IN THE COUNTY COURT AT
CENTRAL LONDON

Case No: L40CL341

Thomas More Building
Royal Courts of Justice
Strand
London, WC2A 2LL

Date: 10th July 2025

Before :

HIS HONOUR JUDGE HOLMES

- -

Between :

MS FLORIJETA DERVISHI — **Appellant**

-and-

THE ROYAL BOROUGH OF KENSINGTON & CHELSEA — **Respondent**

- -

Mr Daniel Grütters (instructed by **Hodge Jones & Allen LLP**) for the **Appellant**
Mr Ian Peacock (instructed by **Bi-Borough Legal Services**) for the **Respondent**

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Hearing date: 25th June 2025
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JUDGMENT

His Honour Judge Holmes:

1. London awoke on the morning of 14th June 2017 to the news that the Grenfell Tower in North Kensington had been destroyed in a devastating fire. Seventy people died that night and two more died later in hospital from the injuries sustained. Florijeta Dervishi lived in Barandon Walk – one of the fingers of properties which emanated from the base of the main tower. Ms Dervishi lost friends in the fire. She also lost the home she shared with her family. The family were rehoused following the fire, but in time, Ms Dervishi – who was 23 at the time of the fire – left the family home. The family relationship had deteriorated; Ms Dervishi says this was as a result of the fire.

2. Ms Dervishi spent a number of weeks street homeless and applied for assistance from the Respondent. As a result of the Respondent's intervention, Ms Dervishi obtained an assured shorthold tenancy of a property in SW5. That is a terrace house which has been converted into eight flats. It is accommodation provided by Southern Housing who aim to move the residents on within two years, provided that the tenant is ready. The move could be to the private sector or to local authority accommodation if they have sufficient priority. The Respondent ended its relief duty on 24th August 2020.

3. Ms Dervishi requested a review of the ending of the relief duty on 28th March 2022. That was refused. A fresh homelessness application was made on 30th June 2022. It was said that the accommodation was not reasonable for her to continue to occupy and she was as a result homeless. On 18th October 2022 the authority determined that she was neither homeless nor threatened with homelessness. Ms Dervishi sought a review of that decision. The review process took exactly two years to conclude. The review decision was sent to Ms Dervishi on 18th October 2024.

4. This case concerns the review officer's treatment of the medical evidence provided by Ms Dervishi to the authority. Ms Dervishi obtained two reports from Dr Paul Wallang, a consultant forensic psychiatrist. The first is dated 8th June 2022 and followed an examination of Ms Dervishi on 6th April 2022. It is a relatively brief document. Dr Wallang is a member of the Royal College of Psychiatrists and at the time of the second report had almost twenty years' experience. The first report was directed towards the issue of need and vulnerability. Nevertheless at paragraph 3.10, Dr Wallang said:

> "Ms Dervishi has suffered with clear and severe trauma symptoms since the Grenfell fire on the 14th of June 2017. Ms Dervishi has recurring,

> distressing, intrusive thoughts and memories of the fire. She is avoidant of cues and triggers associated with the tragedy and has clear hypersensitivity to perceived dangers around fire and hypervigilance to her own personal safety following the fire. These symptoms are in keeping with a diagnosis of Post Traumatic Stress Disorder (PTSD). Moreover, as a consequence of the ongoing trauma Ms Dervishi has also developed depression and anxiety. Ms Dervishi currently struggles with motivation and daily functioning. She is prone to bouts of hopelessness and has strong feelings of anxiety, shame and guilt. She has been referred to the local mental health services and requires structured evidence based therapy to alleviate her PTSD."

5. Then in paragraph 4.1 Dr Wallang said this,

> "Ms Dervishi has a diagnosis of Post Traumatic Stress Disorder and depressive illness with anxiety. At interview, she appeared very low in mood and preoccupied with thoughts of the Grenfell fire and her current unstable housing situation. She lacks motivation through her illness and struggles to function on a daily basis. Her fragile mental state, reduced motivation and anxiety mean that she would in my opinion, on balance, be less able to secure accommodation compared to the ordinary person without the diagnoses of Post Traumatic Stress Disorder, depression and anxiety which are all mental illnesses as defined in the International Classification of Diseases eleventh edition (ICD-11). Such mental disorders constitute a 'vulnerability' in Ms Dervishi."

6. The authority sent the report to NowMedical where it was seen by Dr James Wilson who is described as a "Psychiatric Advisor". Dr Wilson is a member of the Royal College of Psychiatrists. His experience is not set out. Dr Wilson says this,

> "It is further stated the accommodation has many self-contained units and these house vulnerable residents and that this triggers the applicant's vulnerability. The applicant has undergone an assessment by a consultant psychiatrist in Jun 22. This assessment was rather brief who confirmed the applicant had evidence of post-traumatic stress disorder and some impairment in daily functioning. However, I note the applicant has been able to continue working as a waitress. Based on the information available, there is nothing to indicate that her current accommodation is unsuitable on specific psychiatric grounds.

> "In relation to whether the applicant is significantly more vulnerable than an ordinary person if homeless, there is not evidence to indicate, in my view, that the applicant is significantly impaired in her functioning to the extent that she is unable to locate other accommodation or that she would be significantly more vulnerable and suffer injury or detriment if she were to become homeless."

7. The second report of Dr Wallang is dated 16th May 2024 and followed an examination of Ms Dervishi on 26th January 2024. The second report had an earlier version dated 8th April 2024. There are some differences to which I will return. Some of the history contained in the report is worthy of being set out in full:

> "3.6 Ms Dervishi explained that due to her feeling unsafe and on edge she had lost weight over the last six months and was now 51kgs. She said that she struggles to eat in the accommodation due to her constant fear and lack of safety however, was 'trying her hardest to put on weight'.
>
> "3.7 Ms Dervishi said she had 'lost hope' and 'nothing is working'. She continued to describe prominent intrusive thoughts and feelings related to the Grenfell fire and felt elements of her current housing situation were exacerbating her symptoms; particularly her ongoing feelings of lack of safety, frequent loud noises, and constant disturbances which were triggering flashbacks to the night of the fire.
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> "3.10 Since her diagnosis with PTSD, Ms Dervishi explained that she felt 'nobody was taking her seriously' and as a consequence she 'felt lost' and hopeless. She had slumped in her mental state and her already poor sleep had become 'very bad' and was now causing disruption at work, to such a degree that Ms Dervishi explained that she had become increasingly irritable and frustrated with her manager (which had culminated in an argument not long ago).
>
> "3.14 Everywhere she turns in the current accommodation Ms Dervishi said there are 'triggers for intrusive memories' and feelings related to the Grenfell Fire, such as 'smelling smoke from people smoking drugs in other flats, chronic noise, and a prominent burn mark on her floor'.

> "3.20 Ms Dervishi described finding it increasingly difficult to work with her PTSD symptoms and felt that she was 'most likely heading for period of sick leave'. She continues to work at Westfield at 'All-Star-Lanes', however since we last spoke in 2022, Ms Dervishi had reduced her time commitment to sixteen hours due to increasing anxiety, loss of hope, exhaustion and demotivation.
>
> "3.21 She described 'not eating properly' as she was 'on edge all the time' and had no motivation. She found her current room 'heavy and dark' and said this was 'getting her down'. There was also a prominent burn mark on the floor which was very triggering of the Grenfell fire.
>
> "3.22 Ms Dervishi said her ideal residence would be free from chaos, constant loud noises, and the frequent smell of smoke from other residents consuming drugs. She noted that she would ideally need to be close to family, however did not really care where she goes as long as she was out of the extremely triggering environment she now finds herself which is exacerbating her PTSD and making it impossible for her to recover. Ms Dervishi said she was also willing to be placed in a neighboring (sic) borough.
>
> "3.28 Regarding her hygiene and daily living, Ms Dervishi told me she can go days without showers, and she struggles with motivation to bathe or shower. She noted that there had been 'whole weeks when she can go without showering'. There are times when she will turn up to work very late [an hour] due to low energy, lack of sleep, and reduced motivation."

8. Dr Wallang concluded that Ms Dervishi has suffered with clear and severe PTSD symptoms since the Grenfell fire. At paragraph 4.1 of his report Dr Wallang says this,

> "Ms Dervishi has recurring, distressing, intrusive thoughts and memories of the fire. She is avoidant of cues and triggers associated with the tragedy and has clear hypersensitivity to perceived dangers around fire and hypervigilance to her own personal safety following the fire. These symptoms are in keeping with a diagnosis of Post-Traumatic Stress Disorder (PTSD). Moreover, as a consequence of the ongoing trauma Ms Dervishi has also developed depression and anxiety. Ms Dervishi currently struggles with motivation and daily functioning. She is prone to bouts of hopelessness and has strong feelings of anxiety, shame and guilt.

> She has been referred to the local mental health services and requires structured evidence based therapy to alleviate her PTSD. These symptoms have lasted since the Grenfell fire (14th of June 2017) and are substantially affecting Ms Dervishi's day to day activities. Ms Dervishi's PTSD, low mod and anxiety are impairments which have a substantial and long-term adverse effect on her ability to carry out normal day-to-day activities."

9. In paragraph 4.4 of the report, Dr Wallang adds this:

> "It is vitally important that those suffering with PTSD have a safe and supportive environment, free from triggers which would damage an already fragile mental state. Ms Dervishi's current accommodation is inimical to her recovery due to it chaotic and triggering nature. Ms Dervishi requires a calm environment, without other residents who create noise, smoke, threaten her and generally worsen her PTSD symptoms. I would recommend a flat without other residents… In the period between my initial assessment (Wednesday 6th April 2022) and more recent assessment (Friday 26th of January 2024) I have been struck by how much more anxious, low in mood and hopeless Ms Dervishi appears. Her current accommodation in combination with her PTSD is clearly making her more unwell in her mental state and she now has fleeting ideas of 'not wanting to be here anymore' if her situation does not improve. I am very concerned that Ms Dervishi's risk of suicide has increased between my two assessments in April 2022 and January 2024 and will continue to escalate if she is not moved to more reasonable accommodation."

10. Dr Wallang also notes this at paragraph 4.12:

> "Ms Dervishi struggles to attend important appointments including for her health and wellbeing. For example, in order to complete this assessment I attempted to meet with Ms Dervishi on two prior occasions before I was eventually to meet with her on Friday 26th of January 2024. On both prior occasions Ms Dervishi was too anxious and low in mood to make the journey and did not attend the appointments. Ms Dervishi struggles to manage her own health and would need constant encouragement and support to attend to her treatment because of her ongoing low mood, anxiety and lack of motivation due to PTSD."

11. Once again the authority sent the report to NowMedical. On this occasion it was Dr Raquin Cherian who provided the advice. She too is a member of the Royal

College of Psychiatrists. Again, the extent of her experience is not set out. Her advice in full is as follows:

> "I note the additional representations following our previous recommendation. The applicant has been assessed by a psychiatrist, instructed by her legal advisers, who contends that she suffers from depression and PTSD, and that her mental health has worsened significantly since 2022. The applicant is also reported to be significantly functionally impaired. However, there is a clear contradiction between this opinion, based on two one-off assessments in 2002 (sic) and 2024, and information gleaned from a series of contemporaneous notes in the applicant's primary care records.
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> "On an anxiety screening self-reported questionnaire (GAD-7) on 9 Jan 24, the applicant scored 9, indicating mild anxiety (not moderate or severe). A depression screening (PHQ-9) showed a score of 7, indicating moderate depression (not moderately severe or severe). The applicant was signed off work from Jan to Mar 24, with the cited reasons being "work-related stress" and insomnia. On 9 Apr 24, the applicant informed her GP that she felt well enough to return to work, and no further sick notes have been issued since then. This presents contradicting information regarding applicant's functionality and mental health trajectory. The recovery in Apr 24, is reported to have taken place from the mild anxiety and moderately severe depression, at the baseline.
>
> "There is also compelling evidence that the applicant is not severely functionality impaired, as the applicant herself reported being well enough to work, indicating recovery and a good degree of functionality.
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> "The applicant had consultations with her GP for work-related stress, insomnia, and other physical health issues. However, at no point in the past 2 years, was there any indication that interventions or an increase in care were required for PTSD or depression. The applicant has not required treatment with anti-depressants and chose not to engage in therapy following a referral made earlier this year for work-related stress.
>
> "In summary, the contemporaneous consultation notes in primary care contrast with the findings of the psychiatrist appointed by the applicant's legal representative.
>
> "I note that in the current accommodation, the applicant has access to her own flat although communal areas are shared. Fire alarm testing is

> reported to be pre-scheduled and occurs at a specified time and day once a week. It is unclear what steps have been taken to reduce the impact of this transient but planned event. Any concerns related to anti-social behaviour from other residents and any disrepair should be addressed in their own right.
>
> "In my opinion, at present, there is insufficient evidence concerning unsuitability when both a series of contemporaneous medical records and one-off psychiatric reports are taken into account. I would be happy to review the case again, if further information can be provided to understand the said discrepancies."

12. The essential thrust of the advice is that there is too great a contrast between the medical report of Dr Wallang and what is contained in the contemporaneous records. The medical records available in the appeal bundle show the following:

16.01.24 Ms Dervishi seeking a blood test. The request was triaged by Mrs Alia Hossain (a pharmacist). There was then a telephone consultation with another pharmacist, Mr Keyvan Moein. She reported a number of symptoms that including being unable to sleep and being very fatigued and tired. Blood tests were ordered.

18.01.24 There was a contact with a nurse who noted Ms Dervishi's failure to attend for a smear test on 23.11.23. This is recorded, "She apologised for missing he appointment but tells me she was not aware that this appt had been booked. However, tells me has memory difficulties associated with post traumatic stress so admits she may have forgotten about it."

25.01.24 Sees the same nurse who, amongst other things, notes, "Tells me suffering PTS = unwilling to expland (sic)."

30.01.24 Ms Dervishi rings the GP practice. The receptionist notes, "Presenting complaints or issues pt wants to get a sick note, starting yesterday for her work, pt is suffering from depression and hasnt (sic) been sleeping, pt wants the note for 2 months, due to post tramatic (sic) stress". She is again triaged by a pharmacist. A then speaks to a pharmacist later in the day who notes, "wants 2 months off work … sleep is poor for 2 months...affecting her work...work related problems and can't do her job properly doesn't slep at night but sleps during the day 6 h daily … apetite is poor … mood is low … No thoughts of deliberate self harm". On the same day the GAD-7 and PHQ-9 questionnaires were completed. The same pharmacist then makes an entry which includes, "pt says she has post traumatic disorder and was under mh team in the past...and wants 2 months sick

note for work related stress and insomnia … Plan: sleep hygene adv...given … short term promethazine pill for sleep issue … adv..to refer to talkin g therapy..pt agreed … ad..we need to review her sleping issue in 1-2 weeks..pt agreed … adv..if sx p/w..any si..to call crisis no, go to A@E or cb..pt agreed." A was also sent a message saying to contact the surgery if she was struggling with low mood or not being able to cope. The Samaritans number was also given.

She is then seen on a number of occasions for unconnected physical issues.

21.02.24 Ms Dervishi is seen by the talking therapies team. The outcome of first appointment letter says this, "Thank you for attending your initial (telephone) appointment with Community Living Well Psychological Therapies. During our triage session you reported several times that you do not wish to talk about past traumatic experiences and we agreed that you should self-refer back to our service when you think you are able to engage in treatment."

09.04.24 Ms Dervishi makes contact with the surgery seeking a note for return to work. There is a note from Dr Mujong which says, "Miss Dervishi was deemed not fit for work from 29 Jan 2024 to 28 March 2024 due to work related stress and insomnia. She was referred to talking therapy also. We have discussed today her mental health and stress levels and we agreed on her decision to return to work now. She can contact us for further support in the future should she need."

13. The authority sent a 'minded to find' letter on 30th July 2024. That prompted further representations from Ms Dervishi's solicitors on 10th October 2024 before the final decision was made on 18th October 2024.

14. The review decision sets out the medical evidence in some detail. The advice of Dr Raquin Cherian is set out under the heading, "Independent medical advice".

15. The review officer then says this,

> "33. I have carefully considered your personal circumstances and the extent of your health problems when deciding whether your accommodation is reasonable for you to continue to occupy. In this regard, I have paid particular attention to the medical evidence available to me, including the information provided by the medical professionals who have assessed and treated you.
>
> "34. I acknowledge that Dr Cherian has not met you and has therefore not carried out an examination of your mental health. For this reason, I am minded to give more weight to the opinions of the medical professionals who have assessed and treated you. I also note that Dr Cherian refers to

suitability in the last paragraph of their advice, rather than reasonableness, which are different concepts – although in my referral to NowMedical, I did explain that the question to be considered was whether your accommodation was reasonable for you to continue to occupy.

"35. However, whilst having had full regard to the totality of medical evidence available, I am not satisfied that this supports the conclusion that your accommodation is unreasonable for you to continue to occupy. Although I concur with some of the opinions expressed by Dr Cherian, I have carried out my own reasoning on the facts available and reached my own independent conclusion on the (sic) whether your accommodation is reasonable for you to continue to occupy."

16. In terms of setting out the role of Dr Cherian it is difficult to fault. There then follows 30 paragraphs in which the review officer seeks to justify his decision. I will need to return to that document, but first it is sensible to set out the legal principles that I must apply.

LEGAL FRAMEWORK

17. The duties of housing authorities towards those who are homeless are contained in Part 7 of the Housing Act 1996. The statutory scheme is a safety net designed to assist those who find themselves homeless. Where a person applies to an authority for assistance under Part 7, s.184(1) requires that where an authority has reason to believe that the applicant may be homeless or threatened with homelessness they make such inquiries as are necessary to satisfy themselves whether the applicant is eligible for assistance, and if so whether a duty is owed under Part 7.

18. Section 175 provides in relevant part:

"(1) A person is homeless if he has no accommodation available for his occupation, in the United Kingdom or elsewhere, which he-

(a) is entitled to occupy by virtue of an interest in it or by virtue of an order of a court,

(b) has an express or implied licence to occupy, or

(c) occupies as a residence by virtue of any enactment or rule of law giving him the right to remain in occupation or restricting the right of another person to recover possession...

…

(3) A person shall not be treated as having accommodation unless it is accommodation which it would be reasonable for him to continue to occupy..."

19. The appeal is brought under section 204 of the 1996 Act. An appeal under section 204 can only be in relation to a point of law, although the court's jurisdiction on review extends to the full range of issues that would otherwise be the subject of a High Court application for judicial review: *James v. Hertsmere Borough Council* [2020] EWCA Civ. 489, [2020] 1 W.L.R. 3606. It is in effect a judicial review of the review decision, as to which *Begum v. Tower Hamlets LBC* [2003] UKHL 5; [2003] 2 A.C. 430 applies; see Lord Bingham's speech at [7].

20. In *Holmes-Moorhouse v. Richmond-upon-Thames LBC* [2009] UKHL 7; [2009] 1 W.L.R. 413, at [47 and 50] Lord Neuberger made the following comments:

> "47. … review decisions are prepared by housing officers, who occupy a post of considerable responsibility and who have substantial experience in the housing field, but they are not lawyers. It is not therefore appropriate to subject their decisions to the same sort of analysis as may be applied to a contract drafted by solicitors, to an Act of Parliament, or to a court's judgment.
>
> …
>
> "50. Accordingly, a benevolent approach should be adopted to the interpretation of review decisions. The court should not take too technical view of the language used, or search for inconsistencies, or adopt a nit-picking approach, when confronted with an appeal against a review decision. That is not to say that the court should approve incomprehensible or misguided reasoning, but it should be realistic and practical in its approach to the interpretation of review decisions."

21. In *Rother District Council v. Freeman-Roach* [2018] EWCA Civ. 368, [2018] H.L.R. 22, the Court of Appeal said:

> "51. These and many other cases were reviewed by Lord Brown in *South Bucks DC v. Porter (No 2)* [2004] UKHL 33, [2004] 1 W.L.R. 1953. He confirmed at [29] that the burden is on the challenger to show that the decision maker made an error of law. His well-known summary of principle is at [36]. For the purposes of this case it will suffice if I only quote part of it:
>
> > 'Reasons can be briefly stated, the degree of particularity required depending entirely on the nature of the issues falling for decision. The reasoning must not give rise to a substantial doubt as to whether the decision-maker erred in law, for example by misunderstanding some relevant policy or some other important

> matter or by failing to reach a rational decision on relevant grounds. But such adverse inference will not readily be drawn … Decision letters must be read in a straightforward manner, recognising that they are addressed to parties well aware of the issues involved and the arguments advanced.'
>
> "52. Accordingly, in the present context it is not for the reviewing officer to demonstrate positively that he has correctly understood the law. It is for the applicant to show that he has not. The reviewing officer is not writing an examination paper in housing law. Nor is he required to expound on the finer points of a decision of the Supreme Court…"

22. The inquiries made by an authority must be sufficient, and will be inadequate only where it failed to make inquiries which no reasonable authority could have failed to make: *R v. Royal Borough of Kensington and Chelsea ex p. Bayani* (1990) 22 H.L.R. 406. An authority which has made inquiries can only be criticised for failing to make further inquiries if no reasonable authority could have failed to regard them as necessary, *R v. Nottingham CC ex p. Costello* (1989) 21 H.L.R. 301; and *Cramp v. Hastings BC* [2005] EWCA Civ. 1005; [2005] H.L.R. 48.

23. Local authorities are required to pay close regard to medical evidence submitted in support of an application, see *Osmani v. Camden L.B.C.* [2004] EWCA Civ. 1706; [2005] H.L.R. 22 where at [38(8)] the Court said this, "Nevertheless, although authorities should look for and pay close regard to medical evidence submitted in support of applicants' claims of vulnerability on account of mental illness or handicap, it is for it, not medical experts, to determine this statutory issue of vulnerability."

24. The role of a local authority's own medical advisor has been discussed in various cases. It was said in *Hall v. Wandsworth L.B.C.* [2004] EWCA Civ. 1740; [2005] H.L.R. 23 at [42] that a local authority is able to obtain its own expert evidence. The evidence in that case was from the applicant's GP and comment upon it from a Dr Keen, the council's medical advisor. The approach to such advice has been considered in other cases. In *R v. Westminster C.C., ex p. Bishop* (1993) 25 H.L.R. 459, where the essence of the decision appears to have been that the deputy judge was correct to hold that where a local authority has sought the advice of a medical advisor, that does not absolve the decision maker from giving proper consideration to the issue. That is particularly so where the medical advisor has not examined the person concerned and is therefore relying upon second-hand information (at p.465).

25. In *Shala v. Birmingham C.C.* [2007] EWCA Civ. 624; [2008] H.L.R. 8 the applicant relied upon letters from a GP, which in turn made reference to the opinion of a psychiatrist. The authority had then sought the advice of Dr Keen. Sedley, L.J. said this in paragraphs 22 and 23,

> "22. It is appropriate in this light to consider the role of a practitioner such as Dr Keen. While this court in *Hall v. Wandsworth LBC* [2005] H.L.R. 23 at [42], described his report to the local authority as constituting not merely common sense comment but expert advice, the limited extent and character of his expertise has to be borne in mind by those using his services. As another constitution of this court pointed out in *Khelassi v. Brent LBC* [2006] EWCA Civ. 1825 at [9], [22], Dr Keen is not a psychiatrist, with the result that the county court judge had been fully entitled to regard his dismissive comments on a qualified psychiatrist's report insufficiently authoritative for the local authority to rely on. In this situation a local authority weighing his comments against the report of a qualified psychiatrist must not fall into the trap of thinking that it is comparing like with like. His advice has the function of enabling the authority to understand the medical issues and to evaluate for itself the expert evidence placed before it. Absent an examination of the patient, his advice cannot itself ordinarily constitute expert evidence of the applicant's condition.
>
> "23. Dr Keen twice advised on Mrs Shala's condition without examining her. There is no rule that a doctor cannot advise on the implications of other doctors' reports without examining the patient; but if he or she does so, the decision-maker needs to take the absence of an examination into account. Local authorities who rely on such advice, and doctors who give it, may therefore need to consider—as many already do—whether to ask the applicant to consent to their having their own examination. Between these two poles, however, there is a third possibility—that the local authority's medical adviser, again with the patient's consent, may speak to the applicant's medical adviser about matters which need discussion. It may be thought, for example, that Dr Keen would have been helped by discussing with Dr Deb or Dr Mukherjee, or both, just how depressed Mrs Shala was (Dr Deb's epithet ''quite'' has a sizeable range of meaning) and whether the anti-depressant dosage prescribed for her reflected only moderate depression or was conditioned by factors such as her being concomitantly on other medication or a disinclination of the practitioner to over-prescribe. The caveat we would enter, because of misunderstandings which can easily arise, is that any such discussion

> should be informal and only an agreed minute of it, if one results, become part of the case materials."

26. Finally, in *Guiste v. Lambeth L.B.C.* [2019] EWCA Civ. 1758; [2020] H.L.R. 12 following on from *Shala* the applicant was seen by a consultant psychiatrist who prepared a report. The local authority sought advice from two medical advisors, both of whom were psychiatrists but they did not examine the applicant. The applicant's advisors suggested that the doctors should discuss the case. This was declined. At paragraph 64, Henderson, L.J. said:

> "This evidence, from a distinguished consultant psychiatrist, and directed to the key legal point in issue, could not in my view be disregarded, and if the review officer was going to depart from it, I think it was necessary for her to provide a rational explanation of why she was doing so. The difficulty which I have is that, even on a benevolent reading, I am unable to find any such rational explanation in the Review Decision. On the contrary, I find it very hard, if not impossible, to trace a coherent line of reasoning in paras 66–75 of the Review Decision… If Ms Ubiam was intending to base her conclusion on the views of the two psychiatrists instructed by NowMedical, she needed to explain why their views should prevail over that of Dr Freedman, when they were less highly qualified that she is, and (more importantly) they had never met or interviewed Mr Guiste."

DISCUSSION

27. The Appellant seeks to challenge the decision on two grounds:

> (1) The Review Decision fails to provide sufficient reasoning and/or reaches perverse conclusions about the reason for rejecting the expert evidence from Dr Wallang.
>
> (2) The Review Decision failed to conduct sufficient further inquiries into the Appellant's deteriorating mental health or lack thereof.

GROUND 1

28. Mr. Grütters, representing the appellant, argues that the review officer acted perversely by giving more weight to the fact that there were no complaints or diagnoses in Ms. Dervishi's GP records, rather than to the expert opinion of Dr. Wallang, a consultant psychiatrist. Dr. Wallang had assessed Ms. Dervishi during two ninety-minute consultations and concluded that her accommodation was 'having a clearly detrimental effect on her fragile mental state' and was constantly triggering her PTSD symptoms and was preventing her from

recovering from her mental illness. Mr. Grütters says the only way the review officer could reasonably decide that the overall medical evidence did not support this conclusion would be to completely reject Dr. Wallang's expert opinion. However, the officer did not explain why Dr. Wallang's diagnosis might be wrong. Instead, the officer seemed to rely more on two short self-assessment questionnaires, which only asked sixteen questions about the previous two weeks. Mr. Grütters argues that it makes no sense to prefer these limited questionnaires over a thorough psychiatric evaluation, especially without giving any reason for dismissing the expert's findings.

29. Mr Peacock counters that the review officer provided reasons for his conclusions. There was a stark contrast between the position in the medical records and the report of Dr Wallang. He highlighted the approach for a "sick note" from work on 30th January 2024 and the questionnaires completed before seeing the medical practitioner that day which suggested mild anxiety and moderate depression. Her GP agreed that she was able to return to work on 9th April 2024. That he says is entirely supportive of the review officer's conclusion.

30. Mr Peacock also focused on the differences between the report completed on 8th April 2024 and the version completed on 16th May 2024. The first of those two reports made reference to the property being shared accommodation. The second version removed these references and replaced them with references to shared common parts. Mr Peacock says this to seek to question the approach or reliability of the information provided by Dr Wallang.

31. It is necessary to consider the basis of the review officer's decision. The review officer is correct to identify that there is a contrast between the severe PTSD symptoms that Dr Wallang notes and the only entry in GP records which records the results of two brief self-administered questionnaires which show moderate depression and mild anxiety. Of the GP records, the review officer says, "nor do they reveal particularly concerning features of mental illness, including suicidal risk or intent. Further, your medical records do not reveal that your accommodation is significantly exacerbating your mental health." The representation of Ms Dervishi's solicitors is noted: that the opinion of a psychiatrist who has actually examined the appellant should be preferred to the absence of a diagnosis in the records. This conclusion is then reached:

> "36. There is a clear discrepancy between the reports provided by Dr Wallang and the medical records obtained from your GP. Dr Wallang advises that you have suffered with clear and severe PTSD symptoms since the Grenfell Tower fire, and have also developed depression and

anxiety; your accommodation is triggering your PTSD symptoms and exacerbating your mental health conditions; and your risk of suicide has increased, and will continue to do so, if you do not move to more appropriate accommodation.

"37. Whereas the medical records from your GP reveal that you have presented with moderate depression and mild anxiety, and were diagnosed with work related stress and insomnia. They do not confirm that you have been diagnosed with a particular severe and enduring mental illness, including PTSD, by a specialist NHS mental health service; nor do they reveal particularly concerning features of mental illness, including suicidal risk or intent. Further, your medical records do not reveal that your accommodation is significantly exacerbating your mental health.

"39. I have carefully considered all the medical evidence available to me, including the information from Dr Wallang and your medical records obtained from your GP. I have decided, however, to give more weight to your NHS medical records obtained from your GP than the reports from Dr Wallang. This is because your medical records contain details of your consultations, diagnosis, treatment, assessments and referrals to other services which have happened within the NHS.

"40. Your GP is your treating primary care service within the NHS – you consult regularly with them about your health issues, they prescribe you medication, they refer you to specialist services, and they sign you off work when necessary. In addition, where you require more specialist treatment within the NHS, either from primary care, secondary care or impatient services, this will be included within your medical records. In my opinion, your GP and the other NHS services who have assessed you, are best placed to provide contemporaneous medical evidence about you.

"41. Whilst I acknowledge that Dr Wallang is a Consultant Forensic Psychiatrist and he had access to your medical records, he has completed a one-off psychiatric report on two occasions in the last 28 months and he has not treated you in any capacity, as this is not within his remit. This is compared to the NHS services who have assessed and treated you, such as your primary care GP service who has discussed your health problems with you over a substantial period of time, and actually treated you and referred you to other services – I note that you have been registered with Barlby Surgery since 8 September 2011."

32. The review officer deals with the suggestion that Ms Dervishi was reluctant to discuss her mental health with her GP. The review officer notes, however, that Ms Dervishi did discuss her mental health with her GP on 30th May 2022, 30th January 2024 and 9th April 2024. The review officer also notes that Ms Dervishi has discussed her physical health with her GP. Then in paragraph 44, the review officer says this:

> "44. I believe it is reasonable to conclude that if you were currently suffering from particularly concerning symptoms of mental illness and experiencing a significant deterioration in your mental health – to the extent set out in Dr Wallang's reports – it is likely that you would have discussed this with your GP, including when you disclosed personal information to them about your mental health on the dates set out above; and you would have done so with the primary care mental health services when you had contact with them – particularly as it is the NHS services who can treat you, refer you to specialist services and sign you off work if necessary."
>
> "45. As such, I believe it is reasonable to conclude that if your mental health had deteriorated significantly as contended, it is likely that this would be noted in your contemporaneous NHS medical records.
>
> "46. Moreover, I believe it is reasonable to conclude that if your accommodation specifically was significantly exacerbating your mental health to a concerning degree, it is likely that you would have disclosed this to your treating NHS services, and your contemporaneous medical records would explicitly note that your accommodation was having a detrimental effect on your mental health – particularly given the significance and importance of this issue for you."

33. The review decision then repeats the same conclusions in slightly different words, but I cannot detect any difference in the reasoning.

34. Is there a flaw in the logic relied upon by the review officer? The GP records reveal what has been complained about and what the various medical professionals have done with that information. The only actual assessment tool which has been used are the two questionnaires administered on 30th January 2024. Ms Dervishi only speaks to a GP once which was on 9th April 2024. The remainder of the time she is dealt with by either a nurse or a pharmacist. There is no investigation of whether Ms Dervishi has PTSD or not. The questionnaires are indicative, but they are not diagnostic, or at the very least are not as reliable

as the opinion of a consultant psychiatrist who has spent a not inconsiderable period of time with the person.

35. It is the absence of a more detailed complaint, or of a complaint of symptoms similar to those set out by Dr Wallang, that concerns the review officer. However, there is no assessment which comes to a contrary conclusion to Dr Wallang. The review officer notes the absence of referral or treatment by secondary mental health professionals. That is right, but again it is difficult to see how that absence of a referral is sufficient to outweigh the opinion of a consultant psychiatrist who has seen the applicant.

36. It is also noticeable that the review officer does not specifically say that he does not accept the opinion of Dr Wallang. The review officer (and the medical advisor) do not set out any deficiencies in Dr Wallang's analysis. Indeed the most that the medical advisor is able to say is that the first report is "rather brief". Mr Peacock took me to some issues with Dr Wallang's understanding of whether Ms Dervishi was sharing accommodation or common parts, but none of those points were relied upon by the review officer. In any event, they are corrected in the second version of the report and Dr Wallang has repeated his expert's statement of truth after the corrections have been made.

37. In contrast the review officer does not engage with Dr Wallang's observations at paragraph 4.2, namely that Ms Dervishi neglects basic self-care, and more specifically in paragraph 4.12 where he says:

> "Ms Dervishi struggles to attend important appointments including for her health and wellbeing. For example, In order to complete this assessment I attempted to meet with Ms Dervishi on two prior occasions before I was eventually able to meet with her on Friday 26th of January 2024. On both prior occasions Ms Dervishi was too anxious and low in mood to make the journey and did not attend the appointments. Ms Dervishi struggles to manage her own health and would need constant encouragement and support to attend to her treatment because of her ongoing low mood, anxiety and lack of motivation due to PTSD."

38. It is in those passages that Mr Grütters finds support for his proposition that the review officer has not considered whether it is the PTSD itself which is stopping Ms Dervishi from seeking assistance from her GP or from wanting to engage in talking therapies. It does appear clear that the review officer has not considered that possibility.

39. The authorities indicate the care that review officers must take in discounting medical evidence from qualified practitioners who have examined an applicant. In *Shala* it was said that the review officer must take into account the absence of an examination by the authority's medical advisor in comparing the advice with the report of a doctor who has examined the applicant. In this case the authority's medical advisor and the applicant's expert are both members of the Royal College of Psychiatry. The disparity in qualification is therefore not as stark as it has been in some cases, but the level of experience held by the medical advisors is not known, whereas Dr Wallang is known to have almost 20 years' experience. The disparity in the opportunity to examine the applicant is present here as is acknowledged by the review officer.

40. In paragraph 41 of the review decision, the author acknowledges that Dr Wallang is a consultant forensic psychiatrist and that he had access to Ms Dervishi's medical records. The review officer also acknowledges that Dr Wallang has examined Ms Dervishi. In my judgment there is a marked difference in weight between the opinion of a consultant forensic psychiatrist on the one hand and what can be deduced or inferred from medical records on the other. That difference in weight is not acknowledged by the review officer.

41. I am conscious that the court must stand back and look at the reasons as a whole and must be careful not to engage in too over technical analysis of the language chosen. However, the medical records are not, in my judgment, a sufficient basis upon which Dr Wallang's opinion, given in two reports, can be discounted in the way that it is in the review decision. There is no analysis of his report to justify any decision not to accept it, and nor could there be on the evidence. The central reasoning of the review decision is, in my judgment, fundamentally flawed. Just as a review officer needs to exercise care before preferring the opinion of a medical advisor who is not as well qualified and has not examined the applicant, he must be just as careful not to discount expert evidence in preference for what is contained in medical records, particularly in circumstances where those records are primarily being relied upon for what they do not say rather than the scant detail that they do contain. It is perverse to prefer either the absence of a complaint to a GP, or the answers given in two short questionnaires, to the opinion of a qualified expert.

42. Had the review officer had doubts about the report, or was concerned about the disparity between the reports and the records, he had several options open to him. He could have asked questions of Dr Wallang. He could have agreed to Dr Wallang speaking with the authorities' medical advisor (as was suggested in paragraph 23 of *Shala*). He could have had Ms Dervishi examined by the

authorities' medical examiner or a different psychiatrist. Those steps would have been an appropriate way of dealing with any concerns that the review officer may have had. Discounting the opinion of the medical expert without taking one or more of those steps was not a course which was open to him.

GROUND 2

43. The second ground focuses on further inquiries which the review officer should have made. As will be clear from my concluding paragraph under Ground 1, it is difficult in this case to separate the issues. It will also be clear that in my judgment further inquiries were warranted before the decision was taken. I have set out my analysis above and nothing will be gained by my repeating it.

RESULT

44. The appeal is allowed. The decision is quashed and must be taken again. I make an order in the terms agreed by counsel. I am grateful to both counsel for their assistance in this case.