provider.

54. The Defendant acknowledges, however, that the drafting of a health care plan by the registered care provider does not excuse the Defendant from the duty to ensure that a health care plan is in place and accepts that it is ultimately responsible for ensuring the plan's adequacy. In this regard, the evidence of Ms Collin acknowledges that, once a care package is in place, the Defendant is responsible for monitoring the care provider, including ensuring that any health care plan is in place and is being updated. Within this context, Mr Lawson and Mr Rylatt submit that the content of the Defendant's duty under s.42(3) of the 2014 Act with respect to any health care plan specified in Section G of the EHC plan is to satisfy itself that there is an adequate health care plan in place and, if it considers the health care plan inadequate or requires updating, to go back to the provider. In the absence of a statutory requirement for a health care plan, or statutory guidance providing for such a plan, Mr Lawson and Mr Rylatt submit that the Defendant is not under a "high" duty in this regard.

55. Within the foregoing context, the Defendant submits that there *was* a health care plan in place drawn up by the commissioned care provider, Enviva, on 21 June 2023. Whilst the Defendant concedes that the health care plan was out of date, Mr Lawson and Mr Rylatt further submit that the Defendant sought an update of the health care plan from Enviva, consistent with its duty under s.42(3) of the 2014 Act to arrange for the health care plan stipulated by Section G of the EHC plan, Enviva having been asked to, and stated that they would, provide an updated health care plan to the Defendant on a number of occasions. These matters, they contend, were sufficient to discharge the Defendant's duty under s.42(3) of the 2014 Act. In the circumstances, Mr Lawson and Mr Rylatt submit the question of the sufficiency of the contents of the plan does not arise. Once again, for reasons I shall come to, is not necessary when determining Ground 1 to examine the detailed submissions they make in the alternative with respect to the adequacy of the care plan dated 13 June 2023.

56. In determining Ground 1, one of the difficulties is what is meant by the term "health care plan" in the present context. Pursuant to s.37(2)(d) of the 2014 Act, an EHC plan is a plan specifying any health care provision reasonably required by the learning difficulties and disabilities which result in the subject child having special educational needs. Pursuant to s.37(3), an EHC plan may also specify other health provision reasonably required by the child or young person. The Special Educational Needs and Disability Regulations 2014 r.12(1)(g) requires the EHC Plan to set out in Section G any health care provision reasonably required by the learning difficulties or disabilities which result in the child or young person having special educational

needs. There is no corresponding statutory duty to set out the other health provision reasonably required by the child or young person in the EHC plan.

57. Paragraph 6.11 of the statutory guidance *Special Educational Needs and Disability Code of Practice: 0 to 25 years* (hereafter the 'SEND Code of Practice') makes reference to "Individual Health Care Plans". These plans are, however, intended to deal with the care of the child in school in the context of the duty on maintained schools and academies under the 2014 Act to make arrangements to support children with medical conditions, the Code of Practice providing that "[i]ndividual healthcare plans will normally specify the type and level of support to meet the medical needs of such pupils" and that where children and young people also have SEN, their provision should be "planned and delivered in a coordinated way with the healthcare plan". With respect to such Individual Health Care Plans, the Code of Practice further provides as follows:

> "**Section G:** Any health provision reasonably required by the learning difficulties or disabilities which result in the child or young person having SEN. Where an Individual Health Care Plan is made for them, that plan should be included."

58. The Glossary of Terms attached to the SEND Code of Practice does not otherwise define the term "health care plan" but defines a 'care plan' as follows:

> "A record of the health and/or social care services that are being provided to a child or young person to help them manage a disability or health condition. The Plan will be agreed with the child's parent or the young person and may be contained within a patient's medical record or maintained as a separate document."

59. The National Framework is stated as being intended to provide guidance for clinical commissioning groups (now ICBs) when assessing the needs of children and young people whose complex needs cannot be met by universal or specialist services. The guidance is stated to take account of the structures of NHS commissioning created by the Health and Social Care Act 2012 and the then new integrated approach to the commissioning of services for children and young people with SEND introduced by the 2014 Act.

60. Whilst paragraph [100] of the National Framework stipulates that care planning should begin early and that the planning of the care package should consider certain factors, the National Framework makes no specific reference to 'care plans' or 'health care plans'. The National Framework states at paragraphs [21] and [22] that the EHC plan should be the leading document for planning children's continuing care for children with special educational needs and that "commissioners and local authorities should consider how the two processes can be brought together, to articulate a single set of needs and outcomes". The National Framework further states as follows in Annex B, echoing the aim of a single plan set out in the SEND Code of Practice:

> "**Education, health and care plan**
>
> At the heart of the new arrangements for children and young people with SEND introduced by the Children and Families Act 2014 is the concept of a

> single plan for each child with SEND, which covers their education, health and social care needs. A local authority must conduct an assessment of education, health and care needs when it considers that it may be necessary for special educational provision to be made for the child or young person.
>
> CCGs and local authorities will work together to
>
> - establish and record the views, interests and aspirations of the parents and child or young person;
> - provide a full description of the child or young person's special educational needs and any health and social care needs;
> - establish outcomes across education, health and social care based on the child or young person's needs and aspirations;
> - specify the provision required and how education, health and care services will work together to meet the child or young person's needs and support the achievement of the agreed outcomes.
>
> The Code of Practice is the statutory guide to the EHC process and covers all the legal requirements and important good practice. Special educational needs and disability code of practice: 0 to 25 years. Statutory guidance for organisations who work with and support children and young people with special educational needs and disabilities (2014)."

61. With respect to the contents of any health care plan, in the context of the emphasis on the EHC plan being the leading document for planning children's continuing care, the National Framework does not deal with the contents of a health care plan and the statutory guidance again concentrates on the content of Section G of the EHC plan. Paragraph 9.69 of the SEND Code of Practice states in respect of Section G that provision should be detailed and specific and should normally be quantified, it should be clear how the provision will support achievement of the outcomes, demonstrate clarity as to how advice and information gathered has informed the provision specified and can choose to specify other health care provision reasonably required by the child or young person, which is not linked to their learning difficulties or disabilities, but which should sensibly be coordinated with other services in the EHC plan.

62. In the foregoing context, beyond the reference in the SEND Code of Practice to an Individual Health Care Plan that may be included in Section G as a *specific* plan for use in school, there is no general or wider statutory requirement for a "health care plan" in the context of NHS Continuing Care for children, nor is one required by statutory guidance. In neither the National Framework nor the SEND statutory guidance are there any statutory requirements regarding the content of a "health care plan". In the circumstances, it is difficult to speak of a requirement for a "lawful health care plan" by reference either to any statutory requirement for such a plan or by reference to statutory requirements with respect to the contents of such a plan.

63. Pursuant to r.12(2) of the Special Educational Needs and Disability Regulations 2014 however, the Defendant *was* required to agree the healthcare specified at Section G of

the EHC plan in *this* case, which in this case *did* include the provision of a document described as a "health care plan". As noted, the evidence of Ms Collin is that when the Defendant agreed to the insertion of the "health care plan" in Section G of the EHC plan, the Defendant's understanding was that this was a reference to the care plan developed by the commissioned registered care provider, which at that time was Enviva, pursuant to r. 9(3)(a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the NHS Standard Contract. Regulation 9(3)(a) requiring a registered person to design care or treatment with a view to achieving the service users' preferences and ensuring their needs are met and the NHS contract making it a condition that Enviva would develop a Care Plan in accordance with Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

64. Further, the Defendant concedes that having agreed the contents of Section G, it had a duty pursuant to s.42(3) of the 2014 Act to "arrange the specified health care provision for" A. The term "arrange" in s.42(3) of the 2014 Act has not been the subject of judicial consideration and there is no authority on the interpretation of the term "arrange" with respect to the non-delegable duty to arrange healthcare. However, adopting a purposive interpretation, the duty to arrange the specified health care provision must, in my judgment, encompass the Defendant satisfying itself that the specified health care provision it is under a duty to arrange has *in fact* been put in place and to take further reasonable steps to arrange it if has not been. In circumstances where, pursuant to s.42(6) of the 2014 Act, the term "specified" in s.42(3) means specified in the EHC plan and where both parties concede that a health care plan may be compiled by the provider, in this case the Defendant's duty to arrange the health care provision encompassed the health care plan specified in Section G of A's finalised EHC plan. That duty extended to the Defendant satisfying itself the health care plan stipulated was in place and taking further reasonable steps to arrange it if it was not. This much is, again, conceded by the Defendant in the evidence of Ms Collin and the submissions of Mr Lawson and Mr Rylatt. In any event, it is consistent with the Defendant's duty pursuant to s.3(1) of the 2006 Act to arrange for the provision to such extent as it considers necessary to meet the reasonable requirements of the people for whom it has responsibility.

65. The Defendant's essential submission in response to the Claimant's first ground is that it discharged its duty under s.42(3) of the 2014 Act because a health care plan already existed, in the form of the Enviva care plan dated 13 June 2023, and that it repeatedly requested an updated plan from Enviva, which failed to deliver such a plan. I am not persuaded by those submissions.

66. The SEND statutory guidance emphasises in Chapter 3 that, pursuant to s.26 of the 2014 Act, local authorities and ICBs must make joint commissioning arrangements for education, health and care provision for children and young people with SEN or disabilities with the aim of providing personalised, integrated support that delivers positive outcomes for children and young people. The statutory guidance makes clear that central to achieving this aim in respect of individual children is the Education, Health and Care needs assessment that leads to the decision whether to issue an EHC plan. The statutory guidance further makes clear that where an EHC plan is issued, as it was in this case, the health care provision specified in Section G of the EHC plan

must be agreed by the ICB and that the ICB *must* ensure that the health care provision specified in the EHC plan is made available to the child or young person.

67. In this case, the stipulation for a health care plan in Section G of A's EHC plan of 23 November 2024, agreed by the Defendant pursuant to r.12(2) of the Special Educational Needs and Disability Regulations 2014, arose in the context of a detailed review process, conducted in accordance with the relevant statutory guidance. That review process began *after* the provision of the health care plan by Enviva dated 13 June 2023 and culminated, via meetings of the Continuing Care Panel on 21 June 2023, 24 July 2023 and 8 August 2023 and the Tribunal, in an EHC plan dated 23 November 2023 which, at Section G, stipulated A's health care provision, *including* a health care plan.

68. Within the foregoing context, I am satisfied that the key question with respect to Ground 1 is not the adequacy of the individual terms of the health care plan dated 13 June 2023, but rather the adequacy of the position taken by the Defendant following the conclusion of the review process culminating in the EHC plan in November 2023 with respect to that existing health care plan and the adequacy of efforts taken by the Defendant to secure an updated health care plan from the registered care provider.

69. As recognised by the Defendant, s.42(3) of the 2014 Act is in mandatory terms. It imposes an absolute and non-delegable duty on the Defendant to arrange the specified healthcare provision, being the healthcare provision specified in Section G of the EHC plan. It is not a "best endeavours" obligation (see *R(L) v Hampshire County Council* [2024] EWHC 1928 (Admin) at [42]). Within this context, a review process having taken place and been concluded, I am satisfied that it was not sufficient to fulfil its mandatory duty under s.42(3) of the 2014 Act for the Defendant to rely on a care plan that it concedes was outdated and which *predated* the review process that led to the stipulation for a health care plan in Section G of A's EHC plan dated 23 November 2023. Rather, it was reasonable to expect that the Defendant would arrange for a health care plan that reflected the outcome of the comprehensive, multidisciplinary review process that commenced in June 2023 and concluded in the finalised EHC plan in November 2023. Whilst the Defendant seeks to demonstrate that it made sufficient efforts to arrange a health care plan by seeking an updated health care plan from Enviva, in my judgment the Defendant did not take reasonable steps in this regard. Although there were clearly difficulties with Enviva, I am not satisfied that a request for an updated care plan first made in May 2024, five months after the conclusion of the review process and finalisation of the EHC plan, and then only at a time when thought was being given to terminating the contract with Enviva, met the demands of the mandatory duty on the Defendant under s.42(3) of the 2014 Act to arrange for the Claimant the health care plan specified in the EHC plan in November 2023.

70. In the circumstances, I am satisfied that Ground 1 is arguable and that permission should be given. Having considered the arguments, I am further satisfied that the Defendant is in breach of its duty under s.42(3) of the 2014 Act to arrange for the Claimant to have the health care plan specified in Section G of his EHC plan dated 23 November 2023 and that, accordingly, the claim succeeds on Ground 1.

Ground 2

71. By Ground 2 the Claimant contends that, within the context of the requirements of the National Framework, the Defendant's decision to terminate Enviva's contract on 9 July 2024 and to proceed to replace them with a new provider, Nursing Direct, on 10 July 2024 was irrational. Specifically, the Claimant contends that it was unreasonable for the Defendant to attempt to change providers in circumstances where there was no adequate alternative care provider in place. Mr Wise and Mr Persey concentrated on the following two matters in this regard:

    i) There was no lawful health care plan in place, as contended for by way of Ground 1, which is a prerequisite to a lawful transition and where the 3 September 2024 report of Dr Petropoulos is clear that a health care plan is a prerequisite to an effective transition.

    ii) Nursing Direct had not been trained by Enviva, PS, the clinical professionals or the Claimant's parents in a careful handover period.

72. Mr Wise and Mr Persey submit that the Defendant should have, with the Interested Party, worked with the clinicians, community care professionals and parents to ensure a health care plan was agreed and in place *prior* to care being transitioned from Enviva. Instead, at the point of transition they contend that there was only an out of date health care plan that predated the recommendation for a health care plan made in the finalised EHC plan dated 23 November 2023. Whilst Mr Wise and Mr Persey concede by their Reply that were problems with the performance of Enviva, and that the decision to terminate the contract might have been rational if A was at risk of harm, they submit that it was irrational to replace A's care package in those circumstances absent evidence of harm.

73. Finally, the Claimant contends that the Defendant's reasons for terminating Enviva were perverse, poorly particularised and changing and that the Defendant acted unreasonably in refusing to rescind its decision to terminate the contact. Mr Wise and Mr Persey submit that in circumstances where the Defendant itself had engaged PS to work with Enviva, and continues to engage Enviva on at least one other care packages, the criticisms on which it now seeks to rely to justify the termination of the contract do not withstand scrutiny.

74. In response to the contention that there was no health care plan in place as a prerequisite to an effective transition, the Defendant repeated its contention as to the extent of its duty regarding the provision of a care plan and its assertion that it met that duty by reason of the existence of the care plan dated 13 June 2023 and in endeavouring to secure an updated health care plan from Enviva, which submissions I have dealt with above. They further submit that the failure by Enviva to respond to requests for an updated health care plan was one of the reasons that the Defendant decided to terminate its contract. In this context, the Defendant asserts that the Claimant's first and second grounds are mutually contradictory, the Claimant asserting that there was no health care plan from Enviva, or an inadequate health care plan, whilst at the same time criticising as irrational the decision of the Defendant to give notice to Enviva, the provider who had failed in that regard despite the efforts of the Defendant.

75. Mr Lawson and Mr Rylatt submit that upon taking over commissioning from the mother on 1 April 2024 the Defendant found a registered care provider which was

unable properly to resource A's care package and was forced to place ever increasing reliance for delivery of the care package on an unregistered staffing provider. In this context, Mr Lawson and Mr Rylatt submit that the subsequent change in approach with respect to that registered care provider that forms the foundation of Ground 2 was a rational response to that situation, which comprised the repeated concerns about Enviva expressed on behalf of the Claimant by his mother, the failure by Enviva to provide an updated health care plan at the request of the Defendant, the fact that as the registered care provider Enviva was undertaking an ever decreasing amount of care as against the unregistered staffing provider PS and the lessons learnt by the Defendant from the incident with another registered staffing provider on 26 November 2023. Within this context, and having already provided two extensions of the notice of termination, Mr Lawson and Mr Rylatt submit that it cannot be said that the Defendant's decision to terminate the contract with Enviva was irrational in the public law sense.

76. As to the Claimant's contention that it was the Defendant who sourced PS, the Defendant relies on evidence that PS were brought in on an urgent basis for rota cover to support with shift coverage whilst Enviva worked towards training a team of carers and that PS were funded directly by the Defendant only because the mother was not meeting the ICB's governance requirements. The Defendant further avers that the sub-contracting relationship requested on 19 April 2024 was to ensure that essential governance was in place pending REACH taking over the package of care in circumstances where by March 2024 PS, as an unregistered staffing provider, were providing approximately 100 hours per week of care as compared with 45 hours per week from Enviva, the registered care provider, which at the time their contract was terminated was providing only 11 hours of care. Mr Lawson and Mr Rylatt submit that the fact that the Defendant engaged PS for these purposes does not render irrational the Defendant's decision to terminate the contract of a registered care provider which remained incapable of providing a safe level of care.

77. With respect to the Claimant's contention that Nursing Direct had not been trained by Enviva, PS, the clinical professionals or the Claimant's parents ahead of the transition, the Defendant submits that the evidence demonstrates that following notice being given to Enviva the Defendant in fact made strenuous efforts to work with the parents to put in place an alternate provider and to ensure a smooth and safe transition of care for A. They further submit that when the mother withdrew her consent for the provider around which the transition process had been planned less than three weeks prior to the end of Enviva's contract and sought a hiatus on communications with the Defendant, the Defendant had no choice but to commission Nursing Direct and agree for PS nurses to work with Nursing Direct during the transition to ensure minimum disruption for A. The Defendant further relies on the evidence of Ms Collin that it is possible for staff to take over a care package quickly if required, particularly nurses, experienced staff and staff working in teams and the fact that the mother previously accepted PS nurses taking over care to fill gaps in Enviva's provision on 24 hours' notice. In the circumstances, Mr Lawson and Mr Rylatt submit that the Defendant, having worked with REACH to prepare them to replace Enviva, a provider in respect of whom the mother had given her consent but then objected at a very late stage, having regard to its duties to A it was appropriate for the Defendant to commission an alternative provider it used on its most complex care packages to ensure care for A without any gap in provision.

78. Finally, the Defendant avers that s31(3D) of the Senior Courts Act 1981 applies in this case such that the Court should refuse permission to apply for judicial review on Ground 2 as the outcome for A would not have been substantially different if the conduct complained of had not occurred.

79. I am satisfied that Ground 2 of the claim is arguable and am not persuaded that it is highly likely that the outcome for the A would not have been substantially different if the conduct complained of had not occurred. Accordingly, I grant permission on Ground 2. However, having considered in detail the substantive arguments with respect to Ground 2, I am not satisfied that the Defendant's decision to terminate the contract with Enviva on 9 July 2024, having given notice on 3 May 2024, and to arrange for Nursing Direct to provide the health care provision specified in Section G of the EHC plan can be said to have been irrational in the public law sense.

80. A decision will not be unreasonable or, using older language, irrational if it falls within the range of reasonable decisions open to the decision maker (see *Boddington v British Transport Police* [1999] 2 AC 143 at 175H). Conversely, a decision will be unreasonable, or irrational, if it is a decision that no sensible authority acting with due appreciation of its responsibilities would have taken (see *R v Chief Constable of Sussex, ex p International Trader's Ferry Ltd* [1999] 2 AC 418 at 452 B-F). The threshold for establishing irrationality is very high, although it is not insuperable (see *R (Johnson) v Secretary of State for Work and Pensions* [2020] EWCA Civ 778 at [107]). Not every reasonable exercise of judgment is right, and not every mistaken exercise of judgment is unreasonable (see *In re W (An Infant)* [1971] AC 682). The intensity of judicial review varies with the subject matter. In *R (KM) v Cambridgeshire CC* [2012] PTSR 1189, the Supreme Court held at [36] that in cases concerning community care (in that case under s.2(1) of the Chronically Sick and Disabled Persons Act 1970) the intensity of the review will depend on the profundity of the impact of the determination. On the facts of the present case, the necessary intensity of review is high.

81. The test for unreasonableness is contextual. As conceded by Mr Wise and Mr Persey, there were legitimate concerns regarding the performance of Enviva with respect to the delivery of A's care package. Further, the evidence demonstrates that those concerns were significant when viewed in the context of the statutory duties placed on the Defendant.

82. The mother herself reported difficulties with Enviva sourcing carers for A in early August 2023, a situation that mother described in later emails as having persisted for years. In September 2023 the mother continued to report that the family was being "messed around so badly by Enviva that [the family] just can't cope anymore", that there was a lack of nurse management despite the care package being in a state of "crisis" and that that Enviva required constant chasing by reason of disorganisation and poor communication. In her email of 18 September 2023, the mother herself spoke of putting Enviva "on notice" and on 28 September 2023 requested an additional provider. On 5 October 2023 the mother went further and informed the Defendant that "Enviva aren't going to sort themselves out anytime soon. I'm (sic) fact things are only getting worse. Our current team is frustrated with them too and so they would be interested in going over to a new agency."

83. The concerns of the parents were amply reflected in the performance of Enviva, the registered provider, in making care provision. By December 2023, two months after the mother had expressed interest in a new agency, Enviva were covering seven shifts per week and PS three to four shifts per week. As at March 2024, Enviva were covering between one and three shifts per week and PS were covering seven shifts per week. On 6 March 2024, the mother reported an incident with an Enviva carer that had taken place in February 2024. It took Enviva until 24 April 2024 to provide a written explanation of how it had responded to the incident, despite repeated requests from the Defendant. At the point the Defendant took over commissioning Enviva in April 2024, moving the case from a PHB to a notional budget, the Defendant discovered that Enviva had not invoiced the mother since June 2023. It also became apparent that PS were providing nursing hours above the Defendant's commissioned care package and that PS were providing two nurses on an increasing number of A's care shifts rather than a nurse and a carer. Whilst, as I have noted, it was only from May 2024 that the Defendant sought to secure an updated care plan from Enviva, that care plan was not forthcoming. Whilst Enviva asserted at the transition meeting on 10 June 2024 that it could staff the care package, all of the available evidence suggested otherwise, not least because as at that point Enviva were only providing 11 hours of care out of the 168 hour care package.

84. As Mr Wise and Mr Persey emphasised during their submissions, a critical component of Ground 2 is what they contend was the failure of the Defendant to put in place an adequate alternative care provider before it terminated the contract with Enviva. I accept that it was incumbent on the Defendant to arrange for an alternative care provider to be in place at the time the contract was terminated. For the reasons set out above, I further accept that there was no up to date health care plan in placed at the point at which the contract with Enviva was terminated. However, once again, the test for unreasonableness is contextual. For the purposes of determining Ground 2, it is necessary to put those matters into context.

85. On 11 January 2024, the parents were provided with four alternative CQC registered agencies to consider. At a meeting on 24 January 2024, the mother agreed to Voyage Care and REACH being explored as potential options. The mother met with REACH on 14 March 2024 and shared with them the Enviva health care plan and consultant reports. On 24 April 2024 REACH undertook a home visit to A. The Defendant continued preparations in this context. As noted above, minutes of the meeting on 9 May 2024 record that the Defendant was to arrange meeting with health, education, and social care and REACH to discuss the care plan. The Defendant met with REACH, Enviva and PS in May 2024 to discuss the transition plan and the Defendant set up weekly transition meetings. Whilst the Defendant only began to seek an updated care plan from Enviva in May 2024, it did so at that point to aid the transition.

86. The steps taken by the Defendant did move matters forward in terms of transition planning. Enviva agreed to share an updated working document of its existing 13 June 2023 health care plan, with the intention that a transitional health care plan would be developed by Enviva, PS and REACH. The Defendant secured an agreement from REACH to subcontract with PS nursing staff for a short period to ensure minimal disruption for A at the point the Enviva contract ceased. On 12 June

2024, REACH provided the mother with profiles of four paediatric nurses and five carers.

87. Significant transition planning having taken place to ensure that REACH was in a position to take over from Enviva as the registered care provider on 9 July 2024, on 21 June 2024 the mother notified the Defendant that she was no longer willing to work with REACH based on her own assessment of the experience of the staff proposed. This was only a little over two weeks prior to the Enviva contract ceasing. At this time, the Defendant also received a number of emails from professionals involved in A's care raising concerns regarding the mother's physical and emotional health and requesting, on behalf of the parents, a two week pause in emails and meetings. Whilst from a human perspective the request is understandable, in the circumstances the Defendant was faced with both the withdrawal of consent to the alternate provider that had been the subject of considerable transition planning and a limitation on further discussions with the parents.

88. Having regard to its statutory duties, it is clear that the Defendant could not just stand back and do nothing at this point. Further, having identified a registered care provider, Nursing Direct, who could provide A's care package from 10 July 2024 and Nursing Direct having confirmed on 25 June 2024 that it would have availability to mobilise the Claimant's package of care immediately, the Defendant continued to try and engage the parents. The Defendant wrote to the mother on 26 June 2024 asking whether she would agree to meet with Nursing Direct. At the meeting held on 2 July 2024 the Defendant requested that the mother meet with Nursing Direct. That request was followed up in writing on the same day. That communication explained that the intention was for PS nurses to work with Nursing Direct during the transition. The father replied that the mother was too unwell to respond. On 3 July 2024 the Defendant wrote to the father to ask if he was willing to meet Nursing Direct. No meeting transpired.

89. In addition, the Defendant again examined whether it would be possible to rescind the notice given to Enviva on 3 May 2024. As I have noted, a strategy meeting was convened by the Interested Party at 4pm on 5 July 2024, including the Defendant's Director of Safeguarding, Assistant Director for Complex Care, and the Interested Party's Assistant Director of Children's Social Care again considered the question of rescinding the notice. A joint decision was taken that, in circumstances where A's care remained almost entirely delivered by an unregistered staffing provider and in the context of the lessons drawn from the incident with an unregistered staff provider on 26 November 2023, given the quality and governance concerns about Enviva, including the failure to provide an updated health care plan, it was not possible rescind the notice to Enviva or extend the contract any further. Whilst I accept that there is evidence that the Defendant continued to use Enviva on at least one other care package, it was entitled to take its decision with respect to A's care package having regard to the specific difficulties that had presented themselves with respect to A's package.

90. In the foregoing context, I am satisfied that the Defendant's decision on 9 July 2024 to terminate Enviva's contract and to arrange for Nursing Direct to provide the health care provision for A specified in Section G of his EHC plan was a decision that was within the range of reasonable decisions then open to the Defendant in the circumstances.

91. The decision on 9 July 2024 to terminate Enviva's contract fell to be made in circumstances where (a) Enviva continued to be unable, as the registered care provider, to meet the requirements of the care package for A without substantial recourse to an unregistered staffing provider, following an extended history of Enviva being unable to do so and in circumstances where the Defendant had reviewed its position in light of the incident with another staffing provider in November 2023; (b) the Defendant attempted to obtain an updated health care plan from Enviva but one had not been forthcoming, the Defendant being provided instead with an agreement by Enviva to share an updated working document of the existing 13 June 2023 health care plan with the intention that a transitional health care plan would be developed by Enviva, PS and REACH; (c) a little over two weeks prior to the Enviva contract ceasing the parents had then withdrawn their consent to working with REACH, the registered care provider that the Defendant had identified to replace Enviva and in respect of which it had undertaken transition planning for an extended period; (d) there were significant limitations on the Defendant's ability to engage in any substantive dialogue with the family in the context of the concurrent request for a two week hiatus in email correspondence and meetings; and (e) the Defendant had identified and confirmed the availability of a registered care provider which provided the Defendant's most complex care packages to take over the care of A upon the termination of Enviva's contract. With respect to consultation with A's family, I accept that the SEND Code of Practice paragraph 1.1 emphasises the importance of the child's parents "participating as fully as possible in decisions." Equally however, at paragraph [96] under the heading "Arrangement of provision" the National Framework provides as follows with respect to the involvement in the family:

> "Involvement of the family is essential, not least to discuss options in relation to the parental role as carers. However, the care package should not be driven by the family's preferences where this conflicts with the needs of the child or young person, or the CCG's commissioning strategy."

92. I acknowledge that the condition under which A labours is rare, meaning training should be delivered by the clinical team working with A and who know him well, that any changes to A's care package require careful evaluation and discussion with those who have a good understanding of his requirements, including his parents, and that when introducing new caregivers, a carefully structured and phased transition plan should be implemented. I likewise acknowledge that any deficits in A's care can have very serious consequences. In the circumstances set out in the foregoing paragraph however, and having regard to the high although not insuperable threshold for establishing irrationality, it cannot be said in my judgement that that the decision of the Defendant to terminate the Enviva contract on 9 July 2024 and to put in place Nursing Direct to provide the care package for A was irrational in the public law sense. Whilst another ICB might have balanced differently the competing considerations informing the decision that was taken, I am satisfied that the decision taken by the Defendant was one then reasonably open to it. In the circumstances, Ground 2 is not made out.

Ground 3

93. By Ground 3 the Claimant contends that, applying the approach set out by the Court of Appeal in *R(CP) v North-East Lincolnshire Council* [2019] EWCA Civ 1614, the Claimant's *parents* are entitled to restitution on the grounds of unjust enrichment.

The Claimant asserts that the Defendant has been enriched by not paying for the healthcare package since on or around 10 July 2024, that that enrichment was at the expense of the Claimant's parents by reason of their having to fund A's care and that the enrichment was unjust because the Claimant's parents had no choice but to ensure that Enviva and PS continue to deliver the Claimant's healthcare package in circumstances where the Defendant had failed to take the basic steps required to safely transition to a new provider and there was risk of serious harm or death if nurses or carers with poor understanding of the Claimant's needs were required to deliver his sensitive and complex healthcare package.

94. Mr Wise and Mr Persey submit that a claim for restitution on the grounds of unjust enrichment is justiciable in a claim for judicial review. They contend that, as in *Richards v Worcestershire County Council* [2018] PTSR 1563, this is a case where the care provision provided by the Defendant continued but the Defendant's funding discontinued. They further rely on *R (CP) v North-East Lincolnshire Council* [2020] PTSR 664 as supportive of the justiciability of the claim for restitution, the Court of Appeal referring to "compensation by restitution or otherwise", and *Surrey CC v. NHS Lincolnshire CCG* [2021] QB 896. Mr Wise and Mr Persey further submit that, in any event, nothing turns on the specific basis for the order of compensation, whether it is restitution or otherwise, the Court having a discretion to order a remedy of compensation if it considers restitution inappropriate. In the circumstances, Mr Wise and Mr Persey submit that this is the appropriate forum for such a claim as it arises from a public law challenge, there being no reason in principle why it cannot in a properly brought within a public law claim. In response to the Defendant's contention that the claim is insufficiently quantified, Mr Wise and Mr Persey submit that the court can make an order that the Defendant is liable for the costs from 11 July 2024 to the point the ICB put in a care package that relieves them of the payment, to be quantified at a later point.

95. On behalf of the Defendant, Mr Lawson and Mr Rylatt concede that s.31(4) of the Senior Courts Act 1981 provides that on an application for judicial review the High Court may award to the applicant damages, restitution or the recovery of a sum due if the application includes a claim for such an award arising from any matter to which the application relates and the court is satisfied that such an award would have been made if the claim had been made in an action begun by the applicant at the time of making the application. The Defendant further accepts that the decision of the Supreme Court in *Barton v Gwyn-Jones* [2023] AC 684 at [77] provides the four questions that the court must ask itself when faced with a claim for unjust enrichment. The Defendant submits however, that *Richards v Worcestershire County Council* does not support the Claimant's pleaded case, nor that *R (CP) v North-East Lincolnshire Council* is relevant. They submit that *Surrey CC v. NHS Lincolnshire CCG* can be distinguished on its facts.

96. In addition to the foregoing matters, the Defendant contends that the claim for restitution on the grounds of unjust enrichment has not been properly pleaded, contending that procedural rigor is particularly important where a Claimant seeks to expand the range of remedies available in judicial review. More fundamentally, Mr Lawson and Mr Rylatt submit that the Claimant has not himself suffered any loss capable of grounding a claim in restitution. In the circumstances, they submit that the Claimant cannot satisfy the second question in *Barton v Gwyn-Jones* as any

enrichment of the Defendant has not been at the Claimant's expense, but rather that of his parents. In the circumstances, Mr Lawson and Mr Rylatt submit that the parents are seeking, with the Claimant's public funding, to bring a money claim in respect of a cause of action that does not vest in him.

97. As can be seen, the court heard detailed argument about the extent to which restitution on the grounds of unjust enrichment is available as a remedy in proceedings for judicial review. However, it is not necessary for the court to decide that point of some little complexity in light of a more prosaic point arising from the particular facts of this case. Namely, that the Claimant is not paying for his continuing healthcare provision, his parents are.

98. Accordingly, putting aside the question of whether restitution on the grounds of unjust enrichment is available as a remedy in proceedings for judicial review, and whether in any event these judicial review proceedings are the appropriate forum for such a claim in this case given the significant issues of fact and causation that appear to arise in that context, the Claimant himself has suffered no pecuniary loss that can properly be said to ground a claim for restitution on the grounds of unjust enrichment. The Claimant cannot demonstrate, as is required within the framework set out by the Supreme Court in *Barton v Gwyn-Jones*, that any unjust enrichment of the Defendant has been at the Claimant's expense.

99. The matters set out by the Claimant under Ground 3 really relate to the question of remedy. For the reasons set out above, I am not satisfied that the Claimant is entitled within these judicial review proceedings to a remedy of restitution on the grounds of unjust enrichment. If the parents seek to recover from the Defendant the monies *they* have expended on the Claimant's care since 11 July 2024 then, provided they can identify a cause of action, it remains open to them to pursue a civil claim in the County Court.

CONCLUSION

100. For the reasons set out above I am satisfied that Ground 1 is arguable and that the claim succeeds on Ground 1. Whilst I am satisfied that permission should be given in respect of Ground 2, I am not satisfied that Ground 2 is made out for the reasons given. Finally, and again for the reasons I have set out above, I am not satisfied that the Claimant is entitled within these judicial review proceedings to a remedy of restitution on the grounds of unjust enrichment.

101. In the circumstances, the Claimant's claim succeeds on Ground 1. As to relief, it would not seem necessary to make a Declaration with respect to the breach of s.42(3) of the 2014 Act given the matters set out in detail in this judgment. I would be minded to grant a mandatory order requiring the Defendant to arrange the health care plan stipulated in Section G of A's EHC plan dated 23 November 2023 informed by the detailed review assessment process that preceded that EHC plan. This will, of course, be subject to a mutually acceptable registered care provider being identified for A's care package moving forward. I will allow counsel to address me further on relief if agreement cannot be reached between the parties in the light of this judgment.