

Deprivation of liberty in hospital

Introduction

The law governing the deprivation of a person's liberty in a hospital is complex. In very many cases, it involves the interface of two statutory regimes (the Mental Health Act 1983 ('MHA 1983') and the Mental Capacity Act 2005 ('MCA 2005') and in every case it involves (or should involve) consideration of the vexed question of what amounts to a deprivation of liberty for the purposes of domestic legislation and Article 5 of the European Convention of Human Rights ('ECHR').

Following the recent restructuring of the National Health Service, these are questions that will now be confronted by both healthcare bodies and local authorities, the latter assuming the functions of the Supervisory Body for deprivation of liberty safeguards in hospitals.

This paper, which is aimed at those working in hospital settings (both public and private) as well as local authorities, seeks to provide a summary of the law governing situations where an individual is potentially deprived of his or her liberty in hospital.

As this paper involves discussions of complex points of law, we start with a summary of its key points, framed in the form of questions that must be asked on each occasion, and a framework for answering those questions. That framework is (of necessity) framed in relatively bald terms and is only a limited substitute for consideration of the finer points which follow in the body of the paper.

Key questions

Is the person objectively deprived of their liberty and/or is there a risk that cannot be sensibly ignored that they are deprived of their liberty?

As the law stands at the moment, the key relevant factors that should be taken into account are:

- (1) whether the person objects to their confinement;
- (2) the relative normality of the person's life;
- (3) what would otherwise be the circumstances of an adult of similar age with the same capabilities as the patient, affected by the same condition or suffering the same inherent mental and physical disabilities and limitations as the patient;
- (4) as part of the overall assessment, the purpose for the placement; and
- (5) the extent to which it can be said that clinical staff exercise complete and effective control over the person in his treatment, care, residence and movement.

It should be noted that a person can be deprived of their liberty where the restrictions upon their movement are of only a very short duration (as little as an hour), if those restrictions are total, and especially if they give rise to particular anxiety or distress on the part of the person in question.

Does the person have capacity to consent to that deprivation of liberty?

In answering that question, it is necessary to ask whether the patient has capacity to understand, retain, use and weigh the information relevant to the decision to be accommodated in hospital for purposes of being given treatment.

The focus must be upon the concrete situation to which the person is being asked to submit in the hospital in question.

It is likely that the relevant information will include:

- (1) that the patient is in hospital to receive care and treatment for a mental disorder;
- (2) the core elements of that care and treatment (for instance, if relevant, that it includes supervision, physical restraint and/or prescription and administration of medication to control their mood);
- (3) what steps would be taken in respect of searching of the patient and their property;
- (4) what would happen if the patient tried to leave hospital.

If the patient does not have capacity to consent to deprivation of liberty, can that deprivation be authorised?

In the majority of cases, this will depend on:

- (1) whether the patient is or is not eligible to be made the subject of a standard authorisation under the provisions of Schedule A1 to the MCA 2005. In this regard, a person who lacks capacity to consent to being admitted to hospital, but who is clearly objecting to it, should generally be treated like someone who has capacity and is refusing to consent to mental health treatment. If it is considered necessary to detain them in hospital, and they would have been detained under the MHA 1983 if they had the capacity to refuse treatment, this is a strong pointer that the MHA 1983 should be used;
- (2) (if they are eligible) whether they meet the other criteria under Schedule A1, in particular, whether the deprivation of liberty is in their best interests. Where there is a real dispute about where a patient's best interests may lie, the provisions of Schedule A1 must not be used to 'stifle' that dispute, but a decision of the Court of Protection must be sought.

In a very few situations, it may not be possible to authorise the deprivation of an incapacitated adult's liberty in hospital either under the MHA 1983 or the MCA 2005 where:

- (1) a short-term deprivation arises in an emergency situation and an authorisation cannot be sought during the currency of that deprivation of liberty; or
- (2) the deprivation of liberty is not sought for purposes of securing the patient's best interests, but for the protection of others (and the patient do not fall within the scope of the MHA 1983).

In either of these cases, legal advice should be sought as soon as possible, but in neither case should seeking such advice stand in the way of providing immediately necessary care and attention to the person.

If the patient does not have capacity to consent to deprivation of liberty, and that deprivation of liberty can be authorised under either the MHA 1983 or the MCA 2005, which is the least restrictive way of best achieving the proposed assessment or treatment?

If there is a genuine choice between the two regimes, which can only be the case of a 'compliant incapacitated' patient, then a value judgment will need to be formed as to the impact of the use of the DOLS regime under MCA 2005 with the impact of detention under the MHA 1983.

The structure of the paper

The paper is divided into two parts. Part 1 provides an overview of the deprivation of liberty issues that arise in a hospital¹ setting, focussing on two key concerns: how to determine whether a deprivation of liberty arises or is likely to occur; and, how to identify the appropriate legal basis on which to detain an individual. Part 2 then considers the application of the law on deprivation of liberty in the common scenario where an informal patient remains in hospital following discharge from detention under the provisions of the MHA 1983.

Introduction

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The cases that are discussed in this paper are all the subject of more detailed individual comments available at www.copcasesonline.com, and this paper draws upon some of those comments.

1. Deprivation of liberty in a hospital setting: an overview of the law

1.1 The meaning of deprivation of liberty

The meaning of deprivation of liberty is currently in a state of flux, being the subject of potentially conflicting views from the English courts and the European Court of Human Rights ("ECtHR") and now on appeal to the United Kingdom Supreme Court. The current uncertainty stems principally from the Court of Appeal's decisions in *Cheshire West and Chester Council v P* [2011] EWCA Civ 1257 [2011] 2 FLR 583 and *P and Q v Surrey County Council* [2011] EWCA Civ 190, [2011] 2 FLR 583 [2011] COPLR Con Vol 931.

¹ 'Hospital' for these purposes being a hospital falling within the scope of the definition in Schedule A1 to the MCA 2005, i.e. (in the case of an NHS hospital) a health service hospital as defined by s. 275 National Health Service Act 2006 or s.206 National Health Service (Wales) Act 2006, or a hospital as defined by s. 206 National Health Service (Wales) Act 2006 vested in a Local Health Board, and (in the case of an independent hospital) a hospital as defined by s. 275 National Health Service Act 2006 that is not an NHS hospital; and in relation to Wales, means a hospital as defined by s.2 Care Standards Act 2000 that is not an NHS hospital. Section 275 NHS Act 2006 defines hospital as (a) any institution for the reception and treatment of persons suffering from illness, (b) any maternity home, and (c) any institution for the reception and treatment of persons during convalescence or persons requiring medical rehabilitation, and includes clinics, dispensaries and out-patient departments maintained in connection with any such home or institution.

² As amended by the Mental Health Act 2007.

³ The Department of Health afforded limited additional funding to local authorities to support them in the extension of their statutory role, emphasising in so doing that '[h]ospitals will remain responsible as managing authorities for compliance with the DOLS legislation, for understanding DOLS and knowing when and how to make referrals. Hospitals remain responsible for ensuring that all staff in hospitals are Mental Capacity Act (MCA) compliant. Clinical Commissioning Groups (CCGs) will oversee these responsibilities; and be responsible for training and MCA compliance. All CCGs must have a named MCA lead and MCA policies to support their responsibilities'. See http://www.dh.gov.uk/health/files/2012/09/Deprivation-of-Liberty-Safeguards_Funding-Fact-Sheet-for-2013-14.pdf, page 4.

It is not possible within the confines of this paper to rehearse the full history to the current legal position or to debate the correctness of the Court of Appeal's decisions in *Cheshire West* and *P and Q*.⁴ Instead, this first section provides a short overview of the current position.

A helpful summary of Court of Appeal's decisions in *Cheshire West* and *P and Q* is provided in the judgment of Baker J in *CC v KK and STCC* [2012] EWHC 2136 (COP). The question in that case was whether the placement in a nursing home of an elderly lady suffering from Parkinson's Disease and vascular dementia amounted to a deprivation of liberty.

Baker J summarised the Court of Appeal's approach as follows:

'90 In Cheshire West, the Court of Appeal reiterated the importance of "normality" in assessing whether the circumstances amount to a deprivation of liberty, but added a further dimension – the concept of the relevant comparator – to address a problem posed by Munby LJ at paras 38-39:

"38. The emphasis upon the concrete situation, the context, is obviously important but in truth it does little more than describe a forensic process. Reference to the degree and intensity of the restriction no doubt gives some indication of the principle in play but it hardly provides a benchmark or yardstick by which to evaluate the circumstances and assess whether or not there is a deprivation of liberty. And the call to examine the facts can too easily lead to the worrying and ultimately stultifying conclusion that the decision in every case can safely be arrived at only after a minute examination of all the facts in enormous detail.

39. This cannot be right. There must be something more which enables us to pursue a more focussed and less time-consuming enquiry. In my judgment there is. The task is to identify what it is we are comparing X's concrete situation with. In short, what is the relevant comparator?"

91 This question is analysed in the following paragraphs leading to the following conclusion at para 102 (viii) to (xii):

"In determining whether or not there is a deprivation of liberty, it is always relevant to evaluate and assess the 'relative normality' (or otherwise) of the concrete situation But the assessment must take account of the particular capabilities of the person concerned. What may be a deprivation of liberty for one person may not be for another. ... In most contexts (as, for example, in the control order cases) the relevant comparator is the ordinary adult going about the kind of life which the able-bodied man or woman on the Clapham omnibus would normally expect to lead But not in the kind of cases that come before the Family Division or the Court of Protection. A child is not an adult. Some adults are inherently restricted by their circumstances. The Court of Protection is dealing with adults with disabilities, often, as in the present case, adults with significant physical and learning disabilities, whose lives are dictated by their own cognitive and other limitations In such cases the contrast is not with the previous life led by X (nor with some future life that X might lead), nor with the life of the able-bodied man or woman on the Clapham omnibus. The contrast is with the kind of lives that people like X would normally expect to lead. The comparator is an adult of similar age with the same capabilities as X, affected by the same condition or suffering the same inherent mental and physical disabilities

⁴ For a much longer discussion, see Alex's paper "Tying ourselves into (Gordian) knots," available at http://www.39essex.com/resources/article_listing.php?id=748.

and limitations as X. Likewise, in the case of a child the comparator is a child of the same age and development as X.”

The Court of Appeal’s decisions have been the subject of significant judicial and academic criticism and both are now being jointly appealed to the Supreme Court. It is envisaged that the decision of the Court of Appeal may well be revisited, not least because there appears to be a tension between the approach taken by the Court of Appeal and the approach taken by the ECtHR in cases decided subsequent to *Cheshire West* and *P&Q*.⁵

Baker J anticipated this in his judgment in *KK*. In relation to the Court of Appeal’s approach to identifying the “relevant comparator” for the purposes of determining whether or not a deprivation of liberty has occurred he stated:

“92 I anticipate that this aspect of the decision in Cheshire West will receive particular scrutiny in the Supreme Court. It has been the subject of academic criticism on the grounds that, insofar as it may permit some people to be denied a declaration of deprivation of liberty in circumstances where others would be entitled to such a declaration, it may be discriminatory. The decision of the Court of Appeal is, of course, binding on this court.”

Baker J also noted that there is a mismatch in at least one fundamental respect between the approach taken by the Court of Appeal and the approach of the ECtHR. He stated:

“93 A further uncertainty arising from the Cheshire West decision in the Court of Appeal concerns the relevance of the purpose for which the individual is in the placement when determining whether that placement amounts to a deprivation of liberty. On this point, it would not be appropriate, in a first instance judgment that is already lengthy, to traverse the ground analysed by Munby LJ in Cheshire West (supra) at paras 60 to 77. His conclusion, however, is stated at para 102 (vi) and (vii):

‘In determining whether or not there is a deprivation of liberty, it is legitimate to have regard both to the objective ‘reason’ why someone is placed and treated as they are and also to the objective ‘purpose’ (or ‘aim’) of the placement Subjective motives or intentions, on the other hand, have only limited relevance. An improper motive or intention may have the effect that what would otherwise not be a deprivation of liberty is in fact, and for that very reason, a deprivation. But a good motive or intention cannot render innocuous what would otherwise be a deprivation of liberty. Good intentions are essentially neutral. At most they merely negative the existence of any improper purpose or of any malign, base or improper motive that might, if present, turn what would otherwise be innocuous into a deprivation of liberty. Thus the test is essentially an objective one.’

*94 This analysis was, to some extent, based on the speeches in the House of Lords in the Austin (“kettling”) case. It now has to be read in the light of the decision of the Grand Chamber of the European Court in that case, reported as *Austin and others v United Kingdom* [2012] ECHR 459 , and in particular the observation at para 58 – 59 of the majority judgment:*

⁵ Subsequent to the Court of Appeal’s decision in *Cheshire West* and *Austin*, the ECtHR has had cause to consider the questions of deprivation of liberty in a number of cases: *Austin and others v United Kingdom* [2012] ECHR 459 in *Stanev v Bulgaria* (Application No. 3760/06, decision of the Grand Chamber of 17.1.12); *DD v Lithuania* (Application No. 13469/06, decision of 14.2.12); *Kedzior v Poland* ((Application no. 45026/07, decision of 16.10.12); and *Mihailovs v Latvia* (Application no. 35939/10, decision of 22.1.13).

‘... [T]he purpose behind the measure in question is not mentioned in [previous judgments of the European Court] as a factor to be taken into account when deciding whether there has been a deprivation of liberty. Indeed, it is clear from the Court's case-law that an underlying public interest motive, for example to protect the community against a perceived threat emanating from an individual, has no bearing on the question whether that person has been deprived of his liberty, although it might be relevant to the subsequent inquiry whether the deprivation of liberty was justified under one of the subparagraphs of Article 5(1) The same is true where the object is to protect, treat or care in some way for the person taken into confinement, unless that person has validly consented to what would otherwise be a deprivation of liberty However, the Court is of the view that the requirement to take account of the “type” and “manner of implementation” of the measure in question ... enables it to have regard to the specific context and circumstances surrounding types of restriction other than the paradigm of confinement in a cell Indeed, the context in which action is taken is an important factor to be taken into account, since situations commonly occur in modern society where the public may be called on to endure restrictions on freedom of movement or liberty in the interests of the common good.’

95 In his subsequent lecture entitled “Safeguarding and Dignity: Protecting Liberties – When is Safeguarding Abuse?” cited above, Munby LJ made these observations about the impact of the Grand Chamber decision in *Austin*:

‘Where does this leave us? And where in particular does it leave the decisions in P and Q and Cheshire West? It is early days and you will understand that I must be careful what I say. A provisional and very tentative view might be that questions of reason, purpose, aim, motive and intention are wholly irrelevant to the question of whether there is a deprivation of liberty; that anything in the domestic authorities (and particular in Cheshire West) which suggests otherwise needs to be reconsidered; that in all other respects P and Q and Cheshire West stand as good law; that none of this affects the correctness of the actual decisions in the two cases; and that none of this is likely to have any decisive effect on the outcome in the general run of cases of the kind with which we are concerned.’

96 One anticipates that the impact of the Grand Chamber decision in *Austin* will be a further aspect of the forthcoming appeals to the Supreme Court.”

It will be clear from this short overview that the Supreme Court will have to consider a range of important questions when it hears the appeals in *P & Q* and *Cheshire West*. It is far from clear how the various issues will be resolved. In his judgment in *CC*, Baker J remarked of this uncertainty that it is “it is obviously of great importance to all professionals practising in this field that [it] is resolved promptly”.⁶ However, the appeal in *Cheshire West* and *P and Q* will not be heard by the Supreme Court until October 2013, such that we are unlikely to have a judgment until the end of 2013, if not the beginning of 2014.

How is a hospital or a local authority to approach the question of DOLs in a hospital setting pending those appeals? Until we hear from the Supreme Court, the law which must be applied is that set out in the decisions of the Court of Appeal in *Cheshire West* and *P and Q*. Whilst each case must be decided on a case-by-case basis it is instructive to look to the case-law for guidance.

In Part 2 of this paper, we look at two recent decisions which provide useful guidance as to how to go about this enquiry in the specific context of hospitals, but first turn to the operation of the two relevant statutory regimes.

⁶ [2012] EWHC 2136 (COP), paragraph 81.

1.2 The legal basis for depriving a person of their liberty

If it is concluded that a deprivation of a patient's liberty is likely to occur it is necessary to identify the correct legal basis for detaining that patient.

Hospitals have, in certain circumstances, powers to detain people under the MHA 1983 and the MCA 2005.⁷ Determining the appropriate basis on which to detain can raise difficult questions and the first part of this section considers the interface between the two statutory regimes. It is uncertain whether those in a hospital setting enjoy any power to detain patients on an emergency basis, outwith the scope of the two statutory regimes. This question is considered in the second part of this section.

1.2.1 The interface between the MHA and the MCA

In order to understand the interface between the deprivation of liberty regimes under the MHA 1983 and MCA 2005 it helps to consider each statutory regime in outline.

The MHA 1983 is principally concerned with the admission of patients to hospital for assessment and treatment for their mental disorder. Those powers of compulsion were extended by the MHA 2007 to include compulsory community treatment orders (also referred to as supervised community treatment) for patients previously detained in hospital who are now living in the community, but who continue to need treatment for their mental disorder. The purpose of the MHA 1983 is to provide the statutory framework for the compulsory care and treatment of people for their mental disorder when they are unable or unwilling to consent to that care and treatment, and when it is necessary for that care and treatment to be given to protect themselves or others from harm. The key point for the exercise of these powers is the inability or unwillingness of the patient who suffers from a mental disorder to consent to the relevant care and treatment. This encompasses people who, notwithstanding their mental disorder, have capacity to do so – and it is entirely possible for someone detained under the MHA 1983 to have capacity in relation to a treatment decision.⁸ Inability to consent will also include people who do not have capacity, but the question whether an individual patient has or does not have decision-making capacity is not the key determinant of whether the powers conferred by the MHA 1983 should be used.

The MCA 2005 is based wholly on a capacity test. Its provisions have no application to people who have the capacity to make their own decisions. Some who lack capacity will not come within the definition of those for whom compulsory powers under the MHA 1983 can be exercised. People with learning difficulties, for example, who may thereby not be able to give their consent to treatment, will not generally be subject to the compulsory powers of the MHA 1983, unless they are also abnormally aggressive or seriously irresponsible.⁹ Other examples are people in a persistent vegetative state or anyone suffering from 'locked-in' syndrome, which prevents them from communicating, persons with brain injuries or temporarily unconscious, drunk or under the influence of drugs.

The key differences between the approaches under the MHA 1983 and the MCA 2005 can be summarised as follows. First, the MCA 2005 relates to a person's functioning – i.e. their (in)capacity to make a particular decision – whereas the MHA 1983 relates to a person's status, as someone

⁷ As amended by the Mental Health Act 2007.

⁸ See, for a pre-MCA 2005 example, *Re C (Adult: Refusal of Treatment)* [1994] 1 WLR 290. See also the much more recent, post-MCA 2005, decision in *Re SB* [2013] EWHC 1417 (COP), where Holman J held that the fact that a woman was detained under s.2 MHA 1983 did not prevent her from having capacity to determine whether to terminate her pregnancy at the twenty-third week of its term.

⁹ By virtue of the operation of ss.1(2A)(a) and (2B) MHA 1983.

diagnosed as having a mental disorder within the meaning of the Act and subject to its powers. Second, the MCA 2005 requires acts done or decisions made under the Act on behalf of persons who lack the requisite capacity to be done or made in their best interests.¹⁰ The MHA 1983, by contrast, contains no equivalent requirement; under its provisions, an individual can (for instance) be detained solely on the basis of the risk that they pose to others. Third, the MCA 2005 covers all decision-making, whereas the MHA 1983 is, to a very large degree, limited to decisions about care in hospital and medical treatment for mental disorder. Fourth, the MCA 2005 specifically excludes¹¹ anyone giving a patient medical treatment for mental disorder, or consenting to a patient being given medical treatment for mental disorder, if the patient is, at the relevant time, already detained and subject to the compulsory treatment provisions of Part 4 MHA 1983.

There are, however, areas of overlap. For example, people who are detained in hospital under the MHA 1983 and who also lack capacity to make financial decisions may be subject to the provisions of the MCA 2005 when it comes to the taking of such decisions. Similarly, people who are detained in hospital under the MHA 1983 and lack capacity to make decisions about treatment for a physical disorder or ailment may be treated by reference to the provisions of s.4 -5 MCA 2005 (and are potentially subject to a decision being made by the Court of Protection as to their best interests as regards such treatment). Conversely, an elderly person, for example, with Alzheimer's disease, whose day-to-day life is managed in accordance with the provisions of the MCA 2005, may be made subject to the MHA 1983 if it is no longer possible to care for such a person at home and he or she requires treatment for the mental disorder and is resisting being admitted to hospital.

The area of overlap which causes the most difficulty is as regards the authorisation of deprivation of liberty of an individual in hospital. The MHA 2007 amended the MCA 2005 so as to render it lawful to deprive a person of their liberty either if it is a consequence of giving effect to an order of the Court of Protection on a personal welfare matter or, if the deprivation of liberty is in a hospital or care home, if a standard or urgent authorisation (under the provisions of Schedule A1 to the MCA 2005) is in force.

A standard or urgent authorisation cannot be granted, however, if the patient is 'ineligible.' Likewise, by virtue of section 16A MCA 2005, the Court of Protection cannot authorise a person to be deprived of their liberty if they are, or they become, ineligible.

Schedule 1A sets out (in an appallingly drafted fashion) how to determine whether a patient is ineligible. At the risk of overly simplifying Schedule 1A to the MCA 2005, there are five cases in which a person is ineligible. The first scenario is where a person is currently detained in hospital under the MHA 1983. In that case, the individual may not simultaneously be subject to a deprivation of liberty authorisation under the MCA 2005. Three of the other cases involve scenarios where a person is subject to measures under the MHA not amounting to detention. In that case, the individual may not simultaneously be subject of a deprivation of liberty authorisation under the MCA 2005 which would conflict with a compulsory measure under the MHA 1983.

The final category involves the scenario where a person is "within the scope" of the MHA but not detained under it. In this case, a person would be ineligible to be deprived of their liberty and an order under s.16A MCA 2005 if he was an objecting mental health patient who "could" be detained under sections 2 or 3 of the MHA 1983. If treatment could not be provided under the MCA 2005, it would appear that an application "could" be made to detain the person under MHA section 2 or, depending

¹⁰ Section 1(5) MCA 2005.

¹¹ Section 28 MCA 2005.

on the views of his nearest relative, under section 3. In deciding then whether he “could” be detained in hospital in pursuance of such an application, we must assume that two medical recommendations under the MHA 1983 have been given. In short, a mental health patient objecting to treatment which cannot be provided under the MCA 2005 is within the scope of the MHA 2005 even if not detained under it. Such a person cannot, therefore, be deprived of their liberty under the MCA 2005.

A significantly more user-friendly guide to the scheme of (and purpose) behind Schedule 1A can be found in a letter from the Department of Health reproduced in the Upper Tribunal judgment in *DN v Northumberland, Tyne and Wear NHS Foundation Trust* [2011] UKUT 327 (AAC) (Judge Jacobs):

“18. Mr Rook wrote that the Department did not wish to become a party, but set Upper Tribunal its understanding of the relationship between the MHA and the MCA. His analysis is, naturally, a policy rather than a legal one, but it is valuable for explaining clearly how the MCA was intended to apply:

‘... in case it is of assistance to the Tribunal, the Department does have some general observations to make about the relationship between the two Acts, and in particular between the MHA and the so-called “deprivation of liberty safeguards” (MCA DOLS) in Schedule A1 of the MCA.

As the Tribunal is aware, the MCA DOLS provide a system whereby local authorities and primary care trusts may authorise a person’s deprivation of liberty in a care home or hospital (respectively) for care or treatment, where the person concerned lacks the capacity to make the relevant decision themselves.

As the Department understands it, there is no general rule that the MHA takes precedence over the MCA (or, indeed, vice versa).

In general, the possibility that a person’s needs for care and treatment could be met by relying on the MCA – with or without an authorisation under the MCA DOLS – [is] relevant to decisions that have to be made under the MHA in the same way as all alternative possibilities.

Decision-makers under the MHA must, inevitably, consider what other options are available when deciding whether it is right for compulsory measures under the MHA to be used, or continue to be used. The use of the MCA (with or without an authorisation under MCA DOLS) may be one of those options.

All such alternative options must be considered on their merits. The fact that someone could be deprived of their liberty and given treatment under the MCA does not automatically mean that it is inappropriate to detain them under the MHA, any more than (say) the possibility that someone with capacity may consent to continuing treatment for their mental disorder automatically makes their continued detention under the MHA improper.

There are, however, specific circumstances in which the fact that someone is, or could be made, subject to compulsory measures under the MHA means that they cannot also be deprived of their liberty under the MCA.

Those circumstances are set out in the ‘eligibility requirement’ in paragraph 17 of Schedule A1 to the MCA, the meaning of which is defined by Schedule 1A to the same Act. A person who is ineligible as determined in accordance with Schedule

IA cannot be deprived of their liberty under the MCA and therefore cannot be the subject of any authorisation under the MCA DOLS.

[...]

The Government's policy intention was that people who lack capacity to consent to being admitted to hospital, but who are clearly objecting to it, should generally be treated like people who have capacity and are refusing to consent to mental health treatment. If it is considered necessary to detain them in hospital, and they would have been detained under the MHA if they had the capacity to refuse treatment, then as a matter of policy it was thought right that the MHA should be used in preference to the MCA."

Charles J, who had previously (in *GJ v The Foundation Trust* [2009] EWHC 2972 (Fam), [2009] COPLR Con Vol 567) appeared to state that the MHA 1983 had general primacy over the MCA 2005, has very recently confirmed in *AM v South London & Maudsley NHS Foundation Trust & Secretary of State for Health*,¹² that general propositions in respect of issues that arise concerning the interrelationship between MHA 1983 and MCA 2005 are 'dangerous;' and (2) his references to 'primacy' in that earlier decision were made in and should be confined to the position where the person was within the scope of MHA 1983.

The decision in *AM* is also of importance for the confirmation given by Charles J as to the approach that should be adopted by decision-makers responsible for determining whether a person who requires assessment or treatment as an in-patient in a psychiatric hospital in circumstances amounting to a deprivation of liberty should be detained under the provisions of MHA 1983 or whether the provisions of MCA 2005, Sch A1 should be used.¹³ He set out three questions that such decision-makers need to ask:

1. does the person have capacity to consent to admission as an informal patient?¹⁴
2. might the hospital be able to rely upon the provisions of the MCA 2005 lawfully to assess or treat the person (most importantly, would the person be compliant with the arrangements, as a non-compliant patient who is within the scope of the MHA 1983 can only be detained under the provisions of that Act)?
3. if there is a choice between reliance on the MHA 1983 and the MCA 2005, which is the least restrictive way of best achieving the proposed assessment or treatment?

In answering this last question, Charles J emphasised that that the decision-maker must consider the actual availability of the MCA 2005 regime and compare its impact, if it were to be used, with the impact of detention under the MHA 1983.¹⁵ He continued:

¹² [2013] UKUT 0365 (AAC) [2013] COPLR forthcoming.

¹³ Charles J's judgment encompassed situations other than those amounting to a deprivation of liberty, but for present purposes the discussion is limited to those which either do or are likely to amount to such a deprivation. Whilst strictly of persuasive effect only before the Court of Protection (see, by analogy, *Secretary of State for Justice v RB* [2010] UKUT 454 (AAC), it is suggested that that this decision, reached after full argument and by the judge formerly in charge of the Court of Protection, should carry significant weight before that latter court.

¹⁴ As to which, see also *A Primary Care Trust v LDV* [2013] EWHC 272 (Fam) [2013] COPLR 204, discussed further below.

¹⁵ Para 72.

“73. This involves the FTT (and an earlier MHA decision maker) taking a fact sensitive approach, having regard to all the relevant circumstances, to the determination of the “necessity test” and thus in the search for and identification of the least restrictive way of best achieving the proposed assessment or treatment (see paragraphs 15 and 16 above). This will include:

- i) consideration of what is in the best interests of the incapacitated person in line with the best interests assessment in the DOLS process, and so for example conditions that can be imposed under the DOLS, fluctuating capacity and the comparative impact of both the independent scrutiny and review and the enforcement provisions relating to the MHA scheme on the one hand and the MCA scheme and its DOLS on the other, and possibly
- ii) as mentioned in paragraph 50 above a consideration of the likelihood of continued compliance and triggers to possible non-compliance and their effect on the suitability of the regimes, which links to the points made in paragraph 4.21 of the MHA Code of Practice [¹⁶] and paragraph 4.48 Deprivation of Liberty Safeguards Code of Practice [¹⁷].

74. Further, in my judgment it involves the decision maker having regard to the practical / actual availability of the MCA regime (see by analogy *A Local Authority v PB & P* [2011] EWHC 501 (CoP) at in particular paragraphs 18 to 22). As to that, I repeat that the FTT (and earlier decision makers under the MHA) are not able to implement or compel the implementation of the MCA regime and its DOLS and so (a) the position of those who can implement it and whether they could be ordered to do so, and (b) when the MCA regime and its DOLS would be implemented, will be relevant. This was correctly recognised on behalf of the Appellant by the acceptance and acknowledgement of the point that when a discharge under the MHA of a compliant incapacitated person was warranted it should usually be deferred to enable the relevant DOLS authorisation to be sought (and I add obtained).

75. In my judgment, the rationale for this more flexible approach, is that in certain circumstances which it has defined in the MHA and the MCA Parliament has provided statutory regimes which may or do provide alternatives and so choices which fall to be considered by the relevant

¹⁶ Which provides that: “[w]hether or not the deprivation of liberty safeguards could be used, other reasons why it may not be possible to rely on the MCA alone include the following:

- the patient’s lack of capacity to consent is fluctuating or temporary and the patient is not expected to consent when they regain capacity. This may be particularly relevant to patients having acute psychotic, manic or depressive episodes;
- a degree of restraint needs to be used which is justified by the risk to other people but which is not permissible under the MCA because, exceptionally, it cannot be said to be proportionate to the risk to the patient personally; and
- there is some other specific identifiable risk that the person might not receive the treatment they need if the MCA is relied on and that either the person or others might potentially suffer harm as a result.”

¹⁷ Which provides that “[e]ven where a person does not object and a deprivation of liberty authorisation is possible, it should not be assumed that such an authorisation is invariably the correct course. There may be other factors that suggest that the Mental Health Act 1983 should be used (for example, where it is thought likely that the person will recover relevant capacity and will then refuse to consent to treatment, or where it is important for the hospital managers to have a formal power to retake a person who goes absent without leave). Further guidance on this is given in the Mental Health Act 1983 Code of Practice.”

statutory decision makers under the two schemes. This is such a situation but it is one in which the FTT only has jurisdiction (and power) to make a decision applying the MHA. This has the results that:

- i) the FTT (and earlier decision makers under the MHA) have to apply the statutory tests imposed by the MHA and the possible application of the MCA and its DOLS are relevant to that exercise,*
- ii) the FTT (and the earlier decision makers under the MHA) have to assess whether as a result of the identified risks the relevant person ought to be detained, or kept in hospital in circumstances which on a objective assessment give rise to a risk that cannot be ignored that they amount to a deprivation of liberty (see for example paragraph 22 of Upper Tribunal Judge Jacobs decision in DN v Northumberland & Wear NHS Foundation Trust),*
- iii) if the answer is “yes”, this triggers a value judgment applying the “necessity test” as between the choices that are or will or may become available,*
- iv) the search applying the MHA “necessity test” is for the alternative that best achieves the objective of assessment or treatment of the type described in ss. 2 and 3 MHA in the least restrictive way. This potentially introduces tensions and so a need to balance the impact of detention under the MCA and an authorisation under the DOLS as the means of ensuring that a deprivation of liberty to best achieve the desired objective is lawful and governed by a statutory regime, and*
- v) the theoretical and practical availability of the MCA regime and its DOLS is one of the factors that needs to be considered by the MHA decision maker in carrying out that search, as are their overall impact in best achieving the desired objective when compared with other available choices and so detention under ss. 2 or 3 MHA.”*

The decision in *AM* gives some useful clarity as to the approach should be adopted where there is a choice between the MHA 1983 and the MCA 2005; but what happens where a person is within scope of the MHA 1983 but cannot be detained under it? For example, what happens where an AMHP considers that an application under the MHA 1983 cannot be made and a best interests assessor considers that a patient is within scope of the MHA 1983 and is objecting to the mental health treatment in question, and is hence ineligible for a DOLS authorisation by virtue of Schedule 1A. In this scenario, the patient would fall between the two regimes of detention, as he would be ineligible under the MCA 2005 but not detained under the MHA 1983.

This situation was considered by Baker J in *A Primary Care Trust v LDV & Ors.*¹⁸ The facts illustrate the deprivation of liberty issues that can arise in the common scenario that a patient is discharged from s.3 MCA 2005 but remains in the care of a hospital.

The case concerned a 33-year-old woman suffering from a learning disability. She had suffered years of traumatic experiences, not only at home but also in foster care and subsequently in a series of institutional settings, including Winterbourne View. In April 2011, she was transferred to a medium-secure unit at St Andrew's Hospital in Northampton and there detained under the provisions of section 3 1983. On 25 May 2012, however, a First Tier Tribunal (Mental Health) made an order under

¹⁸ [2013] EWHC 272 (Fam).

s.72(3) MHA 1983 for her deferred discharge from hospital to take effect from 28 September 2012. The tribunal held inter alia that LDV “needs to be placed in a residential establishment in the community, equipped to meet the needs of a person suffering from mild learning disability with challenging behaviours, and supported by a package of aftercare comprising medical, nursing and social worker oversight and the provision of day-care.”

The care coordinators, led by the PCT for her home area, therefore began the process of identifying a suitable community placement for LDV. As a preliminary step, however, LDV moved in early September 2012 to WH, a private hospital situated closer to her home area.

On 20 September 2012, at around the time of her move to WH, two doctors at St. Andrew’s approved under section 12 of MHA recommended that LDV be re-detained under section 3. As a result, a Mental Health Act Assessment was carried out by the Approved Mental Health Professional (‘AMPH’) employed by the local authority. The AMHP was, of course, aware of the tribunal decision to discharge LDV from detention and concluded that, as there had been no material change in her circumstances since that decision, it would be unlawful for LDV to be detained under the MHA, following the decision of the House of Lords in *R v East London NHS Trust, ex parte Count Von Brandenburg* [2004] 2 AC 280. In those circumstances she therefore declined to make an application under s.3. The deferred discharge took place on 28 September 2012. In fact, LDV did not leave the hospital on that date, and her status thereafter was – and remained – that of a patient under an informal admission within the scope of s.131 MHA 1983.

During her assessment, the AMHP also identified that the restrictions in LDV’s care plan at WH seemed to amount to a deprivation of liberty. She advised that, should LDV remain at WH as an informal patient under the same restrictions, and without a legal framework to authorise them, there was a significant risk of an unlawful deprivation of liberty. She therefore advised the PCT and the hospital trust that authorisation should be sought for the restrictions in the care plan through a court order.

On 12 October 2012, the consultant psychiatrist at WH responsible for LDV’s care and treatment made a request for a standard authorisation under the Deprivation of Liberty Safeguards as set out in Schedule A1 to the MCA 2005 and, at the same time, granted an urgent authorisation under that Act until 18 October 2012. The request was made to the PCT, as the supervisory body under the DOLS. The PCT had in place arrangements with the local authority to enable it to fulfil its obligations as supervisory body. The local authority, acting on the PCT’s behalf, appointed a best interests assessor for the purpose of carrying out the necessary assessments. The best interests assessor also reached the view that the circumstances of LDV’s accommodation at WH amounted to a deprivation of liberty, and further concluded that LDV was “ineligible to be deprived of her liberty” under Schedule A1 on the basis that, in her opinion, LDV was within the scope of the MHA and the criteria in paragraph 5 of Schedule 1A were met. The request for a standard authorisation was therefore refused.

The matter proceeded to the Court of Protection, where the PCT sought determination of the following questions:

- a. Did LDV’s circumstances at WH amount objectively to a deprivation of liberty?
- b. Did LDV have capacity to consent to her accommodation at WH in circumstances which amount to a deprivation of liberty, and in particular, what information is relevant to that decision?

- c. If LDV's circumstances amounted to a deprivation of liberty and she lacked capacity to consent to that deprivation of liberty, how could her deprivation of liberty be authorised? Specifically, was she eligible to be deprived of her liberty under the MCA 2005, whether under a standard authorisation in accordance with the provisions of Schedule A1 or pursuant to an order of the court under section 16(2)(a). Alternatively, could she be lawfully detained under the MHA 1983?

At a preliminary hearing, Baker J determined that LDV's circumstances amounted to a deprivation of liberty and that she lacked capacity to consent to the same. These aspects of Baker J's decision are considered further in the case study in part 2. A further hearing listed to consider how LDV's deprivation of liberty could be authorised did not proceed. We are therefore left without a definitive answer to this difficult question, but we have no doubt that it will be determined in due course (whether by reference to LDV's circumstances, or those of another patient in her situation).

Another potential lacuna was identified by Baker J in *An NHS Trust v Dr A* [2013] EWHC 2442 (COP), in which a Dr A was on a hunger strike was found (1) to lack capacity to make decisions as to whether he should be force-fed; (2) to require such force-feeding in his best interests; and (3) to need to be deprived of his liberty for purposes of such force-feeding. Baker J found that Dr A was ineligible to be deprived of his liberty under the MCA because he was within scope of the MHA 1983 and objecting; Dr A was then detained under s.3 MHA 1983, but the doctors concerned with his treatment considered that the force-feeding could not properly be considered to be medical treatment for his mental disorder. Baker J held that, in consequence¹⁹ he could not be force-fed under the provisions of the MHA 1938; nor could an order be made under s.16 MCA 2005 authorising his force-feeding and ancillary deprivation of liberty because of the prohibition in s.16A against welfare orders being made depriving ineligible adults of their liberty. Baker J resolved this dilemma by holding that he could properly make an order under the inherent jurisdiction authorising the force-feeding and the consequent deprivation of liberty of Dr A as being in his best interests, but, as he noted,²⁰ it was "*alarming to find that the legal position on this fundamental issue is far from straightforward.*"

Finally, we should note that, even if the person is eligible to be deprived of their liberty by way of a (urgent or standard) authorisation under Schedule A1, it is still necessary for them to meet all the other criteria set down in Schedule A1. In particular, it is necessary for the best interests requirements to be met. Interestingly and importantly, this requirement does not merely encompass the considerations set down in s.4 MCA 2005, but also additional, specific, considerations, namely that: (1) it is necessary for the person to be deprived of their liberty in order to prevent harm to them; and (2) the deprivation of their liberty is a proportionate response to the likelihood of the person suffering harm, and the seriousness of that harm.²¹ Very careful consideration must therefore be given to whether the deprivation of liberty to which they are (to be) subject is the least restrictive option, a point emphasised by Charles J in *A Local Authority v PB and P*.²² It is also vital to remember that the mechanisms provided by Schedule A1 to authorise the deprivation of a person's liberty must not be used to stifle real debates about where their best interests may lie: in such a case, the proper course of

¹⁹ *B v. Croydon Health Authority* [1995] (Fam) 133 and *R v Collins ex parte Brady* [2000] Lloyd's Rep Med 355.

²⁰ Paragraph 55. The resolution of the problem of jurisdiction occupied exactly half of his judgment.

²¹ Paragraph 16 of Schedule A1.

²² [2011] EWHC 2675 (COP) [2012] COPLR 1, at paragraph 64.

action is to seek a decision from the Court of Protection: *Hillingdon London Borough Council v Neary*.²³

1.2.2 Emergency powers of detention

Before turning to the case study, we explore a further scenario where a hospital patient could fall within a gap in the statutory framework for authorising detention of patients. Consider the situation where an emergency arises in hospital requiring restraint of an informal patient for a relatively short period of time. The patient appears not to have capacity to take decisions regarding their welfare but there are no grounds for detention under the MHA 1983.

Two questions arise: does the restraint of that patient adult for a relatively short period of time amount to a deprivation of liberty? If it does, how can that deprivation of liberty be authorised?

Both questions were touched upon in *Commissioner of the Police for the Metropolis v ZH*.²⁴ ZH was a severely autistic, epileptic nineteen year old young man who suffered from learning disabilities and could not communicate by speech. In September 2008, he was taken by the specialist school he attended to a swimming pool for a familiarisation visit. Matters went very badly awry during the course of that visit, in particular following the decision of the manager of the pool to ring the Police when difficulties were experienced in persuading ZH to move away from the side of the pool. The arrival of the police gave rise to an escalating series of events which culminated in ZH first jumping into the pool, being forcibly removed from it, being handcuffed, put in leg restraints and placed in a cage in the back of a police van for a period of around 40 minutes. As a result of this, ZH suffered consequential psychological trauma and an exacerbation of his epileptic seizures.

ZH claimed (by his father as litigation friend) damages against the Commissioner of the Police for the Metropolis for damages, for assault and battery, false imprisonment, unlawful disability discrimination under the Disability Discrimination Act 1995, under the Human Rights Act 1998 alleging breaches of Articles 3, 5 and/or 8 of the ECHR and for declaratory relief. The judgments of Sir Robert Nelson at first instance and of the Court of Appeal upon the Metropolitan Police's unsuccessful appeal are very wide-ranging, but for present purposes we focus upon their consideration of their analysis of the issues arising in respect of the deprivation of ZH's liberty.

Both Sir Robert Nelson at first instance and the Court of Appeal found that ZH had been deprived of his liberty. Sir Robert Nelson's conclusions were as follows:

*“145. The nature and duration of the restraint lead me to the conclusion that there was a deprivation of liberty, not merely a restriction on movement on the facts of this case. Furthermore, even though I am of the view that the purpose and intention of the police (namely at least in part to protect ZH's safety) is relevant to the consideration of the application of Article 5, I am nevertheless satisfied that even when that is taken into account, a deprivation of liberty has occurred. The actions of the police were in general well intentioned but they involved the application of forcible restraint for a significant period of time of an autistic epileptic young man when such restraint was in the circumstances hasty, ill-informed and damaging to ZH. I have found that the restraint was neither lawful nor justified. Even though the period may have been shorter than that in *Gillan v United Kingdom 2010**

²³ [2011] EWHC 1377 (COP) [2011] COPLR Con Vol 632.

²⁴ [2013] EWCA Civ 69.

APP No 4158/05, it was in my judgment sufficient in the circumstances to amount to a deprivation of liberty under Article 5.”

On appeal, at paragraph 83 of his judgment (the sole reasoned judgment), Lord Dyson MR rejected a submission (founded upon the decision of the ECtHR in *Gillan v UK* (2010) EHRR 45) that Strasbourg would usually view a detention of less than 30 minutes as not coming within the scope of Article 5. He went on in the same paragraph to note that the restraint of ZH was “*closely analogous to the classic of paradigm case of detention in a prison or police cell. In particular, it is difficult to see any difference in kind between being detained in the caged area at the back of a police van and being detained in a police cell. In fact, ZH was deprived of movement throughout the entire period of the restraint. The restraint was intense in nature and lasted for approximately 40 minutes and its effects on ZH were serious.*”

Having held (at paragraph 84) that Sir Robert Nelson had correctly had regard to the particular facts of the case and made an assessment of the “*type, duration, effects and manner of implementation of the measure in question,*” and was entitled to reach the conclusion that he did for the reasons that he gave, Lord Dyson discussed the question of the relevance (or otherwise) of the purpose for which ZH had been subject to restrictions, thus:

“85. *We heard argument as to whether the fact that, as the judge found, the purpose and intention of the police was at least in part to protect ZH's safety was relevant to whether there was a breach of article 5. The judge thought that it was, but nevertheless held that there had been a breach. The case of Austin v Metropolitan Police Commissioner [2009] UKHL 5, [2009] 1 AC 564 is relevant here. At para 44, Lord Walker said: "the purpose of confinement which may arguably amount to deprivation of liberty is in general relevant, not to whether the threshold is crossed, but to whether that confinement can be justified under article 5(1)(a) to (f)".*

86. *This approach was endorsed by the ECtHR in Austin v United Kingdom 92012) 55 EHRR 14 at para 58. But the court said at para 59:*

‘However, the Court is of the view that the requirement to take account of the "type" and "manner of implementation" of the measure in question enables it to have regard to the specific context and circumstances surrounding types of restriction other than the paradigm of confinement in a cell. Indeed, the context in which action is taken is an important factor to be taken into account, since situations commonly occur in modern society where the public may be called on to endure restrictions on freedom of movement or liberty in the interests of the common good. As the judges in the Court of Appeal and House of Lords observed, members of the public generally accept that temporary restrictions may be placed on their freedom of movement in certain contexts, such as travel by public transport or on the motorway, or attendance at a football match. The Court does not consider that such commonly occurring restrictions on movement, so long as they are rendered unavoidable as a result of circumstances beyond the control of the authorities and are necessary to avert a real risk of serious injury or damage, and are kept to the minimum required for that purpose, can properly be described as "deprivations of liberty" within the meaning of art.5(1).’

87. *To this extent and in such circumstances, therefore, the purpose and intention of the person applying the restraint may be relevant to whether there is a breach of article 5. It is not necessary to explore this further since, as Mr Coppel points out, this reasoning could not apply in the present context. Quite apart from the fact that this is very close to being a paradigm case, there is nothing common or usual about what happened to ZH and no general acceptance by members of the public that they are liable to be treated as ZH was treated.*”

This case raises important questions for those in a hospital setting. It means that, in principle, temporary (but total) restraint of an informal hospital patient may constitute a deprivation of liberty: the restraint imposed on ZH whilst he was at the pool-side lasted about 15 minutes, the restraint in the police van lasted about 25 minutes, but the Court of Appeal was satisfied that he was deprived of his liberty. Whilst one might say that the restraint of ZH in a police van more closely aligns with the paradigm of detention in a prison cell than does restraint of a patient in a hospital setting, it could not, however, be said that temporary restraint in a hospital falls into the ‘generally accepted’ category of temporary restrictions on freedom of movement identified at paragraph 87 of the decision. Hospital authorities must therefore confront the real possibility that such temporary restraint could constitute a deprivation of liberty.

Difficult questions then arise as to what legal basis, if any, exists to authorise a deprivation of liberty in such an emergency situation.

This issue was considered, although not conclusively decided, in *ZH*. At first instance, Sir Robert Nelson found (para 41) that it would be theoretically possible for the police to have satisfied the conditions of section 5 to 6 MCA 2005 even if some of their number were not aware of the terms of the Act itself. In light of his conclusion, he noted that he was not then bound to go on to consider whether or not the common law defence of necessity could apply in circumstances where the MCA 2005 applied. He chose to do so, however. Relying, in particular, on an earlier decision in a case called *Sessay*,²⁵ ZH submitted that the defence of necessity had no place; the Commissioner submitted to the contrary. Sir Robert Nelson held as follows in this regard:

“44. For my part I am satisfied that where the provisions of the Mental Capacity Act apply, the common law defence of necessity has no application. The Mental Capacity Act requires not only the best interests test but also specific regard to whether there might be a less restrictive way of dealing with the matter before the act is done, and, an obligation, where practicable and appropriate to consult them, to take into account the views of the carers. It cannot have been the intention of Parliament that the defence of necessity could override the provisions of the Mental Capacity Act which is specifically designed to provide specific and express pre-conditions for those dealing with people who lack capacity.”

The conclusions of Sir Robert Nelson in this regard (at paragraph 44) were strictly obiter dicta; they were not discussed by Lord Dyson in his judgment. That having been said: (1) the tenor of Lord Dyson’s judgment was such that it could be said to have represented an endorsement of the entirety of Sir Robert’s judgment – including this paragraph; and (2) the conclusions of Sir Robert Nelson are

²⁵ *R (Sessay) v South London and Maudsley NHS Foundation Trust and another* [2011] EWHC 2617 (QB) [2012] QB 760, in which the Divisional Court held that the scheme of the MHA 1983 was such that the concept of necessity did not apply so as to give a defence to a claim of false imprisonment/unlawful detention where a patient was detained (in their own interests) pending completion of the process for assessment for admission under the provisions of s.2 MHA 1983.

entirely consistent with those of the Divisional Court in *Sessay* regarding the (non-existence) of the defence of necessity where the MHA 1983 applies.

The view expressed by Sir Robert Nelson gives rise to a difficult practical question where an emergency situation arises in respect of an adult who would appear not to have capacity to take decisions regarding their welfare but who is not the subject of any form of court order or a deprivation of liberty authorisation.

To understand the problem, it is necessary to have regard to the wording of both ss.4A and 4B (both inserted by the MHA 2007):

“4A Restriction on deprivation of liberty

- (1) This Act does not authorise any person (“D”) to deprive any other person (“P”) of his liberty.*
- (2) But that is subject to—*
 - (a) the following provisions of this section, and*
 - (b) section 4B.*
- (3) D may deprive P of his liberty if, by doing so, D is giving effect to a relevant decision of the court.*
- (4) A relevant decision of the court is a decision made by an order under section 16(2)(a) in relation to a matter concerning P's personal welfare.*
- (5) D may deprive P of his liberty if the deprivation is authorised by Schedule A1 (hospital and care home residents: deprivation of liberty).*

4B Deprivation of liberty necessary for life-sustaining treatment etc

- (1) If the following conditions are met, D is authorised to deprive P of his liberty while a decision as respects any relevant issue is sought from the court.*
- (2) The first condition is that there is a question about whether D is authorised to deprive P of his liberty under section 4A.*
- (3) The second condition is that the deprivation of liberty—*
 - (a) is wholly or partly for the purpose of—*
 - (i) giving P life-sustaining treatment, or*
 - (ii) doing any vital act, or*
 - (b) consists wholly or partly of—*
 - (i) giving P life-sustaining treatment, or*
 - (ii) doing any vital act.*
- (4) The third condition is that the deprivation of liberty is necessary in order to—*
 - (a) give the life-sustaining treatment, or*
 - (b) do the vital act.*

(5) *A vital act is any act which the person doing it reasonably believes to be necessary to prevent a serious deterioration in P's condition.*”

As noted above, in light of the decision in *ZH*, it is clear that a person can be subjected to a deprivation of liberty which may only last a relatively short period of time. The wheels of the COP administration can move very swiftly (for instance in the case of medical treatment cases involving the necessity for blood transfusion during labour) but would not have been likely to have been able to operate swiftly enough to bring about consideration of *ZH*'s circumstances during the period during which he was later found to have been deprived of his liberty.

In the case of a true emergency where the deprivation of liberty to which the adult is subjected in response arises immediately and is of very short duration (say no more than 30 minutes), but is severe, even if it could be said that the first condition in s.4B is met (i.e. that any deprivation of liberty to which the individual was subjected would be capable of being authorised – most likely by a court order under section 16(2)(a)), it is therefore likely in such cases to be straining the language of section 4B to say that the deprivation of liberty is taking place while a decision respecting that issue is sought from the Court. Even if an interpretation was placed upon section 4B that it applies so long as the most minimal steps have been taken to seek a decision from the Court, perhaps by way of initial telephone contact to get before the Urgent Applications judge, the fact remains that it is likely that there will – even with suitable diligence on the part of the relevant authorities – be circumstances under which section 4B simply cannot be said to offer protection from liability.

The Court of Appeal did not have to grapple with this question in *ZH*, not least as the case arose out of events which took place in 2008 (and hence ss.4A-B were not in force). In such circumstances, however, it is suggested that there does remain a place for the common law defence of necessity because there is a true lacuna. It is of note in this regard that section 4A provides solely for the ability of an individual to deprive another of their liberty under the provisions of the MCA 2005– it does not purport to exclude the deprivation of liberty of an incapacitated adult outside the provisions of the MCA 2005. Further, it would appear that the inherent jurisdiction would still seem to extend to authorising the deprivation of a liberty of an adult falling outside the scope of the MCA 2005: see *Re A and C (Equality and Human Rights Commission Intervening)* [2010] EWHC 978 (Fam) [2010] COPLR Con Vol 10 per Munby LJ:

“74 ... *There is no longer any room for doubt that a judge exercising the inherent jurisdiction of the High Court (whether the inherent jurisdiction of the court with respect to children or the inherent jurisdiction with respect to incapacitated or vulnerable adults) has power to direct that the child or adult in question shall be placed at and remain in a specified institution such as, for example, a hospital, residential unit, care home or secure unit. And the High Court's powers extend to authorising that person's detention in such a place and the use of reasonable force (if necessary) to detain him and ensure that he remains there: see Re PS (Incapacitated or Vulnerable Adult) [2007] EWHC 623 (Fam), [2007] 2 FLR 1083 at para [16]. But if a local authority is to resort to such measures it must, unless it can bring itself within the new 'deprivation of liberty' amendments to the Mental Capacity Act 2005 effected by the Mental Health Act 2007 (the new ss 4A, 4B and 16A and the new Sch A1 and 1A), first enlist the assistance of the court and do so before it embarks upon such measures: see Re PS (Incapacitated or Vulnerable Adult, at para [23], and A Primary Care Trust and P v AH and A Local Authority [2008] EWHC 1403 (Fam),*

[2008] COPLR Con Vol 179, [2008] 2 FLR 1196 at paras [29], [41].”
(emphasis added).²⁶

Whilst Munby LJ in *Re A and C* made it clear that enlisting the assistance of the Court is a pre-requisite to the local authority being able to obtain an order under the inherent jurisdiction, he was not concerned with the emergency situation that we are considering here: for our purposes, what is important is that he did not hold that the MCA 2005 (as now amended by the MHA 2007) now provided the complete code for the authorisation of the deprivation of liberty that (for instance and in light of the judgment in *Sessay*) the MHA 1983 does in respect of those whom it is proposed to admit for purposes of assessment and treatment.

It is suggested, however, that the common law defence of necessity will only avail a person who is able to show that they were confronted with the need to deprive the incapacitated adult of their liberty in a true emergency position where (a) it was not possible to seek the assistance of the Court either before or during the currency of that deprivation of liberty; (b) no other statutory power existed upon which reliance could be placed (for instance s.17 PACE 1984 or s.135 MHA 1983); and (c) where it was necessary so to do to preserve them from serious harm.

Another interesting question which may still fall for consideration upon another day is whether there is an equivalent lacuna in the statutory law so as to allow for the common law defence of necessity to survive where the deprivation of liberty takes place, not for purposes of safeguarding the life and limb of the incapacitated adult, but that of a third party (the MCA 2005 being focussed solely on the best interests of the adult rather than those of anyone else). At common law, the defence of necessity may be pleaded where the detention takes place so as to prevent a danger to another (see *R v Bournewood Community and Mental Health N.H.S. Trust, L* [1999] 1 AC 458 at 490 per Lord Goff: “*the common law permit[s] the detention of those who were a danger, or potential danger, to themselves or others, in so far as this was shown to be necessary.*”) For the purposes of the ECHR, any deprivation of liberty attributable to the State would have to be such as to fall within one of the permitted bases for so doing under Article 5(1), but it is clear that a deprivation of liberty on the basis of mental disorder can be justified on the basis that a person constitutes a danger to others (and that in the event of emergency, the normal requirements as regards the obtaining of medical evidence objectively establishing a mental disorder can be dispensed with: see *Winterwerp v The Netherlands* (1979) 2 EHRR 387 at paragraph 39 and *X v United Kingdom* (Application No 7215/75, decision of 5.11.81) (unreported) at paragraphs 41 and 45).

Again, however, it is likely that any attempt by a public authority to rely upon the common law defence of necessity in such a case will be scrutinised very narrowly by the Courts so as to ensure that it only survives where there is a true lacuna (and so that does not offend against the provisions of Article 5 ECHR).

It is therefore suggested that the best course of action in relation to patients who do meet the criteria for detention under the MHA 1983 and who would appear not to have capacity to make decisions regarding their welfare and in respect of whom there is a risk that restraint (even of a temporary nature) might be required, is to apply for a standard authorisation or to the Court of Protection for authorisation of the use of temporary restraint measures. Difficulties may, of course, be confronted in

²⁶ In *An NHS Trust v Dr A* [2013] EWHC 2442 (COP), Baker J confirmed that he could make an order under the inherent jurisdiction depriving an incapacitated adult of their liberty for purposes of force-feeding them when he could not make such an order under the MCA 2005 because the adult was ineligible to be the subject of a standard authorisation by operation of Schedule 1A and the force-feeding could not properly be considered ‘medical treatment’ for purposes of administration under the MHA 1983: see paragraphs 94 and 96.

seeking to demonstrate that such restraint is “necessary” and a “least restrictive option” in the patient’s best interests in circumstances where no such restraint has been required as a matter of course. Where, however, temporary restraint of an informal patient has been required on a previous occasions it will be easier to demonstrate such necessity. In such cases, it will also be more difficult to rely on the defence of necessity on the basis that it was not possible to seek the assistance of the Court of Protection before or during the currency of that deprivation of liberty.

2. Case study: an informal psychiatric patient discharged from section but remaining in need of care in hospital

We now turn to consider the application of the principles discussed in Part 1 to a scenario commonly confronted by hospital authorities, namely that of an informal psychiatric patient discharged from section but still in continuing need of hospital care.

The position of informal patients is well-recognised as being a vulnerable one: see, for instance, the decision in *Rabone & Anor v Pennine Care NHS Trust* [2012] 2 AC 72. Giving the leading judgment in that case, Lord Dyson analysed the position thus:

“26... *As for psychiatric patients, there is a crucial difference between those who are informal patients voluntarily in hospital and those who are detained by the authority of the state. A psychiatric patient who is voluntarily in hospital, like a patient with a physical illness, is free to refuse treatment and leave.*

27 *I accept, of course, that there are differences between detained and voluntary psychiatric patients; and there are similarities between voluntary patients who are suffering from mental illness and those who are suffering from physical illness. But the differences between the two categories of psychiatric patient should not be exaggerated. There are also important differences between informal psychiatric patients who are at real and immediate risk of suicide and patients in an “ordinary” healthcare setting who are at real and immediate risk of death, for example, because they are undergoing life-saving surgery.*

28 *As regards the differences between an informal psychiatric patient and one who is detained under the MHA, these are in many ways more apparent than real. It is true that the paradigm of a detained patient is one who is locked up in a secure hospital environment. But a detained patient may be in an open hospital with freedom to come and go. By contrast, an informal patient may be treated in a secure environment in circumstances where she is suicidal, receiving medication for her mental disorder which may compromise her ability to make an informed choice to remain in hospital and she would, in any event, be detained if she tried to leave. Informal in-patients can be detained temporarily under the holding powers given by section 5 of the MHA to allow an application to be made for detention under section 2 or 3 of the MHA. The statutory powers of detention are the means by which the hospital is able to protect the psychiatric patient from the specific risk of suicide. The patient's position is analogous to that of the child at risk of abuse in *Z v United Kingdom* 34 EHRR 97, paras 73–74, where the court placed emphasis on the availability of the statutory power to take the child into care and the statutory duty to protect children. No such powers exist, or are necessary, in the case of the capable patient in the ordinary healthcare setting.*

29 *Although informal patients are not ‘detained’ and are therefore, in principle free to leave hospital at any time, their ‘consent’ to remaining in hospital may only be as a result of a fear that they will be detained. In Principles of Mental Health Law and*

Policy (2010) ed, Gostin and others, the authors have written in relation to admission, at para 11.03:

‘Since the pioneering paper by Gilboy and Schmidt in 1979, it has been recognised that a significant proportion of [informal] admissions are not ‘voluntary’ in any meaningful sense: something in the range of half of the people admitted voluntarily feel coerced into the admission; it is just that the coercion is situational, rather than using legal mechanisms.’”

It is notable that many of these concerns appear in the chapter upon coercion in practice in the most recent CQC Report on Monitoring the Mental Health Act 1983.²⁷ The report noted the following concerning statistics:

“In one in five visits – an unacceptable high number – MHA Commissioners thought that patients who were in hospital might be detained in all but name. For example, in 88 out of 481 visits there were no signs of locked doors that explained to voluntary patients how they could leave the ward”.

“In 19% of visits in 2011/12 CQC expressed concern about the de facto detention of voluntary patients – either by physical barriers such as locked door, or by staff imposing blanket rules, or by the information given to voluntary patients about the choices available to them”.

Drawing the dividing line between incapacity and situational coercion in these circumstances is likely to be very difficult. It is therefore important that hospital authorities always analyse this situation by considering the key questions:

- (1) Do the circumstances in which a patient remains in hospital amount to a deprivation of liberty?
- (2) Does the patient have capacity to consent to a deprivation of liberty?
- (3) If not, how can the patient’s deprivation of liberty be authorised?

2.1 Deprivation of liberty

Whether or not the circumstances in which an informal patient remained in hospital following discharge amounted to a deprivation of liberty was considered in the *LDV* case, discussed above.

Having reviewed the authorities on deprivation of liberty including, for the first time in a domestic case, the Strasbourg cases decided subsequent to *Cheshire West*, Baker J concluded that the court had to have regard to the following factors:

- (1) whether the person objects to their confinement: see paragraph 25 of the judgment of Wilson LJ (as he then was) in *P and Q v Surrey County Council*;
- (2) the relative normality of the person’s life: see paragraph 28 of the judgment of Wilson LJ in *P and Q*;
- (3) the relevant comparator, having regard to the particular capabilities of the person concerned: see paragraphs 38, 39 and 102 (viii) to (xii) of the judgment of Munby LJ in *Cheshire West*;

²⁷ http://www.cqc.org.uk/sites/default/files/media/documents/cqc_mentalhealth_2011_12_main_final_web.pdf

- (4) as part of the overall assessment, the purpose for the placement: see judgment of Munby LJ at paragraphs 60 to 77 and 102 (vi) and (vii) in the *Cheshire West*, as qualified for the reasons set out in *CC v KK*, at paragraphs 94-96;
- (5) the extent to which it can be said that the managers of the establishment, in this case WH, exercise complete and effective control over the person in his treatment, care, residence and movement: see the judgments of the European Court in *DD v Lithuania*, at paragraph 146 and *Kedzior v Poland*, at paragraph 57.²⁸

It was common ground that LDV was subjected to the following restrictions (which in the view of both Ms Goodall and Dr A amounted to a deprivation of LDV's liberty): (a) WH was locked to visitors and its patients; (b) LDV had to seek the permission of nursing staff if she wished to leave; (c) in the community, LDV was supervised 1:1; (d) staff would prevent LDV leaving WH and entering the community if she was assessed to be at risk; (e) should LDV have sought to leave WH, staff would seek to dissuade her from doing so using de-escalation techniques; (f) if she were to abscond from WH or staff, the police would be alerted; (g) there were restrictions of movement within the unit; (h) the level of observations of LDV were variable, ranging from level 3 (every 15 minutes) to level 2 (line of sight) to level 1 (i.e. 1:1 close) and observations were increased or decreased according to the assessed level of risk; (g) restraint was used where there is an assessed and immediate risk to herself or others; (h) staff might seek to remove L from the area to de-escalate the situation; (i) personal property might be searched when staff assessed there to be a clear indicator or risk (e.g. ligatures, hoarding of medication, instruments for use to self-harm); (j) personal searches might also be conducted according to indicators of risk; (k) if required, sedative medication may be administered, if necessary intramuscular injection; (l) L's contact with her mother was to be supervised by staff in the community according to assessed need or risk; (m) no contact was permitted with her mother in the hospital.

The PCT advanced a faint case that LDV was not deprived of her liberty on the basis that her long history of mental disorder and institutional abuse, leading to her current presentation and needs, precluded any immediate move into a setting other than one with the level of medical input and expertise available at WH. The restrictions on her liberty would therefore need to be the same wherever she was placed. The PCT suggested that WH, as a community hospital, did fall within the tribunal's recommendation of 'a residential establishment in the community equipped to meet the needs of a person suffering from mild learning disability with challenging behaviours, and supported by a package of after-care comprising medical, nursing and social-worker oversight and the provision of day-care'. As a result, applying the tests of relative normality and the relevant comparator, her circumstances did not amount objectively to a deprivation of liberty.

The Official Solicitor contended that, in assessing the relative normality of LDV, the court had to take into account the tribunal's findings as to LDV's needs summarised above. In light of those findings, the Official Solicitor submitted that a person placed in a residential placement in the community of the nature recommended by the tribunal was the appropriate comparator in determining whether the current circumstances amounted to a deprivation of liberty, and that WH did not amount to such a placement.

Baker J, however, did not have difficulty in finding that LDV was deprived of her liberty:

²⁸ It is perhaps noteworthy that Baker J did not proceed on the basis that identifying the comparator was the sole (or even the most important) aspect of the test, as might have been suggested by *Cheshire West*.

- “25. *With respect to Ms Rickard, it seems to me manifestly clear that L’s current circumstances amount to a deprivation of liberty. It may well be the case that not all of the factors identified in paragraph 2.5 [of the DOLS Safeguards Code of Practice] are satisfied in this case but I accept Mr Dooley’s argument that it is not necessary for every such factor to be present. As paragraph 2.5 itself makes clear, the factors listed therein ‘can be relevant to identifying whether the steps taken involve more than restraint to amount to a deprivation of liberty.’ In this case, a number of the factors are manifestly present as identified by Mr Dooley above. The plain fact is that in this case the care and movement of L is subject to the complete and effective control of the staff at WH. That control extends to treatment, contacts and residence. The treatment includes medication. It has been decided that she will not be released into the care of others or to live elsewhere, unless staff consider it appropriate. Her social contacts are subject to a degree of control.*
26. *I accept Mr. Ruck Keene’s submission that the appropriate comparator is a person properly placed in a residential placement in the community, and that WH does not amount to such a placement. In any event, the concept of relative normality and relevant comparator were not intended by the Court of Appeal to be used to exclude cases such as this from the safeguards introduced into the MCA 2005 as a result of the decision in HL v United Kingdom. In Cheshire West, Munby LJ makes it crystal clear by his reference to the decision in HL v United Kingdom that such circumstances will continue to be seen as amounting to deprivation of liberty.*
27. *The restrictions included in the care plan, as summarised by Ms Goodall in the analysis set out above, are on any view at the more severe end of the spectrum. To my mind, this is, objectively, a plain case of deprivation of liberty.*

Applying the analysis of Baker J in LDV, the arrangements by which an informal patient is discharged from section but remains in hospital, in circumstances where measures are in place to prevent or dissuade them from leaving, might well amount to a deprivation of the informal patient’s liberty. That it is necessary to err on the side of caution in this determination was emphasised by Charles J in *AM v South London & Maudsley NHS Foundation Trust & Secretary of State for Health*,²⁹ in which he confirmed that the DOLS regime “*applies when there may be a deprivation of liberty in the sense that [the regime] applies when it appears that judged objectively there is a risk that cannot sensibly be ignored that the relevant circumstances amount to a deprivation of liberty.*”³⁰

Where the circumstances are such that there is (at minimum) a real risk that the relevant circumstances will amount to a deprivation of the patient’s liberty, where this is the case, it will be necessary to carry out a capacity assessment to determine whether or not they lack capacity to consent to such a deprivation of liberty. It is also clear in light of LDV that that capacity assessment will need to be rather fuller than perhaps has been carried out in the past. We now, therefore, turn to that question.

2.2 Assessment of capacity

²⁹ [2013] UKUT 0365 (AAC) [2013] COPLR forthcoming.

³⁰ Para 59.

Where a patient has been discharged but remains in hospital as an informal patient in circumstances which amount to a deprivation of liberty, it is essential that there is a legal basis for detaining the patient.

Assuming that the patient is no longer eligible to be detained as an objecting medical patient under the MHA 1983, the only basis for detaining the patient is under the MCA 2005. If the grounds for detaining a person under the MCA 2005 are not made out then (subject only to the possible and very limited 'emergency' exception outlined above) there is no legal basis for holding the person as an informal patient.

It follows that, in order to avoid a gap in the legal basis for detention, steps should be taken to authorise a patient's deprivation of liberty prior to a patient's discharge. In this regard, it should be noted that there is nothing in the statutory regime to prevent a prospective application being made under the MCA 2005 in the expectation that the patient concerned will be discharged from detention under the MHA 1983. This is the effect of paragraph 12(3) of Schedule A1 which provides that, in determining whether a person meets the qualifying requirement in relation to the giving of a standard authorisation, those circumstances are to be taken into account as they are expected to be at the later time. It was emphasised by Charles J in *AM* that where the discharge from the provisions of the MHA 1983 of a compliant incapacitated patient is warranted, "*it should usually be deferred to enable the relevant DOLS authorisation to be sought (and I should add obtained).*"³¹

The first step is to carry out a capacity assessment to determine whether the patient lacks capacity to consent to a deprivation of liberty. The assessment of an informal patient's capacity should be approached with caution. If the assessment is being carried out with a view to making a prospective application to the Court of Protection, or the Supervisory Body, to authorise the deprivation of a patient's liberty following discharge, this is presumably because the best interests assessor has determined that it is not in the patient's best interests to return home or be permitted to leave hospital even though section under the MHA 1983 is no longer justified. There will be an understandable inclination to find that an objection on the part of the patient to remaining in hospital is unreasonable and evidence that the patient lacks capacity to make such a decision.

Approaching matters on the basis that a person whose views differ from those of the best interests assessor are more likely to lack capacity has always been a forbidden line of reasoning and one that must particularly cautioned against in this scenario.

The recent decision of Baker J in *CC and KK* reinforces this point. It provides a very useful and detailed analysis of the approach to be taken to determining the functional limb of the capacity test.

The facts of this case are set out in section 1.1 above. In short, it concerned an elderly dementia sufferer who in the face of the unanimous views of both the independent expert psychiatrist and all of the professionals asserted that she had capacity to make decisions concerning her residence. The court received evidence from her, not only in a written statement but also orally in court. Baker J helpfully set out the approach to be taken by the Court when addressing questions of capacity (paragraphs 17-25). Two points are particularly noteworthy in the present scenario.

First, Baker J emphasised that professionals and the court must not be unduly influenced by the "protection imperative"; that is, the perceived need to protect the vulnerable adult (*Oldham MBC v GW and PW* [2007] EWHC 136 (Fam); *PH v A Local Authority, Z Ltd and R* [2011] EWHC 1704

³¹ Para 74.

(Fam)) (para 25). After citing passages from Munby LJ's lecture, 'Safeguarding and Dignity: Protecting Liberties – When is Safeguarding Abuse?' Baker J held (in passages sufficiently important to merit reproduction almost in full):

“67. In this case, I perceive a real danger that in assessing KK's capacity professionals and the court may consciously or subconsciously attach excessive weight to their own views of how her physical safety may be best protected and insufficient weight to her own views of how her emotional needs may best be met.”

Second, Baker J emphasised the importance that the capacity assessor not start the assessment with a blank canvas, stating:

“68. ... The statute requires that, before a person can be treated as lacking capacity to make a decision, it must be shown that all practicable steps have been taken to help her to do so. As the Code of Practice makes clear, each person whose capacity is under scrutiny must be given 'relevant information' including 'what the likely consequences of a decision would be (the possible effects of deciding one way or another)'. That requires a detailed analysis of the effects of the decision either way, which in turn necessitates identifying the best ways in which option would be supported. In order to understand the likely consequences of deciding to return home, KK should be given full details of the care package that would or might be available. The choice which KK should be asked to weigh up is not between the nursing home and a return to the bungalow with no or limited support, but rather between staying in the nursing home and a return home with all practicable support. I am not satisfied that KK was given full details of all practicable support that would or might be available should she return home to her bungalow.”

In that case, the KK was found to be clear, articulate, and betrayed relatively few signs of the dementia which afflicted her. She understood that she needed total support and carers visiting four times a day. Whilst she may have underestimated or minimised some of her needs, she did not do so to an extent that suggests that she lacked capacity to weigh up information. Baker J concluded his judgment on a cautionary note, stating:

“74. This case illustrates the importance of the fundamental principle enshrined in s. 1(2) of the 2005 Act – that a person must be assumed to have capacity unless it is demonstrated that she lacks it. The burden lies on the local authority to prove that KK lacks capacity to make decisions as to where she lives. A disabled person, and a person with a degenerative condition, is as entitled as anyone else to the protection of this presumption of capacity. The assessment is issue-specific and time specific. In due course, her capacity may deteriorate. Indeed that is likely to happen given her diagnosis. At this hearing, however, the local authority has failed to prove that KK lacks capacity to make decisions as to where she should live.”

This judgment provides important lessons for the approach to be taken to determining the functional limb of the capacity test with respect of an informal patient following discharge. It serves as an important reminder that assessors should not allow a professional view that it is best for the patient to remain as an inpatient influence a decision as to patient's capacity. The wisdom and practicable steps principles in s.1 MCA 2005 are designed to guard against this danger. Baker J's emphasis on the need to take such steps – in this case, identifying the full details of the domiciliary care package that would or might be available to KK – is extremely important. Nobody can make an informed decision without being made aware of the salient details and it will often be the assessor that is in the position of providing the person with those details.

Identifying the information relevant to a decision can be a somewhat subjective exercise, with a real danger of capacity assessments being conflated with the assessor's views on best interests and identifying the particular steps required will of course differ in each case. The court's decision in *LDV*, discussed above, provides useful guidance on this question. Baker J noted that this was a preliminary issue to be resolved when considering whether the second condition of a deprivation of liberty under Article 5 is satisfied, namely the subjective element - whether or not the person has validly consented to the confinement in question. He noted that:

“29. A supervisory body under the DOLS requested to authorise the detention of a person in circumstances that amount to a deprivation of liberty must assess whether the specific requirements in Schedule A1 are satisfied, including, inter alia, the ‘mental capacity’ requirement in paragraph 15 which provides: “the relevant person meets the mental capacity requirement if he lacks capacity in relation to the question whether or not he should be accommodated in the relevant hospital or care home for the purpose of being given a relevant care or treatment”. Although the court is not, strictly speaking, bound by the provisions of Schedule A1 when deciding whether or not to make an order depriving a person of his liberty, I accept the submission made on behalf of the Official Solicitor by Mr Ruck Keene that the appropriate course in these circumstances is for the court to approach the question as if it was considering the ‘mental capacity requirement’ under paragraph 15.”

Whilst Baker J noted that he did not wish to seek any sort of precedent either as to the process to be followed or the type of information which is likely to be relevant, but merely to assist the parties in the case before him (paragraph 38), he held that he considered, on the facts of the case clinicians and the court should ask whether LDV has capacity to understand, retain, use and weigh the following information (paragraph 39):

- (1) that she is in hospital to receive care and treatment for a mental disorder;
- (2) that the care and treatment will include varying levels of supervision (including supervision in the community), use of physical restraint and the prescription and administration of medication to control her mood;
- (3) that staff at the hospital will be entitled to carry out property and personal searches;
- (4) that she must seek permission of the nursing staff to leave the hospital, and, until the staff at the hospital decide otherwise, will only be allowed to leave under supervision;
- (5) that if she left the hospital without permission and without supervision, the staff would take steps to find and return her, including contacting the police.

Not least as this was the first case in which the Court has ever considered the components of capacity to decide upon admission as an informal psychiatric patient, we would suggest that each of these matters are likely to be a relevant considerations in any scenario wherever the assessor is considering whether the person has the capacity to consent to an informal admission to a psychiatric hospital in circumstances amounting to a deprivation of their liberty.³²

³² In *AM*, Charles J noted (at para 40) that the question of whether the relevant person has the capacity to consent to admission as an informal patient: “will be likely to include consideration of the person’s capacity to agree (a) to the relevant admission to hospital for the relevant purpose, (b) to stay in hospital whilst its purpose is carried out and (c) to the circumstances relating to a possible deprivation of liberty that will prevail during that admission.” He continued at para 41 that “it seems to me that whilst in theory distinctions between the elements of capacity described above could arise it is unlikely that they will do so with any regularity in practice. Also, it seems to me that it may well be difficult to assert that the person does not have the capacity to

2.3 Authorising a deprivation of liberty

If, following the approach outlined above, an assessor concludes that the informal patient is deprived of his or her liberty and lacks capacity to consent to that deprivation, then it is necessary to obtain authorisation for that deprivation. In this case study, we have assumed that the patient is no longer eligible to be detained as an objecting medical patient under the MHA 1983. Therefore, the MCA 2005 provides the only statutory basis for authorising the patient's deprivation of liberty. The best interests assessor will need to consider whether it is in the patient's best interests to be deprived of his liberty. In doing so, it will be important to remember that, under the MCA 2005 (and by contrast with the analogous position in respect of compulsory admission under the MHA 1983), a deprivation of liberty cannot be authorised solely in the interests of other people (for example, for public protection). The relevant consideration is whether such detention is in the best interests of P, in this case the informal patient, and (as part of this) whether such detention is a properly proportionate way in which to secure against P against harm to him.

It is important that any application for an authorisation under the MCA 2005 is made as soon as possible. It is clear following the *ZH* case discussed above that a deprivation of liberty can arise after only a relatively short period of time. In principle, an authorisation should be in place from the moment the patient is discharged. In a case, such as the *LDV* case, where it is likely that a patient will remain in hospital for a period of time after discharge, best practice would be for assessments to be carried out and any application for an authorisation under the MCA 2005 to be made prior to discharge. Although a person cannot simultaneously be detained in hospital under the MHA 1983 and subject to a deprivation of liberty authorisation under the MCA 2005, there is nothing to prevent a prospective application being made. This point was emphasised in the Department of Health's letter (referred to above),³³ which stated as follows:

“However, that is not to say that a person cannot (in effect) be discharged from one regime to the other. There is nothing to prevent a prospective application being made for an MCA DOLS authorisation in anticipation of, or the expectation that, the person concerned will be discharged from detention under the MHA. Paragraph 12(3) of Schedule A1 to the MCA says, in effect, that when deciding whether the qualifying requirements for an authorisation are met, it is the circumstances which are expected to apply at the time the authorisation is expected to come into effect which are to be considered.”

That approach was endorsed in the *DN* case itself, and provides an important way in which to ensure that decision-making does not take place on the fly.

Conclusion

One of the most troubling aspects of the outcome of the investigations into the events at Winterbourne View was the failure to consider whether the individuals were subject to a deprivation of liberty (let alone how and whether such deprivation of liberty could or should be authorised).³⁴ A lack of

consent to the assessment or treatment but does have the capacity to agree to be admitted to and remain in hospital in the relevant circumstances and for the relevant period, and so whilst the assessment is carried out or the treatment is given that requires the person to be an in-patient.”

³³ Reproduced in the Upper Tribunal judgment in *DN v Northumberland, Tyne and Wear NHS Foundation Trust* [2011] UKUT 327 (AAC) (Judge Jacobs).

³⁴ See the Serious Case Review conducted on behalf of South Gloucestershire Council, available at: <http://hosted.southglos.gov.uk/wv/report.pdf>. The Department of Health's response to the events at the Hospital provides that it will work with the CQC to agree how best to raise awareness of and ensure compliance with

appreciation as to the circumstances under which a deprivation of liberty is arising is also a theme which comes through strongly in the most recent CQC report on the DOLS regime,³⁵ as well as in the DoH's most recent report upon the IMCA service.³⁶

Even more damningly, in its post-legislative scrutiny of MHA 2007 published in August 2013,³⁷ the House of Commons Health Select Committee considered the deprivation of liberty safeguards, and found them profoundly wanting. Evidence was received from (inter alia) the Department of Health, the Care Quality Commission and the Mental Health Alliance, and the Committee concluded thus:

“106. The Committee found the evidence it received about the effective application of deprivation of liberty safeguards (DOLS) for people suffering from mental incapacity profoundly depressing and complacent. The Department itself described the variation as ‘extreme.’ People who suffer from lack of mental capacity are among the most vulnerable members of society and they are entitled to expect that their rights are properly and effectively protected. The fact is that despite fine words in legislation they are currently widely exposed to abuse because the controls which are supposed to protect them are woefully inadequate.

107. Against this background, the Committee recommends that the Department should initiate an urgent review of the implementation of DOLS for people suffering from mental incapacity and calls for this review to be presented to Parliament, within twelve months, together with an action plan to deliver early improvement.”

The lack of clarity about what constitutes a deprivation of liberty is deeply unfortunate, not least as it contributes to a serious lack of consistency when it comes to application of the DOLS safeguards in hospital settings as well as in care homes. In light of the cases discussed however, above, the excuses for ignorance as to the potential existence of a deprivation of liberty (and as to whether the service user has capacity to take relevant decisions) are becoming fewer.

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Deprivation of Liberty Safeguards (DOLS) provisions to protect individuals and their human rights and will report by Spring 2014: see

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127310/final-report.pdf. at paragraph 7.26.

³⁵ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127310/final-report.pdf.pdf,

³⁶ <https://www.gov.uk/government/publications/independent-mental-capacity-advocacy-service-fifth-annual-report--2>.

³⁷ <http://www.publications.parliament.uk/pa/cm201314/cmselect/cmhealth/584/584.pdf>.