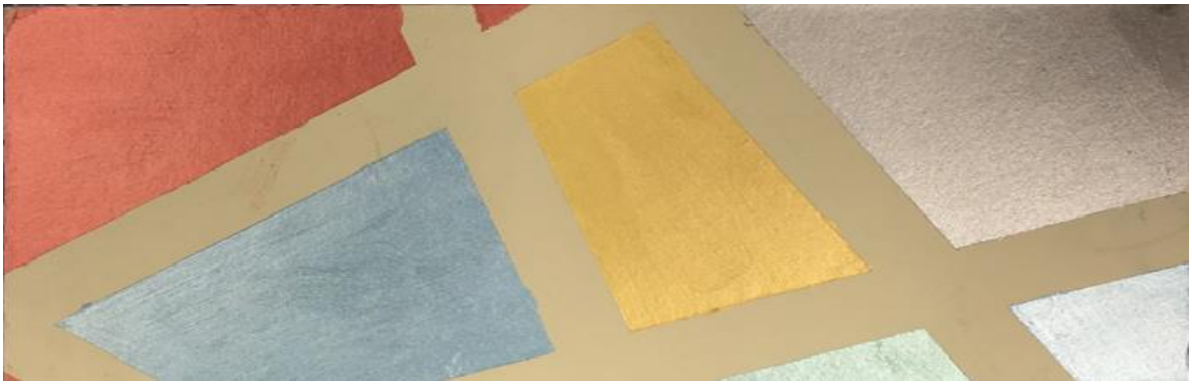
Essex CHAMBERS

MENTAL CAPACITY REPORT:
HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

February 2019 | Issue 91



Welcome to the February 2019 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: a personal view on the Mental Capacity (Amendment) Bill from Tor, damages where the MCA has gone awry and the Supreme Court on the MHA in the community;

(2) In the Property and Affairs Report: neglect and attorneys, a speedy (and sensitive) statutory will and attorneys as personal representatives;

(3) In the Practice and Procedure Report: a challenging decision on the inherent jurisdiction, CoP statistics and guidance on anonymisation;

(4) In the Wider Context Report: the Code of Practice is being revised, guidance on CANH and the Mental Capacity Action Day looms;

(5) In the Scotland Report: a welcome change to guidance in relation to voter registration, and the death of the former Director of the Mental Welfare Commission.

Last, but very much not least, her fellow editors invite you to join in congratulating Tor on her appointment as Queen's Counsel.

You can find all our past issues, our case summaries, and more on our dedicated sub-site here.

Editors
Alex Ruck Keene
Victoria Butler-Cole
Neil Allen
Annabel Lee
Nicola Kohn
Katie Scott
Katherine Barnes
Simon Edwards (P&A)

Scottish Contributors
Adrian Ward
Jill Stavert

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.

Contents

Mental Capacity (Amendment) Bill – a personal view

The government continues to plough ahead with the MCA Amendment Bill (Report Stage and Third Reading being on 12 February) despite near-universal alarm about the weakening of crucial safeguards and non-compliance with the requirements of Article 5. The hashtag #DolsRights on Twitter is being used to collect stories about the benefits of DOLS and successful outcomes, both at court and during the DOLS assessment process, to contradict the claims made, without evidence, that DOLS benefits barely any of the people to whom it applies, and to show how significant the benefits actually are to the individuals concerned. Readers are encouraged to join in with examples from their own experience.

The latest version of the Bill is available here, and the revised Impact Assessment here. Proposed Government amendments for Third Reading which go some way to addressing a few of the concerns raised are summarised by Tim Spencer-Lane thus:

1. An independent hospital cannot be a responsible body – in cases involving deprivation of liberty in an independent hospital, the responsible body in England is the local authority meeting the person's needs or in whose area the hospital is situated, or in Wales the Local Health Board;
2. A duty on responsible bodies to publish information about authorisations and to take steps at the outset of the authorisation process to ensure that the person and appropriate persons understand the process.
3. A regulation-making power to allow Government to set out requirements which must be met for a person to make a determination or carry out an assessment, such as the required knowledge and experience.
4. To require that where a variation is to be made to the authorisation, a review must be carried out first, or if that is not practicable or appropriate, it must be carried out as soon as possible after variation.
5. A new duty to carry out a review if a relevant person makes a request – and a power in such cases to refer the authorisation to the AMCP.

The remaining problems include the following – and there is now not much time to get them fixed) before the Bill is finally approved.

- The statutory definition, which is inevitably going to lead, very swiftly, to further litigation as the courts are asked to interpret it in a way that is compliant with Article 5;
- The absence of any mechanism to challenge emergency detention, which at present could continue without time limit and without access to non-means-tested legal aid;
- The new scheme removes the entitlement to advocacy services specifically aimed at assisting a person who is deprived of their liberty to challenge that in court;
- Too much scope for those with power to decide that scrutiny or advocacy are not required – an AMCP gets to decide whether to accept a referral in some cases; advocates are only appointed for 'unbefriended' people if that is thought to be in their best interests, despite access to the court under Article 5(4) not being a best interests issue. Puzzlingly, in an open letter to Inclusion London, the government suggested that the latter provision is in place because it would be wrong to appoint an IMCA where someone was expressly objecting to having one. Given that (a) the person concerned is, by definition, unlikely to have a complete grasp of the role of an IMCA and the circumstances surrounding their care, and (b) any IMCA appointed could take an independent decision about what level of support to offer the cared-for person, the Government's objection is difficult to understand, not least when one thinks about the much more serious consequence to a person who needs an IMCA but is not given one as a result of this provision.
- Continued over-reliance on the cared-for person expressing an objection to trigger safeguards, when many of those concerned will not be able to express any informed view and where their behaviour may be conveniently viewed as 'part of their condition' rather than something that means further scrutiny of their care arrangements is required.
- The position of 16/17 year olds and the interaction with other statutory frameworks.

Tor Butler-Cole

Giving the MCA teeth

Esegbona v King's College NHS Trust [2019] EWHC 77 (QB) High Court (Queen's Bench Division) (HHJ Coe QC)

Other proceedings – civil

Summary[1]

This case concerned a disastrous failure to follow the principles of the MCA in relation to the discharge from hospital of a seriously ill 68 year old woman. Mrs Esegbona was admitted to hospital from A&E and required repeated admissions to intensive care due to a range of

[1] Note, Katie Scott having been instructed in this case, she has not been involved in preparing this note.

health problems. By the time she was able to be discharged, she had a tracheostomy and required a high level of nursing care such that she was deemed eligible for NHS Continuing Healthcare. She was not compliant with the tracheostomy and there were repeated incidents where she dislodged or removed it. A nursing home placement was found, but fell through due to the unpredictability of her presentation. Eventually a second nursing home was identified, and Mrs Esegbona was discharged there, around 4 months after being medically fit for discharge, and 8 months after being admitted. She died around 10 days later, having removed the tracheostomy tube and suffered a cardiac arrest.

The claim[2] was brought by Mrs Esegbona's daughter alleging negligence by failing to pass on information to the nursing home about the risk of the tracheostomy tube falling out or being removed on purpose and difficulties with obstruction of the tube, and false imprisonment for the period after Mrs Esegbona was fit for discharge and wanted to return home but remained in hospital.

In light of expert evidence that had been obtained by both sides, there was no disagreement that a failure to pass on information about the tracheostomy tube to the nursing home would have been negligent. It was also conceded by the Trust that there had been a period of false imprisonment, when a DOLS authorisation should have been in place. The issues that were disputed, were these:

Was it a breach of duty not to tell the nursing home that Mrs Esegbona had wanted to go home and did not want to be in the nursing home? The court decided that it was.

- Did the failure to pass on information about the tracheostomy and Mrs Esegbona's wishes materially increase the risk of her dying in the manner and environment that she did (albeit it could not be said on the balance of probabilities that she would have lived but for these failures)? The court held that causation was established, relying on findings that she had removed the tracheostomy tube deliberately when in hospital, that this had not been passed on but if it had, she would have been provided with 1:1 care at all times, and that her eventual death was due to a deliberate removal of the tube (contrary to the findings at the inquest into her death).

- The appropriate level of damages for the period of false imprisonment. The court awarded £130 a day (i.e. a total of £15,470), concluding that if the MCA processes had been followed correctly, Mrs Esegbona would either have been discharged home with a package of care or to a nursing home.

- Whether aggravated damages should be awarded in light of the alleged deliberate exclusion of the family in the decision-making process; the fact that the detention occupied the last months of Mrs Esegbona's life; and that the defendant failed to act upon the clear advice of its own psychiatrist about the need for a capacity assessment and a best interests meeting. The court awarded

[2] Which was not a Human Rights Act claim, possibly because the limitation period had expired.

£5,000 in aggravated damages.

Comment

There are a number of surprising findings in this case, including that it is the treating NHS Trust which is responsible for deciding where a patient should be discharged to, rather than the CCG with responsibility for community services pursuant to the NHS Continuing Healthcare Framework, and that it would only have taken a month to fully investigate and decide whether Mrs Esegbona could safely return home with a package of care instead of being admitted to a nursing home.

The case is perhaps best explained by the failure to follow the MCA promptly, even when the need for capacity and best interests assessments were flagged up, and a breakdown in communication with the family which led to entries in the medical records noting that information should be withheld from them and the discharge to the nursing home effected without them being able to have a say in what happened. The cumulative effects of the failings were clearly such as to lead the Trust to concede that Mrs Esegbona was falsely imprisoned. They were clearly right to do so in circumstances where the judge said:

> *The defendant made its decision and was determined to implement it without the family's involvement…I find that that behaviour falls squarely within the definition of "high-handed" and "oppressive". Taken together with the additional features in this case of the defendant's failure to follow the advice of its own psychiatrist on three occasions and their failure to call any evidence in this case to explain the tenor of the notes, I find that it is appropriate to make an award of aggravated damages.*

The events complained of took place in 2010 and 2011 – no doubt some 9 years later, we would like to hope the integration of MCA and the DOLS processes with discharge planning is more effectively embedded into hospital Trusts.

We note, finally, that whilst the case is undoubtedly important as a decision where the court has actually assessed damages for itself (rather than endorsing an agreement), the way in which the case unfolded leaves some questions open. In particular, given that the claim was expressly framed as a common law claim for false imprisonment, rather than an HRA claim for unlawful deprivation of liberty, it will not stand as a direct precedent for the award of damages in such a HRA claim, and we are still reliant in such claims on reading the runes from settlements such as that in the 'Fluffy' case.

The thinnest of legal ice – restricting contact and the MCA

SR v A Local Authority [2018] EWCOP 36 (HHJ Buckingham)

Best interests – contact

Summary

A couple had been married for 58 years, and were devoted to each other. The wife developed dementia. She initially attended a day care centre whilst living at home, but in November 2016 the decision was then taken by the local authority that she should remain at a care home, in part because of risks perceived by professionals arising from the husband's expressed view on euthanasia. She was made

the subject of a DOLS authorisation at that point. Her family objected to her continuing placement at the current placement and wished for her to return home. The woman was reported to have frequently expressed a wish to be with her husband. Attempts to mediate with the family proved abortive, and "*the process of seeking to resolve issues surrounding* [the woman's] *residence and contact, without recourse to the court,* [was] *elongated*." In May 2017, the local authority imposed a restriction on the husband's ability to take his wife away from the placement unaccompanied. No application was made by the local authority either in relation to restricting contact or in relation to the question of where the woman should live; but ultimately the woman's RPR made a s.21A application. Notwithstanding the absence of authority to restrict contact, the husband complied with the restriction imposed save for a day when there had been a bereavement at the care home and a considerable degree of upset in the home in consequence from which the husband had decided to remove his wife temporarily. The care home alerted the police and it appears that armed police were called in consequence.

In the s.21A proceedings, the local authority applied orally for orders restricting contact between the woman and her husband, so as to prevent him taking her out of the care home where she resided unless accompanied by a member of staff or relative. The basis for this application were the local authority's concerns about the husband's expressed views about euthanasia. The court directed that the local authority file a schedule of findings and supporting evidence relied upon to justify the imposition of the restriction sought.

HHJ Buckingham then undertook a detailed examination of the comments made by the husband, noting that he was a man who held and expressed forthright views about matters, restating his support for euthanasia at a best interests meeting in April 2018 and in court. However:

> *44. Whilst I accept that JR's comments have given rise to legitimate anxiety on the part of the professionals, I do not consider that there was adequate investigation into the reasons why JR has made such comments and what he understands by the notion of supporting euthanasia, which from his evidence related to the right to self-determination and dignity. I consider that JR's intransigence at times as relations with professionals became increasingly strained may also not have assisted constructive enquiry and resolution of issues.*
>
> *45. At times JR's evidence was contradictory. He lacks insight to appreciate fully the reasons why his remarks cause such consternation. However, he was consistent that he would never dream of hurting his wife. Is it safe for the court to take that assertion at face value in the light of his expressed views and comments, some of which have been unpalatable? I take note of the fact that following the first comments in August 2016, SR returned home to live with JR until 9th November 2016. Between 9th November 2016 and 27th May 2017, extensive unsupervised contact took place within the care home and outside the care home. To date, JR remains alone with SR for approximately two hours per evening in a closed room. SR has remained safe and subject of devoted affection and attention from her*

> *husband.*
>
> *46. I have reached the conclusion that the restriction sought by A Local Authority is neither justifiable, proportionate or necessary. JR will need to have regard to his wife's settled routines and what is in her best interests when considering how he would wish to revert to more relaxed contact with his wife. He will need to communicate openly with the professionals about proposed contact arrangements and contingency plans, should SR become upset or agitated or behave in an unpredictable way in his sole care. JR and professionals will need to ensure that he is alert to what situations may arise and how best to deal with them. JR will also need to have continuing regard to his own health and how that impacts upon his ability to provide safe care for SR as well as his driving competence.*

Comment

It was, as HHJ Buckingham put it:

> *regrettable that tensions and dispute between professionals and the family have been building up since at least January 2017 over the care and contact arrangements for SR. When it became clear that the family did not support the care or contact arrangements, the matter should have been referred to the court.*

Although overlain with the particularly emotive issue of views about euthanasia, this case is in many ways sadly not unusual. It highlights, or should highlight, the thinness of the legal ice afforded to public bodies seeking to restrict contact without the authority of the court given the clear interference with the Article 8 rights of the woman (and her husband).[3] Although "*Article 8 of the Convention contains no explicit procedural requirements, the decision-making process involved in measures of interference must be fair and such as to ensure due respect of the interests safeguarded by Article 8," very serious limitations of private and family life calling for strict scrutiny (see, amongst others, AN v Lithuania [2016] ECHR 462). The Supreme Court in NHS Trust v Y* [2018] UKSC 46*considered that s.5 MCA 2005 could in principle provide a sufficiently robust basis upon which decisions in relation to life-sustaining treatment could be constructed without the need for automatic recourse to the court, where there is agreement as to what is in the best interests of the person. This suggests that, if restriction on contact could be levered into the definition of an act in connection with care and treatment, s.5 MCA 2005 could, in principle, provide a basis upon which contact could be restricted without incurring liability. However, the quid pro quo must be that "[i]f, at the end of the […] process, it is apparent that the way forward is finely balanced, or there is a difference of* [professional] *opinion, or a lack of agreement to a proposed course of action from those with an interest in the* [person's] *welfare, a court application can and should be made*" (Lady Black in *An NHS Trust v Y*).

[3] As had been flagged by the Law Commission in its Mental Capacity and Deprivation of Liberty report in its proposals in relation to s.5 MCA. The Government's approach to these issues is explained here.

The Supreme Court and the MHA in the community (1) conditional discharge

Secretary of State for Justice v MM [2018] UKSC 60 Supreme Court (Lady Hale, President; Kerr, Hughes, Black and Lloyd-Jones SCJJ)

Article 5 – Deprivation of liberty

Summary

The Supreme Court (Lord Hughes dissenting) has upheld the ruling of the Court of Appeal that neither the Secretary of the State nor the Mental Health Tribunal has the power to impose conditions on the discharge of a restricted patient which would amount objectively to a deprivation of the patient's liberty.

The parameters of the problem are clearly defined: the patient, MM, "*is anxious to get out of hospital and is willing to consent to a very restrictive regime in the community in order that this can happen. The Secretary of State argues that this is not legally permissible*." It was agreed that MM had capacity to consent to the restrictions, which undoubtedly satisfied the 'acid test' set down in *Cheshire West*.

As Lady Hale (for the majority) noted (at paragraph 24) that:

> *It is, of course, an irony, not lost on the judges who have decided these cases, that the Secretary of State for Justice is relying on the protection of liberty in article 5 in support of an argument that the patient should remain detained in conditions of greater security than would be the case were he to be conditionally discharged into the community.*

However, Lady Hale considered that there were three key reasons why MM could not consent to conditions amounting to confinement.

The first was one of high principle. As the power to deprive a person of his liberty is by definition an interference with his fundamental right to liberty of the person, it engaged the rule of statutory construction known as the principle of legality, as explained by Lord Hoffmann in *R v Secretary of State for the Home Department, Ex p Simms* [2000] 2 AC 115, at 131:

> *… the principle of legality means that Parliament must squarely confront what it is doing and accept the political cost. Fundamental rights cannot be overridden by general or ambiguous words. This is because there is too great a risk that the full implications of their unqualified meaning may have passed unnoticed in the democratic process. In the absence of express language or necessary implication to the contrary, the courts therefore presume that even the most general words were intended to be subject to the basic rights of the individual.*

Lady Hale took the view that Parliament had not been asked – as they would have to have been – as to whether the relevant provisions of the MHA:

> *Included a power to impose a different form of detention from that provided for in the MHA, without any equivalent of the prescribed criteria for detention in a hospital, let alone any of the prescribed procedural safeguards. While it could be suggested that the FtT process is its own safeguard, the same is not the case with the Secretary of State, who is in a position to impose whatever conditions he sees fit.* (paragraph 31)

The second was one of practicality. The MHA confers no coercive powers over conditionally

discharged patients; as Lady Hale noted (although many may not realise): "*[b]reach of the conditions is not a criminal offence. It is not even an automatic ground for recall to hospital, although it may well lead to this.*" The patient could therefore:

> *… withdraw his consent to the deprivation at any time and demand to be released. It is possible to bind oneself contractually not to revoke consent to a temporary deprivation of liberty: the best-known examples are the passenger on a ferry to a defined destination in Robinson v Balmain New Ferry Co Ltd [1910] AC 295 and the miner going down the mine for a defined shift in Herd v Weardale Steel, Coal and Coke Co Ltd [1915] AC 67. But that is not the situation here: there is no contract by which the patient is bound.* (paragraph 32).

That led on to what Lady Hale identified as the third and most compelling reason, namely that she considered that to allow a person to consent to their confinement on conditional discharge would be contrary to the whole scheme of the MHA. The MHA provided in detail for only two forms of detention (1) in a place of safety; and (2) in hospital. Those were accompanied by specific powers of conveyance and detention, which were lacking in relation to conditionally discharged patients – "*[i]f the MHA had contemplated that such a patient could be detained, it is inconceivable that equivalent provision would not have been made for that purpose*" (paragraph 34). There was, further, no equivalent to the concept of being absent without leave to that applicable where a patient is on s.17 leave, it again being "*inconceivable*" that "*if the MHA had contemplated that he might be detained as a condition of his discharge […] that it would not have applied the same regime to such a patient as it applies to a patient granted leave of absence under section 17*" (paragraph 36). Finally, the ability of a conditionally discharged patient to apply to the tribunal is more limited than that of a patient in hospital (or on s.17 leave), this being *"[a]t the very least, this is an indication that it was not thought that such patients required the same degree of protection as did those deprived of their liberty; and this again is an indication that it was not contemplated that they could be deprived of their liberty by the imposition of conditions."*

Lord Hughes, dissenting, took as his starting proposition that what was in question was not the removal of liberty from someone who is unrestrained. Rather:

> *The restricted patient under consideration is, by definition, deprived of his liberty by the combination of hospital order and restriction order. That deprivation of liberty is lawful, and Convention-compliant. If he is released from the hospital and relaxed conditions of detention are substituted by way of conditional discharge, he cannot properly be said to be being deprived of his liberty. On the contrary, the existing deprivation of liberty is being modified, and a lesser deprivation substituted. The authority for his detention remains the original combination of orders, from the consequences of which he is only conditionally discharged.*

He then took on each of the set of reasons given by Lady Hale for the majority before concluding at paragraph 48 that:

> [i]*t seems to me that the FTT does indeed have the power, if it considers it right in all the circumstances, to impose conditions upon the discharge of a*

> *restricted patient which, if considered out of the context of an existing court order for detention, would meet the Cheshire West test, at least so long as the loss of liberty involved is not greater than that already authorised by the hospital and restriction orders. Whether it is right to do so in any particular case is a different matter. The power to do so does not seem to me to depend on the consent of the (capacitous) patient. His consent, if given, and the prospect of it being reliably maintained, will of course be very relevant practical considerations on the question whether such an order ought to be made, and will have sufficient prospect of being effective. Tribunals will at that stage have to scrutinise the reality of the consent, but the fact that it is given in the face of the less palatable alternative of remaining detained in hospital does not, as it seems to me, necessarily rob it of reality. Many decisions have to be made to consent to a less unpalatable option of two or several: a simple example is where consent is required to deferment of sentence, in a case where the offence would otherwise merit an immediate custodial sentence.*

Comment

It is clear that this is not a judgment that the majority wished to reach, for the self-evident reason that it will both prevent restricted patients from being discharged from hospital and (worse) require the (technical) recall of any patients who are out of hospital on conditions amounting to a confinement, at least where they have capacity to consent to those conditions. Despite Lord Hughes' heroic efforts to find a way through to a different answer, it is in reality difficult to see how the majority's iron logic was not correct. One cannot help but wonder, however, whether Parliament in 1982 perhaps assumed that a conditionally discharged patient would not be deprived of liberty which is why there are no express provisions for it.

Of course, in at least some situations, the judgment will prompt very careful consideration of whether all of the actual or proposed conditions are in fact strictly necessary, which can only be a good thing. But the combination of this decision and the earlier decision in *Cheshire West*, making clear how low the bar for the test of confinement is set, does seem to lead to an odd outcome. The only way in which that outcome could be reversed, it is clear, is by way of legislation, and the independent Review of the MHA review 1983 has recommended that the Tribunal be given the power to discharge patients with conditions that restrict their freedom in the community, potentially with a new set of safeguards.

In the interim, the Mental Health Casework Section of HM Prison and Probation Service has issued guidance suggesting that there should be greater use of long-term s.17(3) leave. Those already conditionally discharged into confinement will need to be technically recalled to hospital (without physically have to go there) and given escorted s.17(3) leave (perhaps up to 12 months at a time). Whilst a temporary fix, this may give rise to a number of problems. Who will be the responsible clinician? Will the hospital bed still be commissioned whilst the patient is on leave? The impact for the Transforming Care Agenda could be noticeable.

The guidance usefully seeks to address the position of those lacking capacity to consent to conditions amounting to confinement. In *MM*,

Lady Hale for the majority expressly declined to engage with the question of whether "*the Court of Protection could authorise a future deprivation, once the FtT has granted a conditional discharge, and whether the FtT could defer its decision for this purpose*." The guidance suggests that the approach to obtaining authorisation will depend upon whether the primary reason for confining the individual with impaired capacity is:

1. their own interests, in which case, conditional discharge together with authorisation under DoLS/by way of the Court of Protection is suggested: or
2. risk to others, in which case the suggestion is that conditional discharge is inappropriate, but long-term s.17 leave should be used.

The guidance expressly deprecates the use of the inherent jurisdiction of the High Court, as had been invoked in *Hertfordshire County Council v AB* [2018] EWHC 3103 (Fam). It is unfortunate that the Secretary of State had not responded to the invitation from the court in that case to participate, and we suspect that it will not be long before the Secretary of State intervenes in another case on similar facts.

The Supreme Court and the MHA in the community (2) CTOs

Welsh Ministers v PJ [2018] UKSC 66 Supreme Court (Lady Hale, President; Mance, Wilson, Hodge and Black SCJJ)

Article 5 – Deprivation of liberty

Summary

The Supreme Court has reversed the curious and controversial decision in *PJ*, in which the Court of Appeal had held that the MHA 1983 contained within it by necessary implication the power for the patient's responsible clinician to set conditions on a community treatment order ('CTO') that amounted to a deprivation of liberty, so long as it was a lesser restriction on their freedom of movement than detention for treatment in hospital.

Until shortly before the hearing, the Welsh Ministers' principal argument was that the Court of Appeal had been correct. Lady Hale, giving the unanimous judgment of the court, noted that:

> [i]*t would, to say the least, have been helpful to this court to have the views of the Secretary of State for Health, no doubt after consultation with the Secretary of State for Justice, on an issue which affects England as much as it affects Wales. It may, however, be possible to deduce the views of the Secretary of State from the Mental Health Act Code of Practice, which he is required to draw up and lay before Parliament under section 118 of the MHA. The current edition (revised 2015) states quite clearly that "The conditions must not deprive the patient of their liberty" (para 29.31)*

Shortly before the hearing however, and to the visible surprise of the Supreme Court, the Welsh Ministers advanced an entirely an alternative and diametrically opposed argument. This was, in short, that because the conditions in a CTO cannot be enforced, they could not in law amount to a deprivation of liberty and it was therefore permissible to impose them.

Lady Hale had little truck with this argument:

> *18. The Welsh Ministers are entirely*

> *correct in what they say about the legal effect of a CTO. But it does not follow that the patient has not in fact been deprived of his liberty as a result of the conditions to which he is subject. The European Court of Human Rights has said time and time again that the protection of the rights contained in the European Convention must be practical and effective. When it comes to deprivation of liberty, they and we must look at the concrete situation of the person concerned: has he in fact been deprived of his liberty? Otherwise, all kinds of unlawful detention might go unremedied, on the basis that there was no power to do it. That is the antithesis of what the protection of personal liberty by the ancient writ of habeas corpus, and now also by article 5 of the Convention, is all about.*

As the case had always proceeded on the basis that PJ's factual circumstances amounted to a deprivation of liberty, Lady Hale held that this was enough for the Supreme Court's purposes to proceed on the basis that there was a deprivation of liberty on the ground. The question was therefore whether the RC had power, under the MHA, to impose conditions which have that effect.

The Welsh Ministers had a further argument as to why PJ's circumstances should not be seen in law as a deprivation of liberty, namely that the 'acid test' from *Cheshire West* "*should be modified for cases of this sort where the object is to enhance rather than further curtail the patient's freedom.*" They relied, in particular, upon the observations of the European Court in *Austin v United Kingdom* to the effect that "[i]*n order to determine whether someone has been 'deprived of his liberty' within the meaning of article 5(1), the starting point must be his concrete situation and account must be taken of a whole range of criteria such as the type, duration, effects and manner of implementation of the measure in question. The difference between deprivation of and restriction upon liberty is one of degree or intensity, and not of nature or substance*."

However, Lady Hale somewhat tartly dismissed this contention:

> *21. This is indeed the test which has been propounded by Strasbourg for many years, beginning with Guzzardi v Italy (1980) 3 EHRR 333. The jurisprudence was examined in detail in Cheshire West, where all members of the court agreed that the "acid test" of a deprivation of liberty was whether the person was under continuous supervision and control and not free to leave. The concrete circumstances of PJ in this case are much the same as those of P in the Cheshire West case, although PJ is not as seriously disabled as was P. And in both cases, the object of the care plan was to allow them as much freedom as possible, consistent with the need to protect their own health or safety or, at least in PJ's case, that of others. But, as Lord Walker pointed out in the House of Lords in Austin v Comr of Police of the Metropolis [2009] AC 564, at para 43, "It is noteworthy that the listed factors, wide as they are, do not include purpose". There is no reason to distinguish this case from Cheshire West and we are not - and could not be as a panel of five - asked to depart from it.*

Lady Hale therefore turned to the real issue, namely whether the power to impose conditions amounting to a deprivation of liberty could be read into the MHA by necessary implication. She considered that the approach of the Court of

Appeal had been to put before the cart before the horse, taking the

> *assumed purpose of a CTO - the gradual reintegration of the patient into the community - and works back from that to imply powers into the MHA which are simply not there. We have to start from the simple proposition that to deprive a person of his liberty is to interfere with a fundamental right - the right to liberty of the person.*

Applying very similar analysis that that undertaken in the *MM* case with which PJ had been linked at the Court of Appeal stage, and observing the pre-history of CTOs, Lady Hale found that:

> *29. […] the MHA does not give the RC power to impose conditions which have the concrete effect of depriving a community patient of his liberty within the meaning of article 5 of the European Convention. I reach that conclusion without hesitation and in the light of the general common law principles of statutory construction, without the need to turn further to the jurisprudence of the European Court of Human Rights or to resort to the obligation in section 3(1) of the Human Rights Act 1998 to read and give effect to legislation in a way which is compatible with the Convention rights. However, it is doubtful, to say the least, whether the European Court of Human Rights would regard the ill-defined and ill-regulated power implied into the MHA by the Court of Appeal as meeting the Convention standard of legality.*

In relation to the subsidiary question of the powers of the Mental Health Tribunal (or in PJ's case, the Mental Health Tribunal for Wales) if it finds on the facts that the community patient is being deprived of their liberty, Lady Hale held that:

> *33. […] The MHRT has no jurisdiction over the conditions of treatment and detention in hospital, but these can be relevant to whether the statutory criteria for detention are made out, especially in borderline cases. The RC's report to the tribunal must cover, inter alia, full details of the patient's mental state, behaviour and treatment; and there will also be a nursing report and a social circumstances report (Tribunals Judiciary, Practice Direction, First-tier Tribunal Health Education and Social Care Chamber, Statements and Reports in Mental Health Cases, 2013). His treatment and care may well feature in the debate about whether he should be discharged. The tribunal may recommend that the RC consider a CTO and "further consider the case" if the recommendation is not complied with (section 72(3A)(a)). Similarly, the tribunal has no power to vary the care plan or the conditions imposed in a CTO, but the tribunal requires an up to date clinical report and social circumstances report, including details of any section 117 aftercare plan. The patient's actual situation on the ground may well be relevant to whether the criteria for the CTO are made out. Furthermore, if the tribunal identifies a state of affairs amounting to an unlawful deprivation of liberty, it must be within its powers to explain to all concerned what the true legal effect of a CTO is. But the patient can only apply to the tribunal once during each period for which the CTO lasts (six months, six months, then once a year). If the reality is that he is being unlawfully detained, then the remedy is either*

habeas corpus or judicial review.

34. Furthermore, once it is made clear that the RC has no power to impose conditions which amount to a deprivation of liberty, any conscientious RC can be expected not to do so. This is reinforced by section 132A(1) of the MHA, under which it is the duty of the hospital managers to "take such steps as are practicable to ensure that a community patient understands … the effect of the provisions of this Act applying to community patients". Those steps must include giving the information both orally and in writing. The Mental Health Act Code of Practice makes it quite clear that community patients must be informed - in a manner which they can understand - of the provisions of the Act under which they are subject to a CTO and the effect of those provisions and of the effect of the CTO, including the conditions which they are required to keep and the circumstances in which their RC may recall them to hospital (para 4.13). This information should be copied to the patient's nearest relative, unless the patient requests otherwise (para 4.31). Patients should be told of this and there should be discussion with the patient as to what information they are happy to share and what they would like to be kept private (para 4.32).

Comment

This decision is hardly surprising, especially in light of the *MM* decision from an almost identical panel. The last-minute change of tack by the Welsh Ministers was brave, but doomed – PJ's circumstances (as described in paragraph 8) were factually not far off those in a medium secure unit, and to describe them as anything other than a deprivation of liberty would have been deeply problematic.

Unlike *MM*, this decision does not cause head-scratching in terms of its practical consequences, but rather represents the re-aligning of the law as interpreted by the courts with that set down in the 'soft law' of the Code of Practice (at least for England) and what has always been good practice for RCs. Following this decision and that of *MM*, and in light of *Cheshire West*, it is now absolutely clear that the spade of confinement must be called a spade, and powers to impose it must be express. It does, though, put added pressure on the government to think through with care precisely what level of coercion it thinks should occur in the community when it comes to respond to the recommendations of the MHA Review.

Another issue remains. The discretionary CTO conditions in PJ's case expressly required compliance with his care plan, in which the deprivation of liberty was to be located. What if that condition was absent, but the concrete situation of the care plan amounted to a deprivation of liberty? Our view is that, as PJ had capacity, he should logically have been entitled to agree to or refuse those care arrangements. And if he lacked capacity to do so, the MCA could be used to authorise the deprivation of liberty.

Editors and Contributors

Alex Ruck Keene: alex.ruckkeene@39essex.com

Alex is recommended as a 'star junior' in Chambers & Partners for his Court of Protection work. He has been in cases involving the MCA 2005 at all levels up to and including the Supreme Court. He also writes extensively, has numerous academic affiliations, including as Wellcome Research Fellow at King's College London, and created the website www.mentalcapacitylawandpolicy.org.uk. To view full CV click here.

Victoria Butler-Cole: vb@39essex.com

Victoria regularly appears in the Court of Protection, instructed by the Official Solicitor, family members, and statutory bodies, in welfare, financial and medical cases. Together with Alex, she co-edits the Court of Protection Law Reports for Jordans. She is a contributing editor to Clayton and Tomlinson 'The Law of Human Rights', a contributor to 'Assessment of Mental Capacity' (Law Society/BMA), and a contributor to Heywood and Massey Court of Protection Practice (Sweet and Maxwell). To view full CV click here.

Neil Allen: neil.allen@39essex.com

Neil has particular interests in human rights, mental health and incapacity law and mainly practises in the Court of Protection. Also a lecturer at Manchester University, he teaches students in these fields, trains health, social care and legal professionals, and regularly publishes in academic books and journals. Neil is the Deputy Director of the University's Legal Advice Centre and a Trustee for a mental health charity. To view full CV click here.

Annabel Lee: annabel.lee@39essex.com

Annabel has experience in a wide range of issues before the Court of Protection, including medical treatment, deprivation of liberty, residence, care contact, welfare, property and financial affairs, and has particular expertise in complex cross-border jurisdiction matters. She is a contributing editor to 'Court of Protection Practice' and an editor of the Court of Protection Law Reports. To view full CV click here.

Nicola Kohn: nicola.kohn@39essex.com

Nicola appears regularly in the Court of Protection in health and welfare matters. She is frequently instructed by the Official Solicitor as well as by local authorities, CCGs and care homes. She is a contributor to the 4th edition of the *Assessment of Mental Capacity: A Practical Guide for Doctors and Lawyers* (BMA/Law Society 2015). To view full CV click here.

Editors and Contributors

Katie Scott: katie.scott@39essex.com

Katie advises and represents clients in all things health related, from personal injury and clinical negligence, to community care, mental health and healthcare regulation. The main focus of her practice however is in the Court of Protection where she has a particular interest in the health and welfare of incapacitated adults. She is also a qualified mediator, mediating legal and community disputes. To view full CV click here.

Katherine Barnes: Katherine.barnes@39essex.com

Katherine has a broad public law and human rights practice, with a particular interest in the fields of community care and health law, including mental capacity law. She appears regularly in the Court of Protection and has acted for the Official Solicitor, individuals, local authorities and NHS bodies. Her CV is available here: To view full CV click here.

Simon Edwards: simon.edwards@39essex.com

Simon has wide experience of private client work raising capacity issues, including *Day v Harris & Ors* [2013] 3 WLR 1560, centred on the question whether Sir Malcolm Arnold had given manuscripts of his compositions to his children when in a desperate state or later when he was a patient of the Court of Protection. He has also acted in many cases where deputies or attorneys have misused P's assets. To view full CV click here.

Adrian Ward: adw@tcyoung.co.uk

Adrian is a recognised national and international expert in adult incapacity law. He has been continuously involved in law reform processes. His books include the current standard Scottish texts on the subject. His awards include an MBE for services to the mentally handicapped in Scotland; national awards for legal journalism, legal charitable work and legal scholarship; and the lifetime achievement award at the 2014 Scottish Legal Awards.

Jill Stavert: j.stavert@napier.ac.uk

Jill Stavert is Professor of Law, Director of the Centre for Mental Health and Capacity Law and Director of Research, The Business School, Edinburgh Napier University. Jill is also a member of the Law Society for Scotland's Mental Health and Disability Sub-Committee. She has undertaken work for the Mental Welfare Commission for Scotland (including its 2015 updated guidance on Deprivation of Liberty). To view full CV click here.

Conferences

Conferences at which editors/contributors are speaking

Edge DoLS assessor conference

Alex is speaking at the Edge DoLS assessor conference on 8 March, alongside other speakers including Lord Justice Baker and Graham Enderby. For more details, and to book, see here.

Essex Autonomy Project summer school

Alex will be a speaker at the annual EAP Summer School on 11-13 July, this year's theme being: "All Change Please: New Developments, New Directions, New Standards in Human Rights and the Vocation of Care: Historical, legal, clinical perspectives." For more details, and to book, see here.

Advertising conferences and training events

If you would like your conference or training event to be included in this section in a subsequent issue, please contact one of the editors. Save for those conferences or training events that are run by non-profit bodies, we would invite a donation of £200 to be made to the dementia charity My Life Films in return for postings for English and Welsh events. For Scottish events, we are inviting donations to Alzheimer Scotland Action on Dementia.

Our next edition will be out in March. Please email us with any judgments or other news items which you think should be included. If you do not wish to receive this Report in the future please contact: marketing@39essex.com.

Michael Kaplan
Senior Clerk
michael.kaplan@39essex.com

Sheraton Doyle
Senior Practice Manager
sheraton.doyle@39essex.com

Peter Campbell
Senior Practice Manager
peter.campbell@39essex.com

International Arbitration Chambers of the Year 2014 Legal 500

Environment & Planning Chambers of the Year 2015

clerks@39essex.com • DX: London/Chancery Lane 298 • 39essex.com

LONDON
81 Chancery Lane,
London WC2A 1DD
Tel: +44 (0)20 7832 1111
Fax: +44 (0)20 7353 3978

MANCHESTER
82 King Street,
Manchester M2 4WQ
Tel: +44 (0)16 1870 0333
Fax: +44 (0)20 7353 3978

SINGAPORE
Maxwell Chambers,
#02-16 32, Maxwell Road
Singapore 069115
Tel: +(65) 6634 1336

KUALA LUMPUR
#02-9, Bangunan Sulaiman,
Jalan Sultan Hishamuddin
50000 Kuala Lumpur,
Malaysia: +(60)32 271 1085