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IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

QUEEN'S BENCH DIVISION (JUDICIAL REVIEW)

Duggan's (John Anthony) Application [2012] NIQB 78

IN THE MATTER OF AN APPLICATION BY JOHN ANTHONY DUGGAN FOR JUDICIAL REVIEW

AND

IN THE MATTER OF A DECISION OF THE MINISTER WITH RESPONSIBILITY FOR THE DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

TREACY J

Introduction

[1] The applicant is a 75 year old pensioner who is in ill health and who is a regular user of Downe Hospital. He challenges the decision of the Minister for the Department of Health, Social Services and Public Safety ("the Department") made on 4 February 2011, whereby he authorised the South Eastern Health and Social Care Trust ("the Trust") to close the emergency department of the Downe Hospital, during night time hours (10.00pm – 8.00am) and to replace it with an emergency care co-operative, operated by the GP out of hours service.

Background

[2] The factual background is very helpfully summarised in the skeleton arguments of both parties.

[3] For many years, the Downe hospital has operated a 24 hour Consultant led emergency department. The emergency department was permanently open and staffed by at least one doctor qualified in emergency medicine. An emergency medicine consultant had overall responsibility for the department, but the majority

of the shifts were carried out by middle grade doctors. At any one time, there would be one doctor on duty.

[4] In 2002, the Department launched a new strategy for the delivery of health care in Northern Ireland, called ***Developing Better Services*** ("DBS"). It, *inter alia,* recommended that medical services should be delivered through a network of acute hospitals and local hospitals and that the most seriously ill patients should be treated in one of the acute hospitals, with local hospitals providing a range of medical services which do not require acute facilities.

[5] In the case of the Downe, it was to be an "Enhanced Local Hospital" which provided a number of additional services including "a 24 hour A&E service and emergency medical service, including coronary care. It should also provide planned (elective) day procedures but not emergency surgery". The recommendation took account of the rural population which was served by the Downe and travel times to other hospitals and that the Downe would provide services as part of a clinical network, linked to the acute hospitals.

[6] However the strategy qualified the commitment to a 24 hour A&E unit:

> "This hospital will have to work as part of a clinical network if it is to sustain these additional services. This will be challenging for staff at the Downe hospital and the acute hospitals working in partnership with it. The approach will be evaluated on a regular basis to confirm its continuing viability."

[7] In 2003 the Minister announced his acceptance of the DBS recommendations also making a commitment to a programme of major capital investment to fund the new services, which included the construction of a new building for the Downe Hospital. The emergency department which ran from the original site moved into the new building when it opened in July 2009.

[8] The Downe's emergency department was classified as a Type 2 unit. This means that whilst it receives emergency patients it is limited in the services that it can provide. For example, it does not provide emergency surgery, it has no duty anaesthetist, no on site blood bank and no intensive care units. In October 2009, the Trust established a new "by-pass protocol" in conjunction with the Belfast Trust and the Ambulance Service ("NIAS") to ensure that some of the most critically ill patients within the Downe area were transported directly to one of the acute hospitals in Belfast.

[9] Even by 2007 problems with the sustainability of the 24 hour emergency service were apparent. The department was understaffed, with one consultant, one associate specialist and six middle grade doctors. A minimum of eight middle grade doctors was required, with an ideal number of eleven. This appears to have resulted

from the undisputed and ongoing severe regional and national shortage of middle grade doctors specialising in emergency medicine. The Trust could not recruit new middle grade doctors. There were no junior doctors working in the emergency department, as the hospital had ceased to provide training functions. Changes in training requirements meant that junior doctors were no longer required to spend time in an A&E unit as part of their medical training.

[10] The Court was informed that emergency medicine is not an attractive specialty for many young doctors in light of the unsociable working hours. Those who did choose to specialise in this area dominated the job market and could choose jobs. They tended to be attracted to the emergency departments in the larger acute hospitals, where they would treat the most challenging patients. The Downe was located in a somewhat more rural setting and offered only a Type 2 emergency department which was not attractive to many young doctors. There was an almost total dependence upon locum doctors to fill the weekend shifts. This was not sustainable on a long term basis. The Trust had devised an "escalation plan" to cover weekend shifts in the event that a locum could not be found or did not turn up. This had involved some collaboration with the existing GP out of hours service.

[11] Following the opening of the new hospital in July 2009, the Trust's associate director of emergency medicine, Mr McGovern (a consultant doctor) began considering how the emergency department could be reformed safely. A reduction in the requirement for night time working was identified as the most problematic area. In conjunction with Dr Fitzpatrick (lead doctor in out of hours service) an analysis was carried out of the medical needs of patients presenting at the emergency department at night time. The analysis showed that very few of those patients were actually admitted to the hospital, of which a high percentage required to be referred onwards in any event after initial stabilisation. For the remaining patients, the vast majority were within the competence of GPs or were not urgent and could wait until the morning.

[12] Through a series of working groups, the Trust formulated a proposal for a new model of emergency services from the Downe. The various groups included representation from a variety of disciplines and organisations, both within an outside the Trust (eg GP representation and NIAS). One of the groups was a Clinical Group, chaired by the hospital's emergency consultant and with GP representation which helped devise detailed clinical protocols for the safe treatment or management of foreseeable emergency cases which might present at the hospital.

[13] The model of service devised was one of five possible options which were identified by the Trust and which were the subject of an objective appraisal process. It emerged as the clear preferred option, is the option which was the subject of consultation, was approved by the Minister and is now in place. The Trust predicted that the new service would still be able to treat, within the Downe, 97% of those patients who were previously treated there. A summary of the features of the new service included that a consultant led emergency department within the Downe is

open between 8.00am and 10.00pm, seven days per week and is closed during night time hours. Between these times, the responsibility for treating any patients who present to the hospital passes to the GP out of hours service, which is physically located within the hospital, adjacent to the emergency department. Also employed doctors within the emergency department must remain on site after 10pm to treat all patients who presented prior to that time. Clinical protocols are in place for the treatment and management of emergency patients who present and that by-pass protocols operated by NIAS which are used to deliver any emergency patients directly to an acute hospital. Enhanced support services for the duty GP includes admission rights to the medical wards of the hospital; full time emergency nurses; access to diagnostic facilities such as radiology and blood testing; online and telephone support to duty emergency consultants/staff doctors in Ulster hospital or other Belfast hospitals; and access to on-call consultants and doctors within the medical wards of the Downe.

Grounds of Challenge

[14] The applicant acknowledged that the resolution of this case did not involve any new principle of law but upon well settled principles of public law to the facts. The broad grounds of challenge were:

- Lack of Proper Consultation (including lack of disclosure of detailed scoring)
- Misdirection and Failure of Inquiry re Staffing;
- Misdirection re GP Support for the Proposal;
- Misdirection re By-Pass Numbers;
- Failure to Properly Consult the NI Ambulance Service;
- Material Unfairly Presented to the Minister;
- *Wednesbury* Unreasonableness and Substantive Legitimate Expectation; and
- Predetermination and Apparent Bias

[15] The Order 53 statement recites the grounds of challenge as follows:

> (a) The Minister's decision is unreasonable in the *Wednesbury* sense in all of the circumstances, particularly given the facts:
>
> (i) That the A&E unit at the Downe Hospital is being downgraded so soon after the new hospital was built and opened at huge public expense;
> (ii) That there has been no change to, or reduction in, the necessity for a 24 hour A&E unit at the Downe Hospital which was identified by the Department in *Developing Better Services*; and

(iii) That there are legitimate fears about patient safety as a result of acute services being delivered by non-specialist GPs, especially in circumstances where there are no local GPs with a speciality interest in Emergency Care trained or accredited in this area.
(iv) That the Ulster Hospital, to which the majority of patients will be transferred under the new arrangements, is already unable to cope satisfactorily with the burden on its A&E Department.

(b) The applicant had a legitimate expectation – engendered by the Department's views set out in *Developing Better Services,* the Ministerial Statement on *Developing Better Services,* the decision to build and open a new Downe Enhanced Local Hospital with a 24 hour A&E unit and/or the operation of that unit up until the impugned decision – that the 24 hour A&E unit would remain open. The Minister's decision, in breach of that legitimate expectation, is so unfair as to represent an abuse of power.

(c) The consultation carried out by the Trust (on which the Minister based his decision) was unfair in that it failed to disclose to consultees the "detailed scoring and weighting exercise" on which the adoption of the preferred option was based.

(d) The Trust and the Minister have misdirected themselves as to the potential for requiring medical staff, pursuant to their contracts and/or in a rota system, to work at Downe Hospital in order to redress any potential shortage of staff at the Emergency Department there; and/or have failed in their duty of inquiry to explore this issue thereby leaving a relevant consideration out of account.

(e) The Trust and the Minister have failed in their duty of inquiry to properly assess the level of interest in medical staff of working at the Emergency Department at Downe Hospital by failing to take adequate steps to recruit staff to work there.

(f) The Trust and the Minister have misdirected themselves as to support for the new model from local GPs (who are to deliver emergency cover under the new model) when, in fact, there was not the level

of support the Trust or the Minister supposed and, on the contrary, local GPs were opposed to the proposal on the basis, *inter alia,* that it is "unsafe and unsustainable".

(g) The Trust and Minister have misdirected themselves and/or taken an irrelevant consideration into account, namely artificially depressed statistics as to the number of people previously bypassing the Emergency Department at Downe Hospital to go to another hospital, when this was the result of an unduly restrictive by-pass protocol formulated by the Trust.

(h) The Trust failed to consult the Northern Ireland Ambulance Service (NIAS) adequately or at all in relation to the formulation of its proposal and, further, failed to consult properly with NIAS by failing to provide it with sufficient information to allow it to make representation on the impact of the new model on NIAS.

(i) The Minister made his decision at a time when there was still insufficient detail as to the impact on the NIAS and thereby left a material consideration out of account and/or failed in his duty of inquiry.

(j) The Ministerial submission to the Minister failed to set out, or address adequately or at all, a number of bases on which there were objections to the proposal. Accordingly, the material was unfairly presented to the Minister and he thereby misdirected himself in relation to his decision.

Legislative Framework

[16] Sections 2 and 3 of the Health and Social Care (Reform) Act (NI) 2009 are the primary statutory duties which confer broad discretionary powers upon the department in relation to the provision of such health and social care services.

"Department's general duty

2—(1) The Department shall promote in Northern Ireland an integrated system of—

(a) health care designed to secure improvement—

(i) in the physical and mental health of people in Northern Ireland, and

(ii) in the prevention, diagnosis and treatment of illness; and

(b) social care designed to secure improvement in the social well-being of people in Northern Ireland.

(2) For the purposes of subsection (1) the Department shall provide, or secure the provision of, health and social care in accordance with this Act and any other statutory provision, whenever passed or made, which relates to health and social care.

(3) In particular, the Department must—

(a) develop policies to secure the improvement of the health and social well-being of, and to reduce health inequalities between, people in Northern Ireland;

(b) determine priorities and objectives in accordance with section 4;

(c) allocate financial resources available for health and social care, having regard to the need to use such resources in the most economic, efficient and effective way;

(d) set standards for the provision of health and social care;

(e) prepare a framework document in accordance with section 5;

(f) formulate the general policy and principles by reference to which particular functions are to be exercised;

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

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

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

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

(4) The Department shall discharge its duty under this section so as to secure the effective co-ordination of health and social care.

(5) In this Act—

'health care' means any services designed to secure any of the objects of subsection (1)(a);

'health inequalities' means inequalities in respect of life expectancy or any other matter that is consequent on the state of a person's health;

'social care' means any services designed to secure any of the objects of subsection (1)(b)."

Department's general power

3—(1) The Department may—

(a) provide, or secure the provision of, such health and social care as it considers appropriate for the purpose of discharging its duty under section 2; and

(b) do anything else which is calculated to facilitate, or is conducive or incidental to, the discharge of that duty.

(2) Subsection (1) does not affect the Department's powers apart from this section."

Consultation

Relevant legal background

[17] The fundamental legal principles governing the consultation process were not in dispute. Consultation is to be undertaken at a time when proposals are at a sufficiently formative stage; it must include sufficient reasons for particular proposals to allow those consulted to give intelligent consideration and an intelligent response; adequate time must be given for this purpose; and the product

of the consultation must be conscientiously taken into account when the ultimate decision is taken.

[18] I was also referred by Mr McLaughlin to R (Greenpeace) v Sec of State for Trade and Industry [2007] EWHC 311 where Sullivan J reviewed the authorities in this area and observed:

> "[63] In reality, a conclusion that a consultation exercise was unlawful on the ground of unfairness will be based upon a finding by the court, not merely that something went wrong, but that something went 'clearly and radically' wrong."

[19] Mr Scoffield also prayed in aid the following paragraph from ***De Smith's Judicial Review*** 6th Ed 2007 comment at para7-054:

> "Proper consultation requires the "candid disclosure of the reasons for what is proposed" and that consulted parties are aware of the criteria to be adopted and any factors considered to be decisive or of substantial importance… Where the decision-maker has access to important documents which are material to its determination whose contents the public would have a legitimate interest in knowing, these documents should be disclosed as part of the consultation process."

[20] I accept that the proposal to introduce the new model of emergency services was the subject of a detailed and lengthy consultation process. The applicant complains about the failure to publish the Trust's options appraisal document ("OAD") along with the consultation documents in breach of the second *"Sedley"* principle (namely that the proposer "gives sufficient reasons for any proposal to permit of intelligent consideration"). He also complains that resources were "central to the decision making" in a manner which was not disclosed.

[21] As to the first of these challenges regarding the non-publication of the OAD it must be remembered that the Trust published a short paper, announcing three separate consultations by the Trust, which were conducted in parallel. This contained a brief description of the proposal for change to the emergency department. They also published a detailed paper, dedicated to a description of the background to and reasons for the proposal to change emergency services in the Downe and a report summarising the content and outcome of all three consultation processes.

[22] The detailed paper was the principle consultation document. It exposes the detailed background to emergency services at the Downe, the problems it faces and

the threats for the future of the service. The paper clearly identifies and describes all five options which were considered and makes explicit that the options had been the subject of a detailed option appraisal:

> "A project team developed an options appraisal in respect of the options to provide access to emergency care for the residents of the Down area… It outlined the options available and evaluated these against non-financial criteria to establish the optimum way to provide this service to the residents of Down".
>
> "It was considered that these 5 options were the only options, which could be considered. It was agreed that they all should be subject to a scoring and weighting exercise rather than being eliminated through the customary short-listing process….. Following a detailed scoring and weighting exercise carried out by the Project Team and subsequently endorsed by the Urgent Care Reform Board…the preferred option emerged as Option 4…"

[23] In my judgment the public was sufficiently briefed about the options under consideration and that the preferred option had been selected by a formal appraisal process using non-financial criteria. I therefore reject the contention that this process was "kept hidden" and I accept that its existence and function was explicitly apparent. It is, I think, significant that during the lengthy consultation process no-one requested a copy of the OAD, had they done so it would have been provided. Meaningful representations were not prevented. If it had been thought by anyone during the consultation process that they required the OAD to make such representations I would have expected a request to have been made by someone.

[24] The public was made aware of the range of options, the problems facing the service, the constraints upon any future service and the Trust's preferred option. They were materially informed and were free to engage as they saw fit. The aspect of the process about which the Applicant complains is the manner in which the Trust decided upon its preferred option. There was absolutely no confusion about the identity of the preferred option or the range of other options. The public was at all times entirely free to express its views about the merits of the other options.

[25] As to the second criticism that resources were central to the decision the affidavit evidence persuades me that resources or efficiency savings were *not* the motivations for change. On the contrary, the motivation for the new service was a UK wide problem regarding the recruitment of middle grade doctors and the unsustainability of continual reliance upon locum doctors. I accept this was fully explained in the consultation paper and the consultation meetings.

[26] Understandably the Trust was required to take account of the financial ramifications of the proposed service. I accept that it is important to distinguish between the reasons for change in the old service and the financial implications of the new service. The constraint of affordability was not "hidden" in the OAD and was stated clearly in the consultation paper using the same wording. Affordability was identified as one of a number of constraints within which any *new* service must operate. But I am satisfied it was not one of the criteria against which the five options were evaluated. Those criteria were all non-financial and this was manifestly outlined in the consultation paper.

Misdirection and Failure of Inquiry re Staffing

[27] The applicant alleges that the Trust failed to take sufficient steps to rotate the staff that are available, by requiring them to work in the Downe A&E. It is common case that there is a national and regional shortage of middle grade emergency doctors and there is not a surplus of doctors elsewhere available to the Trust.

[28] The unit was being staffed by a total of 5.2 full time equivalent doctors despite the fact that, as the consultation paper made clear, 11 doctors were required in order to staff the rota on a permanent basis with full time doctors. A minimum of 8 was required, which would still result in a dependence upon locums.

[29] Following changes implemented by the Trust after 2007 across other specialities doctors (consultant and middle grade) were required to work in both the Ulster and Downe hospitals. In emergency medicine, this was not possible as a result of the shortage of middle grade staff, in both the Ulster and the Downe. I accept that moving staff from the Ulster would have, as the respondent pointed out, simply moved the problem. This is explained by Messrs McGoran and McGovern and Dr Briscoe: the requirement is for more middle grade doctors qualified in emergency medicine; there is no magic pool of surplus doctors who can be relocated; shortages elsewhere are "critical"; requiring doctors to move from existing posts would simply increase the locum requirement in the original hospital and also increase the likelihood that existing staff would leave and make it harder to recruit.

[30] I cannot accept the applicant's challenge under the present heading. As it seems to me this is, as the respondent claimed, an exercise of managerial judgment by Trust officials about how best to maintain a service using the resources available to it. The Trust was plainly aware of the problem and I discern no public law error in the solution to the problem which they ultimately adopted. I also reject the applicant's criticism of the Trust's recruitment efforts having regard to the evidence filed by the respondent and, in particular, the description of doctor shortages by Dr Briscoe, the recruitment efforts set out by Mr McGoran and in the consultation paper.

Opposition by GPs

[31] The applicant argues that the Trust wrongly claimed at the outset that the proposal had GP support and that the Trust has not taken proper account of the GP representations.

[32] I reject these contentions. It is clear the Trust was always aware of GP opposition and made no attempt to disguise that fact. I accept that the consultation process assisted the Trust in understanding and addressing GP concerns one consequence of which has been a significant change in GP opinion. The service is now widely supported and the Trust is oversubscribed by GPs wanting to work within it. There is some force in the respondent's observation that this is in fact an example of effective consultation in action.

[33] As to the levels of GP opposition the consultation paper identifies the support GPs would require to deliver the new service. The consultation summary document records GP opposition to the proposal in general and some of the issues raised by them during the process. I refer also to the affidavit evidence of Messrs McGoran and McGovern and Dr Johnston on this issue.

[34] The consultation process allowed the Trust to diagnose and tackle the major concerns of GPs now reflected in the way the new service is operated ie the service is not compulsory, it is voluntary for any GPs; GPs are not asked to provide emergency medical services for which they are not qualified; emergency patients are diverted straight to an acute hospital; detailed clinical protocols are in place for treating or managing those patients who do present at night time (devised by a clinical group with GP and consultant participation); GPs are properly supported in the provision of the service by existing resources within the hospital and access to expertise in other hospitals and additional NIAS resources to transport patients elsewhere.

[35] I therefore reject the contention that the Trust either misdirected itself about the existence of GP opposition or the substance of their concerns. The Trust was aware of them and adequately addressed those concerns.

Misdirection by By-Pass Numbers

[36] I reject the applicant's contention that the Minister was presented with "artificially depressed" statistics about the numbers of emergency patients who by-passed the Downe emergency unit in any event.

[37] In 2009 the Trust introduced a by-pass protocol which was prepared following consultation with the Belfast Trust and the NIAS the background to which is described in detail by Mr McGovern. In was introduced pursuant to his medical judgment about the best place to treat serious trauma patients and the fact that the Downe was only a Type 2 emergency unit which was not a safe environment in which to treat those patients.

[38] I do not accept that the Trust misdirected itself. It was aware of the existing by-pass arrangements, had available to it reliable statistics and formulated its proposals on a correct foundation.

Consultation with NI Ambulance Service ("NIAS")

[39] I am also satisfied that the NIAS was sufficiently involved with the process. They were consulted and participated in the groups recommending its introduction. The NIAS involvement included representation on the Project Group, which oversaw the entire process; direct consultation with written representations; identification of the impact upon NIAS as a key issue within the consultation process and ongoing dialogue between the Trust, NIAS and HSCB to assess the additional NIAS resources required for the new service and to secure the requisite funding.

[40] I accept that it was appropriate that this level of detailed planning should be addressed during or following the consultation process. The respondent is surely right to contend that to do so beforehand would no doubt have invited a criticism that consultation did not take place at a "formative stage" or that there had been pre-determination. The important factor is that the relevant resources were identified and secured before a final decision was taken.

[41] Through the consultation process the need for additional NIAS resources was identified and addressed demonstrating the efficacy of the consultation process.

Unfair Presentation of Material to Minister

[42] The applicant complained that the submission which went to the Minister to inform him before making his decision was inadequate in a number of respects namely alleged deficiency as to the summary of the opposition to the proposal and the alleged unfair description of the changes imposed. The Court's attention was drawn to a passage in Fordham, *Judicial Review Handbook* at s51.2 which states:

> "Public bodies and staff who assist them should ensure that relevant material, including views of consultees, are fairly and adequately presented to the decision-makers. They in turn should ensure that the material is properly considered and addressed."

[43] Para 31 of the ministerial submission states:

> "This proposal has attracted considerable local opposition. Responses to the consultation indicated local fears that this was a reduction in services at the Downe Hospital and the role of local GPs and the NIAS in managing the change was queried."

[44] I reject the contention that the submission to the Minister was deficient in either respect as claimed. The Minister had already received direct representations on the issue from the local Council and from political representatives; the proposal came to the Minister following scrutiny by the Trust and HSC Boards; and the Minister requested and conducted a meeting with the Chief Executives of both the Trust and HSC prior to approving the proposal. Further, the Minister was aware of the nature of the proposals and the level of opposition to it and he was perfectly able to make an informed decision and was not misled.

Wednesbury **Unreasonableness and Substantive Legitimate Expectation**

[45] DBS was a strategy for hospital medical services across Northern Ireland. It focused upon retaining 9 acute hospitals and a network of local hospitals. It emphasised the need for greater integration in the fields of primary and secondary care. The care of the most critically ill patients requires to be focused on the acute hospitals. The commitment within DBS to a 24 hour consultant-led A&E unit within the Downe was not unqualified as the passage set out at para6 above makes clear. The emergency department was always anticipated to work as part of the network of hospitals, since it was only a Type 2 emergency unit. The emergency service anticipated for the Downe will continue during the day and it has only been closed during night time.

[46] The reason for the change of service model is a change in the ability of the Trust to deliver the original service on a 24 hour basis in a safe and sustainable manner.

[47] The opening of the new building was new accommodation from which to operate the existing service. Emergency services will continue to be delivered from the new building. There is no question of facilities within the new building being redundant or unused. This has been explicitly acknowledged in the written submissions on behalf of the respondent. I reject the allegation of a "waste of public monies".

[48] Emergency services within the Downe are not the only area of service provision which have changed since the introduction of DBS or the construction of the new hospital. GPs are not being asked to provide emergency medical services for which they are unqualified. They are providing an out of hours service with enhanced support and admission rights. *There is now, the evidence establishes, an oversupply of GPs willing to provide this service.*

[49] The number of additional patients which might be sent to the Ulster Hospital as a result of the change is small. Patients presenting to the Downe at night time, or brought there by ambulance (after consultation with the out of hours service) can still be admitted to the hospital, if their medical needs require. Statistics (gathered

since the introduction of the service) show that patient numbers are in accordance with predictions and that accessibility to the hospital remains very high.

[50] The commitment contained within DBS was not clear, unambiguous or devoid of necessary qualification, which would be required to sustain a claim for a substantive legitimate expectation. Even if I had concluded (which I don't) that an unqualified commitment was provided, it is not unlawful to depart from it, where there are sufficient reasons supported by the public interest – see Paponette v AG Trinidad and Tobago [2010] UKPC 32. The relevant principles were described by Woolf MR in R v North & East Devon Health Authority ex parte Coughlan [2001] QB 213 at para57:

> "Where the court considers that a lawful promise or practice has induced a legitimate expectation of a benefit which is substantive, not simply procedural, authority now establishes that here too the court will in a proper case decide whether to frustrate the expectation is so unfair that to take a new and different course will amount to an abuse of power. Here, once the legitimacy of the expectation is established, the court will have the task of weighing the requirements of fairness against any overriding interest relied upon for the change of policy. "

[51] In my view sufficient reasons in the public interest have been demonstrated to justify the course that has been adopted by the respondent.

Conclusion

[52] For the above reasons I reject all the grounds of challenge.