



A: Introduction

1. The law governing the deprivation of a person's liberty in a hospital can be complex. In every case it involves (or should involve) consideration of the 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'). 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')).
2. These are questions that must be confronted by both healthcare bodies and local authorities, the latter as supervisory bodies considering applications for 'DOLS authorisations' (i.e. authorisations under Schedule A1 to the MCA 2005) in respect of patients deprived of their liberty in hospitals. Those procedures will change in due course with the coming into force of the Liberty Protection Safeguards, and this paper will be updated accordingly.
3. This paper, which is aimed at those working in hospital settings 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.
4. The cases that are discussed in this paper are all the subject of more detailed individual comments available at <http://www.copcasesonline.com/>, to which hyperlinks from case references here will direct; this paper draws upon some of those comments.

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Disclaimer: This discussion paper is based upon the law as it stands as at November 2019. This is not a substitute for legal advice upon the facts of any specific case. No liability is accepted for any adverse consequences of reliance upon it..

The picture at the top, "Colourful," is by Geoffrey Files, a young man with autism. We are very grateful to him and his family for permission to use his artwork.

B: When will a hospital patient be deprived of their liberty?

4. In general, a person will be deprived of their liberty for the purposes of Article 5(1) ECHR where: (1) they are confined to (subject to continuous supervision and control and not free to leave¹) a particular place for a non-negligible period of time; (2) they do not or cannot consent to that confinement; and (3) that confinement is imputable to the state. Practical guidance as to what a deprivation of liberty might look like in particular settings can be found in guidance commissioned from the Law Society by the Department of Health entitled: *Deprivation of Liberty: A Practical Guide* ("the Law Society Guidance").² Lawful authority is required to deprive someone of their liberty, most obviously (in the hospital or care home setting) through the Deprivation of Liberty Safeguards or (in a hospital) under the MHA 1983; in some cases, that authority will have to be sought through a court order.
5. However, the courts, up to and including the Supreme Court,³ have made clear the general principles set out above will not, in general, apply to arrangements made for the provision of immediately necessary life-sustaining medical treatment to a patient in hospital. This will be so even if (for instance) that patient is under continuous observation in an intensive care unit, unable to leave, and is incapable of consenting to the arrangements either because they are unconscious as a result of their illness or the effects of an accident, or because they have been sedated to secure the provision of life-saving treatment.
6. Further observations have been made by the courts following as to the circumstances when hospital patients will be considered to be deprived of their liberty.⁴ Taking these all together, it is suggested that the following key conditions must apply for the patient to fall outside the scope of Article 5 ECHR:
 - a. The patient must be in need of life-sustaining medical treatment, in other words, treatment without which they would die immediately or within a short space of time, or, as it was put by the Court of Appeal in *Briggs* "they are so unwell that they are at risk of

¹ The 'acid test' identified by the Supreme Court in *Cheshire West*.

² Co-written and edited by Alex and available at: <http://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty/>. Note, this guidance predated the case-law discussed here, and must be read subject to it.

³ The leading case being that of the Court of Appeal in *R (Ferreira) v HM Senior Coroner for Inner South London* [2017] EWCA Civ 31. The Supreme Court refused permission to appeal in *Ferreira*. In September 2019, Lady Arden (who had been a member of the Court of Appeal in *Ferreira* and subsequently been appointed to the Supreme Court) confirmed her view that "the situation where a person is taken into (in that case) an intensive care unit for the purpose of life-saving treatment and is unable to give their consent to their consequent loss of liberty, does not result in a deprivation of liberty for article 5 purposes so long as the loss of liberty is due to the need to provide care for them on an urgent basis because of their serious medical condition, is necessary and unavoidable, and results from circumstances beyond the state's control" (see *Re D (A Child)* [2019] UKSC 42, at paragraph 89.

⁴ The Court of Appeal in *Director of Legal Aid Casework & Ors v Briggs* [2017] EWCA Civ 1196; Peter Jackson J in *M v A Hospital* [2017] EWCOP 19; and Cobb J in *PL v Sutton CCG* [2017] EWCOP 22.

dying anywhere other than in hospital." This could include both treatment provided in the critical care setting where a person has been brought in the immediate aftermath of a serious accident and also the provision of clinically assisted nutrition and hydration;

- b. The treatment to be given to the patient, and the arrangements for the delivery of that treatment, should be "normal" life-saving treatment with no unusual features.⁵ We suggest that the easiest way to test this is to ask whether the treatment is materially identical to that which would be given if the patient were in a position capacitously to be able to consent to the treatment and those arrangements.
7. In light of the case-law summarised above, we further suggest that, in deciding whether any individual patient is deprived of their liberty, the following factors need to be considered:
- a. Is the patient in hospital primarily for purposes of assessing or treating mental disorder? If so, it is very likely that considerations of deprivation of liberty will arise, and, in particular, it will be necessary to examine with care whether (1) they are confined (which means being clear about what would happen if they actually tried to leave – for instance would the 'holding power' under s.5 MHA be invoked);⁶ and (2) they have capacity to consent to any confinement? The test for such capacity was set down by Baker J in Re LDV [2013] EWHC 272 (Fam). Note also that there are specific issues which will arise in relation to those who are physically present at hospital and who may be in need of assessment, but who have not yet been admitted as a patient. We address these further in Section C below;
 - b. Is the patient subject to a provision of the MHA 1983 but in a general hospital for purposes of receiving treatment for physical disorder (for instance, on s.17 MHA 1983 from a psychiatric hospital to the general hospital)? Again, it is very likely that considerations of deprivation of liberty will arise. The Court of Appeal in *Ferreira* gave as an example of a situation where an authorisation for deprivation of liberty would be required the case of NHS Trust I v G [2014] EWCOP 30, where a hospital considered that it might have to give obstetric care to a pregnant woman of unsound mind who objected to such treatment. Keehan J made an order authorising a deprivation of liberty and invasive medical treatment on a precautionary basis in respect of the woman, who was to be given s.17 MHA 1983 leave from the psychiatric hospital where she was detained to attend the general hospital to give birth. The pregnant woman in question was to be prevented from leaving the delivery suite and might be compelled to submit to invasive treatment, such as a Caesarean section. The treatment proposed in NHS Trust I v G was

⁵ The Court of Appeal in *Ferreira* rather unhelpfully talked in terms of the same treatment as that which would be delivered to a person without a mental impairment.

⁶ See also Chapter 5 of the Law Society Guidance.

materially different from that which would have been given to a patient of “sound” mind: accordingly, an authorisation of a deprivation of liberty was required;

- c. Are there specific contingency plans either (1) to prevent the patient leaving if, notwithstanding their need for life-sustaining treatment, they are physically capable of leaving; or (2) to prevent family members from removing them from the hospital? If there are, then this is a strong pointer towards the person’s situation being outside the ‘ordinary’ situation envisaged by the Court of Appeal. We should note in this regard that situations of delirium have not been looked at by the courts, and it may be that the steps that required to secure patients against harm arising in consequence of delirium may, in some cases, be sufficiently severe to take them outside the zone of “normal” life-saving treatment;
- d. Is the patient clinically fit for discharge? If the patient is clinically fit for discharge, but those concerned with their care consider that they cannot safely leave the hospital because arrangements for their return home (or, for instance, a move to a care home or nursing home) have not yet been put in place, this is again a strong pointer to their situation falling outside the situation envisaged by the Court of Appeal. It would, of course, be necessary in any such situation to determine whether the patient has the capacity to consent to remain in hospital; if they do, and do consent, there is no deprivation of liberty occurring. However, experience has shown that there are many individuals (often elderly, frequently with dementia) who have come into hospital to address the consequences of an accident or illness, and who are now, in essence, ‘placed’ on a longer-stay ward pending the making of suitable arrangements for them. We would strongly suggest that consideration needs in such cases to be given as to whether they are (1) confined; and (2) capable of consenting to their confinement;
- e. Is the patient receiving palliative care? The courts have not pronounced definitively upon the position of such patients, but by analogy with the position set out above, it is likely that considerations of deprivation of liberty will not be relevant where the patients are no longer physically able to leave the place where they are receiving that care, and there are no unusual/coercive features about the arrangements made for them. In *PL*, Cobb J noted that his provisional view was that a patient who had been moved to a hospital for purposes of having CANH withdrawn would not be deprived of their liberty as she would be “*in a state of very low cognition and possibly consciousness, receiving palliative care, as her life ebbs away,*”⁷
- f. Has the patient given advance consent to their confinement? An important consideration in relation to palliative care, in particular, is that it is likely (although this has not been tested yet before the courts) this that many patients will be able to give

⁷ *PL* at paragraph 79.

advance consent to any confinement to which they might be subject in due course as an aspect of advance care planning. If they have given such advance consent, then we suggest that it is legitimate to consider that this consent will survive their loss of capacity, unless their circumstances are dramatically different to those that they had envisaged.⁸ The same would also, logically, apply to a patient who is going into hospital for elective surgery under general anaesthetic, and, indeed, we suggest, implied into the process of giving consent to such surgery is consent to confinement in the immediate post-operative period, again, so long as the circumstances of that post-operative period are not dramatically different to those that had been envisaged;

- g. Is the patient under 18? In relation to children, there is a specific additional factor, namely the potential for a person with parental responsibility to give consent on their behalf to confinement, but only in relation to those under 16. In *D (A Child) (Deprivation of Liberty)* [2015] EWHC 922 (Fam), Keehan J held that the appropriate exercise of parental responsibility (by a true parent – i.e. not a statutory local authority parent) in respect of a child below the age of 16 would prevent circumstances in respect of hospital admissions which would in the case of an adult amount to a deprivation of liberty falling within the scope of Article 5 ECHR. The appropriate exercise of parental responsibility means, in particular, taking professional advice and not seeking to authorise restrictions going beyond ordinary acceptable parental restrictions. In *Re D (A Child)* [2019] UKSC 42, the Supreme Court held that, where the child turns 16, then even a ‘true’ parent cannot consent on behalf of their child. If the 16/17 year old is confined, and cannot consent, then authority will be required from a court (most likely the Court of Protection) unless they meet the criteria for admission under the Mental Health Act 1983. See further Section B below.
8. It is extremely important to note and understand the reason why the courts have sought to find a way in which to exclude – in general – arrangements for the delivery of physical health treatment from the scope of Article 5 ECHR. It is because they have, in essence, accepted that implementing the machinery of authorisation in such situations for no apparent policy reason constitutes a distraction from the core task of delivering care and treatment on the basis of the statutory framework set down at the ‘front end’ of the MCA⁹– i.e. either on the basis of the

⁸ The Department of Health has issued guidance that in relation to those in the last few weeks of life, “if an individual had capacity to consent to the arrangements for their care/treatment at the time of their admission or at a time before losing capacity, and did consent, the Department considers this consent to cover the period until death and that hence there is no deprivation of liberty.” <http://www.mentalcapacitylawandpolicy.org.uk/wp-content/uploads/2015/10/DH-Letter-to-MCA-DoLS-Leads-Oct-2015-FINAL.pdf>, paragraph 29.

⁹ For those aged 16 and above; similar principles apply in relation to children under 16: for a useful summary of the principles governing medical treatment in relation to children, see *Kings College Hospital NHS Trust v Takesha Thomas & Ors* [2018] EWHC 127 (Fam).

patient's capacitous consent, or on the basis of their best interests.¹⁰ Even if – indeed, especially if – questions of deprivation of liberty do not arise, it is all the more important that hospital staff are confident in and properly apply the concepts of capacity and best interests: as a start, we suggest that they have reference to our guides on both aspects, available [here](#).

9. For completeness, we should also note that, in addition to admission to hospital for treatment, it is possible that transporting a person to or from hospital for treatment may amount to a deprivation of liberty. The DOLS Code of Practice¹¹ states that there may be exceptional circumstances where taking a person to a hospital amounts to a deprivation of liberty, and suggests by way of example where it is necessary to do more than persuade or retrain the person for the purpose of the transportation or where the journey is exceptionally long. Again, the Law Society Guidance is instructive. It suggests that the following situations may give rise to a deprivation of liberty:¹²
- a. Where it is or may be necessary to arrange for the assistance of the police and/or other statutory services to gain entry into the person's home and assist in the removal of the person from their home and into the ambulance;
 - b. Where it is or may be necessary to do more than persuade or provide transient forcible physical restraint of the person during the transportation;
 - c. Where the person may have to be sedated for the purpose of transportation; or
 - d. Where the journey is exceptionally long.

C: The legal basis for depriving a patient of their liberty

10. 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. Hospitals¹³ have, in certain circumstances, powers to detain people under the MHA 1983 and the MCA 2005.¹⁴ Determining the appropriate

¹⁰ See in particular, *Ferreira* at paragraph 95.

¹¹ Paragraph 2.15

¹² Paragraph 4.14.

¹³ '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.

¹⁴ As amended by the Mental Health Act 2007.

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 outside the scope of the two statutory regimes. This question is considered in the second part of this section. We then address circumstances under which a deprivation of liberty will arise where the MHA 1983 cannot be considered.

11. Readers who find the next section unduly complex have our sympathy. We also regret that the coming into force of the Liberty Protection Safeguards will not materially alter the position legally, although they will alter the language used.¹⁵

The interface between the MHA 1983 and the MCA 2005

12. 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.
13. 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 detention or treatment decision.¹⁶ 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.
14. 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

¹⁵ For more details, see Alex's Liberty Protection Safeguards [resources page](#).

¹⁶ 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, and *Re JB* [2014] EWHC 342 (COP), a 'modern-day' Mr C. See generally the guide to capacity assessments produced by the Mental Capacity Law Newsletter editors and Nicola Kohn available [here](#).

exercised. People with learning disability, 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.¹⁷ Other examples are people in a vegetative state or anyone suffering from 'locked-in' syndrome, which prevents them from communicating, or a person who is temporarily unconscious, drunk or under the influence of drugs.

15. 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)ability to make a particular decision – whereas the MHA 1983 relates to a person's status, as someone 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.¹⁸ The MHA 1983, by contrast, contains no express 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 does not authorise¹⁹ anyone to give a patient medical treatment for mental disorder, nor authorise anyone to consent 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.

	Mental Health Act 1983	Mental Capacity Act 2005
Who	The non-compliant capacitated and non-compliant incapacitated. Inability or unwillingness of the patient who suffers from a mental disorder to consent to the relevant care and treatment.	The compliant incapacitated and the non-compliant incapacitated. Person who lacks capacity to make a relevant decision
Purpose	Compulsory care in hospital and medical treatment given to patient for mental disorder.	All decision-making

¹⁷ By virtue of the operation of ss.1(2A)(a) and (2B) MHA 1983. The association between the learning disability and the aggression/conduct is not required for admission under s.2 MHA.

¹⁸ Section 1(5) MCA 2005.

¹⁹ Section 28 MCA 2005.

Trigger	“Necessity test”: When it is necessary to protect patient or others from harm that patient receive care and treatment for mental disorder	“Best interests test”: Acts done or decisions made under the MCA on behalf of persons who lack capacity must be done in their best interests. Where person is to be deprived of their liberty under DOLS, test is “best interests plus” – i.e. in their best interests <u>and</u> necessary and proportionate to the risk of harm that they would suffer otherwise.
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Table 1: Key differences between MHA 1983 and MCA 2005

16. 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 would object to being admitted to hospital.

17. The area of overlap which causes the most difficulty is as regards the authorisation of deprivation of liberty of an individual in hospital. In certain cases, it may be necessary to decide whether to authorise a deprivation of liberty in a hospital setting under the MHA 1983 or the MCA 2005. Guidance on the interface between these regimes is available in Chapter 13 of the (English) Mental Health Act Code of Practice (“MHA Code”), issued in April 2015.²⁰ The remainder of this section sets out a series of questions which aim to provide a framework for determining which legal regime should be used to authorise any deprivation of liberty.²¹ The questions are drawn from the important judgment of Charles J in *AM v South London & Maudsley NHS Foundation Trust & Secretary of State for Health*,²² and the MHA Code.

(1) *Is the person suffering from a mental disorder for which they require assessment or treatment in a hospital?*

18. If the person is not suffering from a mental disorder for which they require assessment or treatment in a hospital (for example, they require treatment for a physical condition) then the MHA 1983 is not available to authorise any deprivation of liberty. If the person has capacity to consent to the proposed accommodation and treatment then such consent must be sought

²⁰ The Welsh Code of Practice, revised in 2016, also has a chapter 13 dealing with the same issues.

²¹ See also *Addressing the Conundrum: the MCA or the MHA*, an article by Oluwatoyin A Sorinmade, Alex Ruck Keene and Lisa Moylan, published in *Clinical Risk*, but available in a pre-publication version at <http://www.mentalcapacitylawandpolicy.org.uk/wp-content/uploads/2015/06/Addressing-the-Conundrum.pdf>.

²² [2013] UKUT 0365 (AAC).

from the individual. If the person lacks capacity to consent, any deprivation of liberty will need to be authorised under the MCA 2005 or such emergency powers of detention as may exist (about which see section 1.2.4 below).

19. Questions (2) and (3) proceed on the basis that a person is suffering from a mental disorder for which they require assessment or treatment in hospital.

(2) Does the person have capacity to consent to the proposed accommodation in hospital for care and/or treatment and to any of the treatment they will receive there for mental disorder?²³

20. If the person has capacity to consent to the proposed accommodation, then they are ineligible to be detained under the MCA 2005.

21. If they agree with capacity to being there, they may be admitted as a voluntary patient under section 131 MHA 1983. If they do not agree, they can be detained under the MHA if the 'necessity test' set by sections 2²⁴ and 3²⁵ MHA 1983 is met.

22. Question (3) assumes that a person is suffering from a mental disorder for which they require assessment or treatment in hospital and lack capacity to consent to the proposed accommodation and treatment in hospital.

(3) Is the person ineligible to be deprived of their liberty under the MCA 2005?²⁶

23. There are certain categories of person who are ineligible to be deprived of their liberty under the MCA 2005. 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.

24. 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.

²³ *AM v SLAM* at paragraph 39; MHA Code at paragraphs 13.53-13.55.

²⁴ I.e. the patient is suffering from mental disorder or a nature of degree which warrants the detention of the patient in a hospital for assessment (or for assessment by medical treatment) and he ought to be so detained in the interests of his own health and safety or with a view to the protection of other persons.

²⁵ I.e. the patient is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and it is necessary for the health or safety of the patient or for the protection of other persons that he should receive treatment and it cannot be provided unless he is detained under this section, and appropriate treatment is available.

²⁶ *AM v SLAM* at paragraph 45; MHA Code at paragraphs 13.56.

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25. 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 but who are not currently in a psychiatric hospital. 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.
26. The final category involves the scenario where a person is “within the scope” of the MHA 1983 but not detained under it. A person is within the scope of the MHA 1983 if he or she requires assessment or treatment for a mental disorder and “could” be detained under ss. 2 or 3 of the MHA 1983. 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. Pursuant to paragraph 5(1)(4) of Schedule 1A of the MCA 2005, a person who is within the scope of the MHA 1983 is ineligible to be detained under the MCA 2005 if he/she objects or would object (if able to) to being a mental health patient or to being given some or all of the mental health treatment.
27. The rationale behind this final category of ineligibility is set out 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):

“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.”

(4) *Choosing between the MHA 1983 and MCA 2005*

28. If a person is suffering from a mental disorder for which they require assessment or treatment in hospital and lacks capacity to consent to the proposed accommodation and treatment in hospital and is not ineligible to be detained under the MCA 2005 (see question (3) above), then decision-makers must determine which regime is more appropriate.
29. Guidance on the approach to take to this determination is found in the revised MHA Code of Practice (“the MHA Code”).²⁷ The MHA Code sets out factors that should feature in the decision-

²⁷ This is the English code, available at <https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983>. The Welsh Code is available at: gov.wales/docs/dhss/publications/160920mentalacten.pdf.

making process and states that the decision-maker should clearly record the reasons for the choice of legal regime.²⁸

30. The MHA Code begins by making the obvious, but nonetheless important, point that choice of legal regime should never be based on a general preference for one regime or the other, or because one regime is more familiar to the decision-maker than the other.²⁹ The key consideration should be whether one regime is generally less restrictive than the other.³⁰ It is emphasised that the MHA Code does not seek to preferentially orientate the decision-maker in any given direction and that a decision should always be made on the circumstances of each case.³¹ Underpinning this position is the assumption that both regimes provide appropriate procedural safeguards to ensure the rights of the person concerned are protected during their detention.³² The MHA Code acknowledges, however, that the nature of the safeguards provided under the two regimes are different. Thus, another factor that decision-makers need to take into account is which safeguards are most likely to best protect the interests of the patient.³³
31. Whilst each case must be decided on its fact, it is instructive to look to the case-law for further guidance.
32. The decision of Charles J in *AM v South London & Maudsley NHS Foundation Trust & Secretary of State for Health*³⁴ contains some useful guidance as to the approach which should be adopted where there is a choice between the MHA 1983 and the MCA 2005. Charles J³⁵ stated that if there is a choice between reliance on the MHA 1983 and the MCA 2005, the decision-maker must consider which is the least restrictive way of best achieving the proposed assessment or treatment. He emphasised 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 1983.³⁶ He continued:

"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

²⁸ MHA Code paragraph 13.60

²⁹ MHA Code paragraph 13.58.

³⁰ MAH Code paragraph 13.58

³¹ MHA Code paragraph 13.60.

³² MHA Code paragraph 13.59.

³³ MHA Code paragraph 13.59.

³⁴ [2013] UKUT 0365 (AAC); [2013] COPLR 510

³⁵ Charles J 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. However, he confirmed in *AM v SLAM* that 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 (i.e. ineligible).

³⁶ Para 72. Charles J there set out a list of considerations in relation to each regime which may point to which is the least restrictive in any given case.

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 [37] and paragraph 4.48 Deprivation of Liberty Safeguards Code of Practice [38]."

33. *Northamptonshire Healthcare NHS Foundation Trust v ML* [2014] EWCOP 2 involved a young man, ML, with a diagnosis of autism and a severe learning disability. The court concluded that it was in his best interests to be placed at Bestwood Hospital and to receive treatment there for 18 to 24 months, a placement strongly opposed by ML's parents. The NHS Trust sought declarations authorising the deprivation of liberty under the MCA 2005, in part as it was concerned that ML's mother and nearest relative might exercise her powers to discharge ML if he were admitted under section 3 MHA 1983. The Official Solicitor argued that the placement should be authorised under the MHA 1983, effectively arguing that the MHA 1983 has primacy where a person falls within the scope of the MHA (i.e. could be admitted under sections 2 or 3 MHA). This argument was rejected by Hayden J, but he did conclude that "it is clear that the magnetic north when contemplating the deprivation of liberty of those who fall within Case E [39] is likely

³⁷ Paragraph 4.46 has been reproduced in the 2015 MHA Code at paragraph 4.22 and provides: "[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."

³⁸ 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."

³⁹ Referring to Case E in the table set out at paragraph 2 of Schedule 1A of the MCA 2005, i.e. P is (a) within the scope of the Mental Health Act, but (b) not subject to any of the mental health regimes.

to remain the MHA⁴⁰ and determined that ML should be admitted to hospital under section 3 MHA 1983.

34. The MHA Code includes an ‘options grid’ summarising the availability of the MHA and the MCA to authorise a deprivation of liberty in a hospital setting.⁴¹ It is reproduced here for ease of reference:

	Individual objects to the proposed accommodation in a hospital for care and/or treatment; or to any of the treatment they will receive there for mental disorder	Individual does not object to the proposed accommodation in a hospital for care and/or treatment; or to any of the treatment they will receive there for a mental disorder
Individual has the capacity to consent to being accommodated in a hospital for care and/or treatment	<u>The non-compliant capacitated</u> <i>Only the MHA is available</i>	<u>The compliant capacitated</u> <i>The MHA is available Informal admission might be appropriate Neither DOLS authorisation nor CoP order available</i>
Individual lacks the capacity to consent to being accommodated in a hospital for care/and or treatment	<u>The non-compliant incapacitated</u> <i>Only the MHA is available</i>	<u>The compliant incapacitated</u> <i>The MHA is available DOLs authorisation under the MCA or potentially order of CoP</i>

Table 2: Options grid summarising availability of the MHA 1983 and MCA 2005 to authorise a deprivation of liberty in hospital

35. 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 section 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

⁴⁰ Paragraph 76.

⁴¹ MHA Code at page 106.

to the likelihood of the person suffering harm, and the seriousness of that harm.⁴² 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*.⁴³ 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 action is to seek a decision from the Court of Protection: *Hillingdon London Borough Council v Neary*.⁴⁴

The inherent jurisdiction

36. The inherent jurisdiction can still be used to authorise a deprivation of a liberty of an adult falling outside the scope of the MCA 2005, and has been invoked to authorise the detention of a person falling between (or outside) the two regimes provided for under the MHA 1983 and the MCA 2005.
37. In *A NHS Trust v Dr A* [2013] EWHC 2442 (COP), Baker J considered the situation of a Dr A, who was on a hunger strike and who was considered (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. Dr A was 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 consequence⁴⁵ Dr A could not be force-fed under the provisions of the MHA 1983; 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,⁴⁶ it was "*alarming to find that the legal position on this fundamental issue is far from straightforward.*"
38. Baker J's decision in *A NHS Trust v A* was referred to by Keehan J in *NHS Trusts 1 and 2 v FG* [2014] EWCOP 30. Giving guidance on the steps which should be taken when dealing with a pregnant woman who has mental health problems and potentially lacks capacity to make decisions about her medical treatment, Keehan J stated that in circumstances where a P's liberty may be deprived to facilitate her obstetric care but P ineligible to be deprived of her liberty

⁴² Paragraph 16 of Schedule A1.

⁴³ [2011] EWHC 2675 (COP) [2012] COPLR 1, at paragraph 64.

⁴⁴ [2011] EWHC 1377 (COP) [2011] COPLR Con Vol 632.

⁴⁵ *B v. Croydon Health Authority* [1995] (Fam) 133 and *R v Collins ex parte Brady* [2000] Lloyd's Rep Med 355.

⁴⁶ Paragraph 55.

under the MCA 2005, the High Court will be able to exercise its inherent jurisdiction to authorise P's deprivation of liberty.⁴⁷

39. We also suggest where (as is not uncommon) there is disagreement as to whether a person is or is not eligible for a DOLS authorisation that:

1. the question of whether a person is, or is not eligible to be deprived of their liberty under the DOLS regime ultimately affords of a single answer and that – in the event of a dispute – the arbiter is the Court of Protection;
2. One would expect that either the AMHP or the BIA – as the case may be – would follow the determination by a Court of Protection judge on the question of eligibility. It would, though, be possible to seek judicial review of an AMHP's decision not to make an application for admission under the MHA 1983;⁴⁸ it would also – we suggest – be possible to seek a judicial review of a BIA's decision not to recommend the grant of an authorisation;⁴⁹
3. In the event of a true 'stand-off,' the High Court could authorise a deprivation of liberty under its inherent jurisdiction until such point as the question of the person's eligibility was resolved. However, it is important to note that there are advantages to the person if the DOLS regime is chosen on a 'provisional' basis and the supervisory body immediately brings a s.21A MCA 2005 to the Court of Protection for determination of the question – in particular, the person will get the benefit of non-means-tested legal aid and hence of representation.

Unconscious patients

40. In light of the case-law summarised above it is unlikely that questions relating to the deprivation of liberty of an unconscious patient (or one in MCS/VS) is likely only to arise very rarely. It is just conceivable that such a patient may be at such risk of being removed from the hospital by family or friends that the hospital has in place a specific contingency plan to prevent such taking place. However, even in such a case, the tenor of the judgment of the Court of Appeal in *Briggs* is that such a case should be looked at through the prism of a welfare dispute (to be resolved by way of an application to the Court of Protection under ss.15/6 MCA 2005) rather than deprivation of liberty.

41. In any event, it is likely that such a case would have to go to court for purposes of authorising the deprivation of the patient's liberty. The Department of Health has made clear that they do

⁴⁷ Paragraphs 127 to 128.

⁴⁸ See *Surrey County Council v MB* [2007] EWHC 3085 (Fam).

⁴⁹ That judicial review would, most probably, have to be against the local authority employing the BIA.

not consider that 'unconsciousness' constitutes a 'mental disorder',⁵⁰ for purposes of the mental health requirement that must be satisfied before a DOLS authorisation can be granted. This would suggest that authority for the deprivation of liberty of such a patient must (if it is to be sought anywhere) be sought from the Court of Protection. At that point, the question of whether unconsciousness can constitute 'unsoundness of mind' for purposes of Article 5(1)(e) ECHR will have to be addressed by the courts. In the admissibility decision in *RB v United Kingdom*,⁵¹ the European Court of Human Rights conflated lacking capacity to consent to confinement with being of unsound mind for purposes of Article 5(1)(e). Although this was not the fruit of rigorous analysis, as this was not in issue before the court, this stands as support for the proposition that the impairment of the mind or brain inherent in being unconscious or in an MCS or VS would suffice as a basis to justify a deprivation of liberty under Article 5(1)(e).

Those under 18

42. If the situation of a child under 16 amounts to a confinement to which a person with parental responsibility does not or cannot consent (see further paragraph 10 above), such deprivation of liberty will have to be authorised. It may be that a child will suffer from a mental disorder sufficient to bring it within the MHA 1983 (there being no minimum age for detention under the MHA 1983).
43. A young person aged 16 and over may (depending upon the circumstances) fall within the scope of the MCA 2005, albeit that any deprivation of their liberty could not be authorised by way of a DOLS authorisation, as such authorisations can only be granted in respect of those aged 18 and over. The authorisation would therefore have to be sought from the court. The High Court also has the power under its inherent jurisdiction to authorise the deprivation of liberty of a child under 18,⁵² but it suggested that it is more likely to be appropriate to go to the Court of Protection in respect of a child aged 16/17 lacking capacity, especially if there is any suggestion that the deprivation of liberty would be likely to continue past the child's 18th birthday.
44. The same considerations as set out above will apply in relation to children who are unconscious or in a VS or MCS.

⁵⁰ See the letter from Niall Fry dated 14 January 2015, available at <http://www.mentalcapacitylawandpolicy.org.uk/wp-content/uploads/2014/04/DH-Letter-to-MCA-DoLS-Leads-14-January-2015-FINAL.pdf>

⁵¹ Admissibility decision of 12 September 2017, Application no. 6406/15, at paragraph 37.

⁵² *Re W (A Minor: Medical Treatment: Court's Jurisdiction)* [1993] Fam 64; *Re C (Detention: Medical Treatment)* [1997] 2 FLR 180. If the unit in the hospital in question constitutes secure accommodation falling within the scope of s.25 Children Act 1989, the procedures and prerequisites set down there would apply.

C: Emergency situations

45. We note, finally, a gap in the current legislative framework. Although it is possible to 'hold' a patient in hospital using the powers in s.5 MHA 1983 on a short-term basis pending assessment for purposes of admission under the MHA 1983, these powers only apply to those who are actually admitted as in-patient. They do not apply to people physically present at the hospital but not yet admitted – most obviously those in A&E. It is far from uncommon for staff to consider that such patients need to be prevented from leaving temporarily pending assessment for admission under the MHA 1983. Although less likely,⁵³ it is also possible that staff may consider that it is necessary to ensure that they do not leave pending assessment of their physical health needs and whether they have capacity to consent or refuse treatment for those needs.

46. The Divisional Court in *Sessay*⁵⁴ held that:

- a. Hospitals could not rely upon the defence of necessity where a person was being prevented from leaving hospital pending completion of the process of assessment for admission under the MHA 1983; but that
- b. In the ordinary course of events, and so long as there was no undue delay, a person could be held for up to 8 hours without it amounting to a deprivation of their liberty or false imprisonment.

47. In *ZH*,⁵⁵ decided after *Sessay*, the Court of Appeal held that:

- a. The doctrine of necessity does not apply where s.5 MCA applies – in other words, where steps are being taken on the basis of a reasonable belief in the person's lack of capacity to consent and reasonable belief that they are in the best interest of the person;
- b. A deprivation of liberty can arise in a short space of time – in that case, around 40 minutes of intense restraint of a young man with autism.

48. A combination of *Sessay* and *ZH* means that hospital staff are potentially placed in a very difficult situation where they consider that they have to restrain a patient from leaving. This situation will be remedied with the coming into force of the Mental Capacity (Amendment) Act 2019, which will provide (in s.4B) an emergency authority to deprive a person of their liberty subject to specific conditions.

⁵³ Especially if the patient is being given immediately necessary life-saving treatment and falls within the '*Ferreira* exception' outlined above.

⁵⁴ *R (Sessay) v South London and Maudsley NHS Foundation Trust and another* [2011] EWHC 2617 (QB) [2012] QB 760.

⁵⁵ [2013] EWCA Civ 69.

49. In the interim, we suggest that the following represents the best (albeit unsatisfactory) way of proceeding:

Where the person is being held for purposes of assessing for admission under the MHA 1983

- a. Move as quickly as possible to undertake the assessment, including, potentially, invoking s.4 MHA 1983 (which allows admission on the basis of one medical recommendation alone where obtaining a second would cause unreasonable delay);
- b. Take only such steps as are strictly necessary and proportionate to prevent the person leaving the hospital, and document such steps, contemporaneously if possible;
- c. Consider calling the police to use their powers under s.136 MHA 1983, especially if there is any prospect that the assessment process is going to last longer than 8 hours. These powers can be deployed in A&E. However, before involving the police, it is important to have regard to what will be the least distressing way to secure the continued presence of the patient – police involvement may well escalate the situation;

Where the person is being held for purposes of securing their physical health

- d. Assess whether they have capacity to decide to remain at the hospital, bearing in mind that the test is whether there is a reasonable belief, calibrated to the gravity of the decision and the urgency with which it needs to be taken;
- e. Take only steps as are strictly necessary and proportionate to prevent the person leaving the hospital. Document such steps, contemporaneously if possible. Although it is likely that the steps will go beyond mere restraint, which is protected by s.6 MCA 2005, and may, technically, constitute a deprivation of the person's liberty, courts/regulatory bodies will be more concerned to see the calibration of the steps taken to the risk of harm the person would suffer otherwise;⁵⁶
- f. Hold an 'after-action' meeting after the situation has resolved to identify whether any different steps could have been taken;

Prevention of risk of harm to others

- g. If, in either situation, there is a real and immediate risk of serious harm to another person, we suggest that necessary and proportionate steps can and should be taken to secure

⁵⁶ See, by analogy, *Bostridge v Oxleas NHS Foundation* [2015] EWCA Civ 79

against that risk whilst steps are taken to identify the relevant legal framework that should be used to deprive the individual of their liberty;⁵⁷

50. In all three cases, we suggest that an 'after-action' meeting after is held the situation has resolved to identify whether any different steps could have been taken and/or whether any steps can be taken to secure quicker assessment under a relevant framework in future.

D: Useful resources

51. Useful free websites include:

- www.39essex.com/resources-and-training/mental-capacity-law – database of guidance notes (including as to capacity assessment) case summaries and case comments from the monthly 39 Essex Chambers Mental Capacity Law Report, to which a free subscription can be obtained by emailing marketing@39essex.com.
- www.courtofprotectionhandbook.com – website accompanying the Legal Action Group's *Court of Protection Handbook*, including Rules, Practice Directions, precedents and procedural updates
- www.mclap.org.uk – website set up by Alex with forums, papers and other. resources with a view to enabling professionals of all hues to 'do' the MCA 2005 better.
- www.mentalhealthlawonline.co.uk – extensive site containing legislation, case transcripts and other useful material relating to both the Mental Capacity Act 2005 and Mental Health Act 1983. It has transcripts for more Court of Protection cases than any other site (including subscription-only sites), as well as an extremely useful discussion list.
- www.scie.org.uk/mca-directory/ - the Social Care Institute of Excellence database of materials relating to the MCA.

52. Other useful materials relating to the *Cheshire West* decision can be found in Chapter 11 of [Deprivation of Liberty: a Practical Guide](#), commissioned from the Law Society by the Department of Health, to which both Alex and Neil contributed. It is important to note that this guide predated the decision in *Ferreira* and the others cases described above, so must be read subject to those cases.

⁵⁷ See, for instance, *Munjaz v Mersey Care National Health Service Trust & Ors* [2003] EWCA Civ 1036 at para 46 per Lady Justice Hale: "[t]here is a general power to take such steps as are reasonably necessary and proportionate to protect others from the immediate risk of significant harm."

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