
Deprivation of Liberty in the Hospital Setting

Introduction

1. The law governing the deprivation of a person's liberty in a hospital is complex. In very many cases, it involves the interface of two statutory regimes (the Mental Health Act 1983 ('MHA 1983') and the Mental Capacity Act 2005 ('MCA 2005')) and in every case it involves (or should involve) consideration of the 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').
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.
3. This paper, which is aimed at those working in NHS 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. It is in many ways a companion piece to the [guide](#) that the editors of the Mental Capacity Law Newsletter issued to key questions to ask following the decision of the Supreme Court in (1) [P v Cheshire West and Chester Council and another](#); (2) [P and Q v Surrey County Council](#) [2014] UKSC 19 ('Cheshire West'). It is, however, significantly more detailed, for which no apology is made.
4. The paper is divided into two parts. Part 1 provides an overview of the deprivation of liberty issues that arise in a hospital setting, focussing on two key concerns: how to determine whether a deprivation of liberty arises or is likely to occur; and, how to identify the appropriate legal basis on which to detain an individual. Part 2 then considers the application of the law on deprivation of liberty in the common scenario where an informal patient remains in a psychiatric hospital following discharge from detention under the provisions of the MHA 1983.

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Disclaimer: This document is based upon the law as it stands as at June 2015; it is intended as a guide to good practice, and 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.

5. The cases that are discussed in this paper are all the subject of more detailed individual comments available at www.copcasesonline.com, to which hyperlinks from case references here will direct; this paper draws upon some of those comments.

Part 1: Deprivation of liberty

1. The meaning of deprivation of liberty

6. After a substantial period of uncertainty, guidance has now been issued by the Supreme Court in *Cheshire West*. The majority of the Supreme Court held that there here are two key questions to ask – the ‘acid test’:
- (1) Is the person subject to continuous supervision and control?
and
 - (2) Is the person free to leave?
7. The Supreme Court made clear that, for a person to be deprived of their liberty, they must be subject both to continuous supervision and control and not be free to leave.
8. The Supreme Court also held that, in all cases, the following are not relevant to the application of the test:
- (1) the person’s compliance or lack of objection;
 - (2) the relative normality of the placement (whatever the comparison made); and
 - (3) the reason or purpose behind a particular placement.
9. It is always necessary in each case always to consider further:
- (1) whether the deprivation of liberty lasts more than a negligible period of time. Precisely how long such a period of time is was not addressed by the Supreme Court in *Cheshire West* (because it did not arise for consideration on the facts of any of the individuals concerned). This question is discussed in some detail in chapter 2 of the Law Society’s Guidance;
 - (2) whether the person is able to give consent to what amounts to an objective deprivation of liberty. We address this question further at paragraphs 84 ff below (by reference to the position of informal psychiatric patients, but the principles are more broadly applicable);
 - (3) whether the objective deprivation of liberty is imputable to the state. We do not consider this further here as this will inevitably be satisfied in the circumstances of the cases with which we are

concerned, save that we note that it also will be satisfied if the state has arranged for a placement in a private hospital (as happened in the *LDV* case discussed further below).

10. Whilst each case must be decided on a case-by-case basis, there are a number of freely available resources which provide helpful guidance as to the circumstances which are likely to amount to a deprivation of liberty. Of particular assistance is guidance commissioned from the Law Society by the Department of Health entitled: [Deprivation of Liberty: A Practical Guide](#) (“Law Society Guidance”).¹ Chapter 4 of the Law Society Guidance considers deprivation of liberty in the hospital setting. It identifies a number of measures that may give rise to a deprivation of liberty, including:²

- Continuous monitoring;
- Length of time sedated and/or ventilated and/or intubated;
- Use of restraint to bring about admission;
- Use of restraint/medication being used forcibly during admission;
- Use of restraint/medication to administer treatment/prevent a patient interfering with administering medication;
- Raised bedrails;
- Staff taking decision on a person’s behalf regarding treatments and contacts with visitors;
- The requirement for a person to remain in a certain area of the hospital and restricting the person to that area;
- The patient not being free to leave the hospital.

11. It is important to note that, where the totality of conditions of hospital admission and treatment are such that there is ‘continuous supervision and control’ and ‘lack of freedom to leave’, this would amount to a deprivation of liberty even if the person is not objecting to the admission or treatment and it is agreed that the admission and treatment is in the person’s best interests.

12. 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 Deprivation of Liberty Safeguards Code of Practice³ 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:⁴

¹ Co-written and edited by Alex and available at: <http://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty/>

² These factors are identified at paragraph 4.24 and 4.34 of the Law Society’s Guidance on Deprivation of Liberty.

³ Paragraph 2.15

⁴ Paragraph 4.14.

- 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;
 - Where it is or may be necessary to do more than persuade or provide transient forcible physical restraint of the person during the transportation;
 - Where the person may have to be sedated for the purpose of transportation; or
 - Where the journey is exceptionally long.
13. A consequence of the Supreme Court's judgment is that it is likely that a very substantial number of patients who have been treated as informal incapacitated patients in the psychiatric setting will now be considered to be deprived of their liberty, and – as such – their situation will require authorisation. We suggest, though, that it is not appropriate to proceed on the basis that all such patients are deprived of their liberty, because it is always necessary to consider whether the acid test is satisfied on the facts of each case.
14. A further consequence is that a patient who is in unconscious or in a PVS/MCS in a general hospital may also be considered to be deprived of their liberty. Again, this will depend on the setting in which they are treated and whether the circumstances satisfy the acid test. It is also suggested that it is likely to be arguable that a patient who has given proper consent to an operation involving general anaesthetic would not be considered to be deprived of their liberty because it can be said that the patient is consenting not merely to the operation but to the circumstances that may prevail in the immediate post-operative stage. It is likely that the question of the circumstances of patients in general hospitals will be the subject of judicial consideration in due course, not least because of the questions that arise in relation to the authorisation of any deprivation of liberty to which they may be subjected: see further paragraph 49 below.
15. The position of children patients following the Supreme Court judgment is not entirely clear:
- a. On one view, it would appear, logically, that they are in exactly the same position as adult patients as regards the question of whether they are (or are not) deprived of their liberty – at least in hospitals run by the state. However, in [D \(A Child\) \(Deprivation of Liberty\)](#) [2015] EWHC 922 (Fam), Keehan J held that the appropriate exercise of parental responsibility 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. Keehan J expressly did not decide whether this principle would also apply in relation to a 16 or 17 year old lacking the material capacity, and this question is to be considered in the autumn of 2015;
 - b. We should also note that we consider that there is no reason in principle why a child or young person could not give consent to what would otherwise be deprivation of liberty on a similar basis that a competent (or capacitous, depending upon their age) child can consent to a medical

procedure).⁵ If (assuming that Article 5(1) is engaged), the child has not consented to the deprivation of liberty, whether because they were not competent because of their age or, in the case of child between the ages of 16-17 to whom the MCA 2005 applies, because of a lack of the material capacity, then it would appear that the deprivation of their liberty will have to be authorised. We return to this below at paragraph 51.

16. Finally, we note that, in April 2014, the Department of Health issued [guidance](#) on reducing the use of restrictive practices inter alia in health care settings. The guidance is non-statutory, but will carry significant weight, not least as compliance with it is to form part of the new standards by which the CQC will assess providers in due course. It is therefore of some note that the Department of Health set out its view as to what would constitute a deprivation of liberty by reference not just to the acid test (at paragraph 99) but also by reference but also by a (reduced) list of the factors that previously appeared in the DOLS Safeguards [Code of Practice](#) (at paragraph 2.5).⁶ Whilst the Supreme Court was clear that those concerned should err on the side of caution in deciding whether someone is deprived of their liberty,⁷ we would suggest that legal advice should be sought if the sole factor set out in the new guidance that is thought to point to a deprivation of liberty is that staff are restricting a person's access to their friends or family. It is not immediately obvious that this would satisfy the requirements of the test set down by the Supreme Court (albeit that it is very likely – if not inevitable – that any such restrictions would require authorisation by the Court of Protection if they are being imposed for any length of time for reasons other than the operation of hospital visiting hours).

1.2 The legal basis for depriving a person of their liberty

17. 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.

18. Hospitals⁸ have, in certain circumstances, powers to detain people under the MHA 1983 and the MCA 2005.⁹ Determining the appropriate basis on which to detain can raise difficult questions and the first

⁵ A child of 16 or 17 can consent to informal admission under the MHA 1983, their capacity be assessed by reference to the MCA 2005 (s131(5)(a) MHA 1983), and can do so even if one or more persons have parental responsibility for them. Below the age of 16, the courts will look to see if the child is *Gillick*-competent: i.e. whether they sufficient maturity and intelligence to understand the nature and implications of the proposed decision.

⁶ NB, that Code of Practice specifically provided (at paragraph 2.5) that the list of factors "*was not exclusive [and that] other factors may arise in future in particular cases,*" and, earlier, that "[f]urther legal developments may occur after this guidance has been issued, and healthcare and social care staff need to keep themselves informed of legal developments that may have a bearing on their practice" (introduction to chapter 2). At the time of writing, it is not clear whether that Code of Practice will be reviewed or whether any review will be otiose because the entire DOLS regime will be rewritten.

⁷ Lady Hale at paragraph 57.

⁸ '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,

part of this section considers the interface between the two statutory regimes. It is uncertain whether those in a hospital setting enjoy any power to detain patients on an emergency basis, outwith the scope of the two statutory regimes. This question is considered in the second part of this section. We then address circumstances under which a deprivation of liberty will arise where the MHA 1983 cannot be considered.

1.2.1 The interface between the MHA 1983 and the MCA 2005

19. 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.
20. The MHA 1983 is principally concerned with the admission of patients to hospital for assessment and treatment for their mental disorder. Those powers of compulsion were extended by the MHA 2007 to include compulsory community treatment orders (also referred to as supervised community treatment) for patients previously detained in hospital who are now living in the community, but who continue to need treatment for their mental disorder. The purpose of the MHA 1983 is to provide the statutory framework for the compulsory care and treatment of people for their mental disorder when they are unable or unwilling to consent to that care and treatment, and when it is necessary for that care and treatment to be given to protect themselves or others from harm. The key point for the exercise of these powers is the inability or unwillingness of the patient who suffers from a mental disorder to consent to the relevant care and treatment. This encompasses people who, notwithstanding their mental disorder, have capacity to do so – and it is entirely possible for someone detained under the MHA 1983 to have capacity in relation to a treatment decision.¹⁰ 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.
21. The MCA 2005 is based wholly on a capacity test. Its provisions have no application to people who have the capacity to make their own decisions. Some who lack capacity will not come within the definition of those for whom compulsory powers under the MHA 1983 can be exercised. People with learning difficulties, for example, who may thereby not be able to give their consent to treatment, will not generally be subject to the compulsory powers of the MHA 1983, unless they are also abnormally aggressive or seriously irresponsible.¹¹ Other examples are people in a persistent vegetative state or

(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.

⁹ As amended by the Mental Health Act 2007.

¹⁰ 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](#).

¹¹ By virtue of the operation of ss.1(2A)(a) and (2B) MHA 1983.

anyone suffering from ‘locked-in’ syndrome, which prevents them from communicating, persons with brain injuries or temporarily unconscious, drunk or under the influence of drugs.

22. The key differences between the approaches under the MHA 1983 and the MCA 2005 can be summarised as follows. First, the MCA 2005 relates to a person’s functioning – i.e. their (in)capacity to make a particular decision – whereas the MHA 1983 relates to a person’s status, as someone 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.¹² The MHA 1983, by contrast, contains no equivalent requirement; under its provisions, an individual can (for instance) be detained solely on the basis of the risk that they pose to others. Third, the MCA 2005 covers all decision-making, whereas the MHA 1983 is, to a very large degree, limited to decisions about care in hospital and medical treatment for mental disorder. Fourth, the MCA 2005 specifically excludes¹³ anyone giving a patient medical treatment for mental disorder, or consenting to a patient being given medical treatment for mental disorder, if the patient is, at the relevant time, already detained and subject to the compulsory treatment provisions of Part 4 MHA 1983.

	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
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.

Table 1: Key differences between MHA 1983 and MCA 2005

23. 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

¹² Section 1(5) MCA 2005.

¹³ Section 28 MCA 2005.

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

24. 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. Helpful guidance on the interface between these regimes is now available in Chapter 13 of the new Mental Health Act Code of Practice ("MHA Code"), issued in April 2015. 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.¹⁴ 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*,¹⁵ and the new MHA Code.

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

25. If the person is not suffering from a mental disorder from which they require assessment or treatment in a hospital (for example, they are 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 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).

26. 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?*¹⁶

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

¹⁴ 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>.

¹⁵ [2013] UKUT 0365 (AAC) [2013] COPLR.

¹⁶ *AM v SLAM* at paragraph 39; MHA Code at paragraphs 13.53-13.55.

28. If they are compliant, they may be admitted as an informal patient under section 131 MHA 1983. If they are non-compliant, they can be detained under the MHA if the ‘necessity test’ set by sections 2¹⁷ and 3¹⁸ MHA 1983 is met.
29. 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?¹⁹

30. 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.
31. 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.
32. Schedule 1A sets out (in an appallingly drafted fashion) how to determine whether a patient is ineligible. At the risk of overly simplifying Schedule 1A to the MCA 2005, there are five cases in which a person is ineligible. The first scenario is where a person is currently detained in hospital under the MHA 1983. In that case, the individual may not simultaneously be subject to a deprivation of liberty authorisation under the MCA 2005. Three of the other cases involve scenarios where a person is subject to measures under the MHA not amounting to detention. In that case, the individual may not simultaneously be subject of a deprivation of liberty authorisation under the MCA 2005 which would conflict with a compulsory measure under the MHA 1983.
33. 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 requires assessment or treatment for a mental disorder and “could” be detained under sections 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, a person who is within the scope of the MHA 1983 is ineligible to be detained under the

¹⁷ 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.

¹⁸ 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 for the protection of other persons that he should receive treatment and it cannot be provided unless he is detained under this section.

¹⁹ *AM v SLAM* at paragraph 45; MHA Code at paragraphs 13.56.

MCA 2005 if he/she objects to being a mental health patient or to being given some or all of the mental health treatment.

34. 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*

35. 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.
36. Guidance on the approach to take to this determination is now found in the revised [MHA Code of Practice](#) (“the MHA Code”).²⁰ The MHA Code sets out factors that should feature in the decision-making process and states that the decision-maker should clearly record the reasons for the choice of legal regime.²¹
37. 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.²² The key consideration should be whether one regime is generally less restrictive than the other.²³ 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.²⁴ 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.²⁵ The MHA Code acknowledges, however, that the nature of the safeguards provided under the two regimes are different. Thus, another factor that

²⁰ Available at <https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983>

²¹ MHA Code paragraph 13.60

²² MHA Code paragraph 13.58.

²³ MAH Code paragraph 13.58

²⁴ MHA Code paragraph 13.60.

²⁵ MHA Code paragraph 13.59.

decision-makers need to take into account is which safeguards are most likely to best protect the interests of the patient.²⁶

38. Whilst each case must be decided on its fact, it is instructive to look to the case-law for further guidance.
39. The decision of Charles J in [AM v South London & Maudsley NHS Foundation Trust & Secretary of State for Health](#)²⁷ 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 J²⁸ 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 1983.²⁹ 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 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*

²⁶ MHA Code paragraph 13.59.

²⁷ [2013] UKUT 0365 (AAC); [2013] COPLR 510

²⁸ 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).

²⁹ Para 72.

regimes, which links to the points made in paragraph 4.21 of the MHA Code of Practice [30] and paragraph 4.48 Deprivation of Liberty Safeguards Code of Practice [31].”

40. [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 [32] is likely to remain the MHA”³³ and determined that ML should be admitted to hospital under section 3 MHA 1983.
41. The MHA Code includes a helpful ‘options grid’ summarising the availability of the MHA and the MCA to authorise deprivation of liberty in a hospital setting.³⁴ It is reproduced here for ease of reference:

³⁰ 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.”

³¹ 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.”

³² 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.

³³ Paragraph 76.

³⁴ MHA Code at page 106.

	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

42. 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 to the likelihood of the person suffering harm, and the seriousness of that harm.³⁵ 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*.³⁶ 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

³⁵ Paragraph 16 of Schedule A1.

³⁶ [2011] EWHC 2675 (COP) [2012] COPLR 1, at paragraph 64.

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*.³⁷

1.2.2 The inherent jurisdiction

43. It would appear that the inherent jurisdiction would still seem to extend to authorising the deprivation of a liberty of an adult falling outside the scope of the MCA 2005: see *Re A and C (Equality and Human Rights Commission Intervening)* [2010] EWHC 978 (Fam) [2010] COPLR Con Vol 10 per Munby LJ (discussed above):

“74 [...] There is no longer any room for doubt that a judge exercising the inherent jurisdiction of the High Court (whether the inherent jurisdiction of the court with respect to children or the inherent jurisdiction with respect to incapacitated or vulnerable adults) has power to direct that the child or adult in question shall be placed at and remain in a specified institution such as, for example, a hospital, residential unit, care home or secure unit. And the High Court’s powers extend to authorising that person’s detention in such a place and the use of reasonable force (if necessary) to detain him and ensure that he remains there: see Re PS (Incapacitated or Vulnerable Adult) [2007] EWHC 623 (Fam), [2007] 2 FLR 1083 at para [16]. But if a local authority is to resort to such measures it must, unless it can bring itself within the new ‘deprivation of liberty’ amendments to the Mental Capacity Act 2005 effected by the Mental Health Act 2007 (the new ss 4A, 4B and 16A and the new Sch A1 and 1A), first enlist the assistance of the court and do so before it embarks upon such measures: see Re PS (Incapacitated or Vulnerable Adult, at para [23], and A Primary Care Trust and P v AH and A Local Authority [2008] EWHC 1403 (Fam), [2008] COPLR Con Vol 179, [2008] 2 FLR 1196 at paras [29], [41].” (emphasis added)

44. The inherent jurisdiction has been invoked by the courts on subsequent occasions to authorise the detention of a person falling between (or outside) the two regimes provided for under the MHA 1983 and the MCA.

45. 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. Baker J found that Dr A was ineligible to be deprived of his liberty under the MCA because he was within scope of the MHA 1983 and objecting; Dr A was then detained under s.3 MHA 1983, but the doctors concerned with his treatment considered that the force-feeding could not properly be considered to be medical treatment for his mental disorder. Baker J held that, in consequence³⁸ 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

³⁷ [2011] EWHC 1377 (COP) [2011] COPLR Con Vol 632.

³⁸ *B v. Croydon Health Authority* [1995] (Fam) 133 and *R v Collins ex parte Brady* [2000] Lloyd’s Rep Med 355.

being in his best interests, but, as he noted,³⁹ it was “*alarming to find that the legal position on this fundamental issue is far from straightforward.*”

46. 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 under the MCA 2005, the High Court will be able to exercise its inherent jurisdiction to authorise P’s deprivation of liberty.⁴⁰
47. HHJ Parry QC in *A Local Health Board v AB* [2015] EWCOP 31 felt constrained to use the inherent jurisdiction to authorise the deprivation of liberty of a patient subject to s.3 MHA 1983 who was given s.17 leave to a general hospital for purposes of undergoing an operation in circumstances to a deprivation to which she could not consent. We suggest, however, that this case is clearly wrong, because this is precisely the situation that Case B of Schedule 1A is designed to cater for. This is discussed in more detail [here](#).
48. 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 the 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 of 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;⁴¹ 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;⁴²
 - (3) In light of the decision in *An NHS Trust v Dr A* that 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.

1.2.3 Patients in a general hospital

49. As noted in section 1 above, there are in light of the decision in *Cheshire West* likely to be patients in general hospitals who are unconscious or in a PVS or MCS who will now be considered to be deprived of

³⁹ Paragraph 55.

⁴⁰ Paragraphs 127 to 128.

⁴¹ See *Surrey County Council v MB* [2007] EWHC 3085 (Fam).

⁴² That judicial review would, most probably, have to be against the local authority employing the BIA.

their liberty. This gives rise to a potentially difficult question (and one that it is clear was not in the forefront of the minds of the Supreme Court justices in the case). Being unconscious or in a PVS would undoubtedly not amount to having a mental disorder for purposes of the MHA 1983, from the perspective of a doctor or an AMHP considering invoking the provisions of that Act. The Department of Health has made clear that they do not consider that 'unconsciousness' constitutes a 'mental disorder,'⁴³ 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. The Court of Appeal in *G v E*⁴⁴ suggested that a 'mental disorder' for purposes of justifying a deprivation of liberty under the DOLS regime under Article 5(1)(e) went considerably wider than the definition contained in the MHA 1983.⁴⁵ We have considerable doubts as to the correctness of this proposition (and it was not followed by the President of the Court of Protection in *Re X No (1)* [2014] EWCOP 25.⁴⁶ For present purposes, however, it stands as (shaky) support for the proposition that the impairment of the mind or brain inherent in being unconscious or in a PVS would suffice as a basis to justify a deprivation of liberty under Article 5(1)(e).

50. Before a binding decision is given by the courts, we would suggest that specific legal advice is sought in respect of these classes of patient.

1.2.4 Those under 18

51. As noted at paragraph 15 above there may well, in the case of those under 16, be a question as to whether the circumstances amount to a deprivation of liberty at all if the child has been placed by or with the consent of a parent appropriately exercising parental responsibility. That principle cannot apply, we suggest, to a person aged 16 or 17.

52. If a person under 18 is to be deprived of their liberty as a patient at the hands of the state, and if they cannot consent thereto, such deprivation will have to be authorised.

53. 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). A child over the age of 16 may (depending

⁴³ 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>

⁴⁴ [2010] EWCA Civ 822.

⁴⁵ See paragraph 60: "*the cases under the MCA 2005 in which the Official Solicitor is invited to act for the person who is believed to be incapable of managing his or her affairs often do not involve mental illness. Very many of them involve varying degrees of learning difficulties. E, sadly, is representative of a class of incapacitated adults who are not mentally ill, and to whom the provisions of the Mental Health Act 1983 do not apply. They are, of course, 'of unsound mind' within Art 5 of the European Convention, but, in our judgment, it plainly does not follow either that they are mentally ill, or that Art 5 of the European Convention requires psychiatric evidence as a threshold to the deprivation of their liberty.*"

⁴⁶ This 'decision' was held by the Court of Appeal subsequently ([2015] EWCA Civ 599) not, in fact, to represent an authoritative judgment. However, no doubt was cast by the Court of Appeal as to the correctness of the President's observations in this regard.

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 has the power under its inherent jurisdiction to authorise the deprivation of liberty of a child who is below the age of 16.⁴⁷

54. The same considerations as set out above will apply in relation to children who are unconscious or in a PVS or MCS.

1.2.4 Emergency powers of detention

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

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

57. Both questions were touched upon in [*Commissioner of the Police for the Metropolis v ZH*](#).⁴⁸ ZH was a severely autistic, epileptic nineteen year old young man who suffered from learning disabilities and could not communicate by speech. In September 2008, he was taken by the specialist school he attended to a swimming pool for a familiarisation visit. Matters went very badly awry during the course of that visit, in particular following the decision of the manager of the pool to ring the Police when difficulties were experienced in persuading ZH to move away from the side of the pool. The arrival of the police gave rise to an escalating series of events which culminated in ZH first jumping into the pool, being forcibly removed from it, being handcuffed, put in leg restraints and placed in a cage in the back of a police van for a period of around 40 minutes. As a result of this, ZH suffered consequential psychological trauma and an exacerbation of his epileptic seizures.

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

⁴⁷ *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.

⁴⁸ [2013] EWCA Civ 69.

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

"145. The nature and duration of the restraint lead me to the conclusion that there was a deprivation of liberty, not merely a restriction on movement on the facts of this case. Furthermore, even though I am of the view that the purpose and intention of the police (namely at least in part to protect ZH's safety) is relevant to the consideration of the application of Article 5, I am nevertheless satisfied that even when that is taken into account, a deprivation of liberty has occurred. The actions of the police were in general well intentioned but they involved the application of forcible restraint for a significant period of time of an autistic epileptic young man when such restraint was in the circumstances hasty, ill-informed and damaging to ZH. I have found that the restraint was neither lawful nor justified. Even though the period may have been shorter than that in Gillan v United Kingdom 2010 APP No 4158/05, it was in my judgment sufficient in the circumstances to amount to a deprivation of liberty under Article 5."

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

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

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

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

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

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

62. This case raises important questions for those in a hospital setting. It means that, in principle, temporary (but total) restraint of an informal hospital patient may constitute a deprivation of liberty: the restraint imposed ZH whilst he was at the pool-side lasted about 15 minutes, the restraint in the police van lasted about 25 minutes, but the Court of Appeal was satisfied that he was deprived of his liberty. Whilst one might say that the restraint of ZH in a police van more closely aligns with the paradigm of detention in a prison cell than does restraint of a patient in a hospital setting, it could not, however, be said that temporary restraint in a hospital falls into the ‘generally accepted’ category of temporary restrictions on freedom of movement identified at paragraph 87 of the decision. Hospital authorities must therefore confront the real possibility that such temporary restraint could constitute a deprivation of liberty.
63. Difficult questions then arise as to what legal basis, if any, exists to authorise a deprivation of liberty in such an emergency situation.
64. This issue was considered, although not conclusively decided, in *ZH*. At first instance, Sir Robert Nelson found (para 41) that it would be theoretically possible for the police to have satisfied the conditions of

section 5 to 6 MCA 2005 even if some of their number were not aware of the terms of the Act itself. In light of his conclusion, he noted that he was not then bound to go on to consider whether or not the common law defence of necessity could apply in circumstances where the MCA 2005 applied. He chose to do so, however. Relying, in particular, on an earlier decision in a case called *Sessay*,⁴⁹ ZH submitted that the defence of necessity had no place; the Commissioner submitted to the contrary. Sir Robert Nelson held as follows in this regard:

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

65. The conclusions of Sir Robert Nelson in this regard (at paragraph 44) were strictly obiter dicta; they were not discussed by Lord Dyson in his judgment. That having been said: (1) the tenor of Lord Dyson’s judgment was such that it could be said to have represented an endorsement of the entirety of Sir Robert’s judgment – including this paragraph; and (2) the conclusions of Sir Robert Nelson are entirely consistent with those of the Divisional Court in *Sessay* regarding the (non-existence) of the defence of necessity where the MHA 1983 applies.
66. The view expressed by Sir Robert Nelson gives rise to a difficult practical question where an emergency situation arises in respect of an adult who would appear not to have capacity to take decisions regarding their welfare but who is not the subject of any form of court order or a deprivation of liberty authorisation.
67. To understand the problem, it is necessary to have regard to the wording of both ss.4A and 4B (both inserted by the MHA 2007):

“4A Restriction on deprivation of liberty

- (1) This Act does not authorise any person (“D”) to deprive any other person (“P”) of his liberty.*
- (2) But that is subject to—*
- (a) the following provisions of this section, and*
 - (b) section 4B.*

⁴⁹ *R (Sessay) v South London and Maudsley NHS Foundation Trust and another* [2011] EWHC 2617 (QB) [2012] QB 760, in which the Divisional Court held that the scheme of the MHA 1983 was such that the concept of necessity did not apply so as to give a defence to a claim of false imprisonment/unlawful detention where a patient was detained (in their own interests) pending completion of the process for assessment for admission under the provisions of s.2 MHA 1983.

- (3) *D may deprive P of his liberty if, by doing so, D is giving effect to a relevant decision of the court.*
- (4) *A relevant decision of the court is a decision made by an order under section 16(2)(a) in relation to a matter concerning P's personal welfare.*
- (5) *D may deprive P of his liberty if the deprivation is authorised by Schedule A1 (hospital and care home residents: deprivation of liberty).*

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

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

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

69. In the case of a true emergency where the deprivation of liberty to which the adult is subjected in response arises immediately and is of very short duration (say no more than 30 minutes), but is severe, even if it could be said that the first condition in s.4B is met (i.e. that any deprivation of liberty to which the individual was subjected would be capable of being authorised – most likely by a court order under section 16(2)(a)), it is therefore likely in such cases to be straining the language of section 4B to say that the deprivation of liberty is taking place while a decision respecting that issue is sought from the Court. Even if an interpretation was placed upon section 4B that it applies so long as the most minimal steps have been taken to seek a decision from the Court, perhaps by way of initial telephone contact to get

before the Urgent Applications judge, the fact remains that it is likely that there will – even with suitable diligence on the part of the relevant authorities – be circumstances under which section 4B simply cannot be said to offer protection from liability.

70. The Court of Appeal did not have to grapple with this question in *ZH*, not least as the case arose out of events which took place in 2008 (and hence ss.4A-B were not in force).
71. In such circumstances, however, it is suggested that there does remain a place for the common law defence of necessity because there is a true lacuna. It is of note in this regard that section 4A provides solely for the ability of an individual to deprive another of their liberty under the provisions of the MCA 2005 – it does not purport to exclude the deprivation of liberty of an incapacitated adult outside the provisions of the MCA 2005. It is suggested, however, that the common law defence of necessity will only avail a person who is able to show that they were confronted with the need to deprive the incapacitated adult of their liberty in a true emergency position where (a) it was not possible to seek the assistance of the Court either before or during the currency of that deprivation of liberty; (b) no other statutory power existed upon which reliance could be placed (for instance s.17 PACE 1984 or s.135 MHA 1983); and (c) where it was necessary so to do to preserve them from serious harm.
72. Another interesting question which may still fall for consideration upon another day is whether there is an equivalent lacuna in the statutory law so as to allow for the common law defence of necessity to survive where the deprivation of liberty takes place, not for purposes of safeguarding the life and limb of the incapacitated adult, but that of a third party (the MCA 2005 being focussed solely on the best interests of the adult rather than those of anyone else). At common law, the defence of necessity may be pleaded where the detention takes place so as to prevent a danger to another (see *R v Bournewood Community and Mental Health N.H.S. Trust*, L [1999] 1 AC 458 at 490 per Lord Goff: “*the common law permit[s] the detention of those who were a danger, or potential danger, to themselves or others, in so far as this was shown to be necessary.*”) For the purposes of the ECHR, any deprivation of liberty attributable to the State would have to be such as to fall within one of the permitted bases for so doing under Article 5(1), but it is clear that a deprivation of liberty on the basis of mental disorder can be justified on the basis that a person constitutes a danger to others (and that in the event of emergency, the normal requirements as regards the obtaining of medical evidence objectively establishing a mental disorder can be dispensed with: see *Winterwerp v The Netherlands* (1979) 2 EHRR 387 at paragraph 39 and *X v United Kingdom* (Application No 7215/75, decision of 5.11.81) (unreported) at paragraphs 41 and 45).
73. Again, however, it is likely that any attempt by a public authority to rely upon the common law defence of necessity in such a case will be scrutinised very narrowly by the Courts so as to ensure that it only survives where there is a true lacuna (and so that does not offend against the provisions of Article 5 ECHR).
74. It is therefore suggested that the best course of action in relation to patients who do meet the criteria for detention under the MHA 1983 and who would appear not to have capacity to make decisions regarding their welfare and in respect of whom there is a risk that restraint (even of a temporary

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

Part 2: Case Study

An informal psychiatric patient discharged from section but remaining in need of care in hospital

75. We now turn to consider the application of the principles discussed in Part 1 to a scenario commonly confronted by hospital authorities, namely that of an informal psychiatric patient discharged from section but still in continuing need of hospital care.
76. Patients discharged from section may continue to be treated for their mental disorder in hospital informally provided that the care and treatment does not amount to a deprivation of liberty or, if it does, they have capacity to consent to the restrictions amounting to a deprivation of their liberty.
77. The position of informal patients is well-recognised as being a vulnerable one: see, for instance, the decision in *Rabone & Anor v Pennine Care NHS Trust* [2012] 2 AC 72. Giving the leading judgment in that case, Lord Dyson analysed the position thus:

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

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

28 As regards the differences between an informal psychiatric patient and one who is detained under the MHA, these are in many ways more apparent than real. It is true that the paradigm of a detained patient is one who is locked up in a secure hospital environment. But a detained patient may be in an open hospital with freedom to come and go. By contrast, an

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

29 *Although informal patients are not 'detained' and are therefore, in principle free to leave hospital at any time, their 'consent' to remaining in hospital may only be as a result of a fear that they will be detained. In Principles of Mental Health Law and Policy (2010) ed, Gostin and others, the authors have written in relation to admission, at para 11.03:*

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

78. The effect of coercion forms a consistent theme in CQC reports upon Monitoring the Mental Health Act 1983. Drawing the dividing line between incapacity and situational coercion in these circumstances is likely to be very difficult. It is therefore important that hospital authorities always analyse this situation by considering the key questions:

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

2.1 Deprivation of liberty

79. Whether or not the circumstances in which an informal patient remains in hospital following discharge amounted to a deprivation of liberty must be determined by applying the acid test set out in *Cheshire West*. For a person to be deprived of their liberty, they must be both subject to continuous supervision and control and not be free to leave.

80. There is no case-law at the time of writing that deals specifically with the application of the acid test to this scenario. Chapter 5 of the Law Society Guidance⁵⁰ contains a list of examples of potentially liberty-restricting measures that apply in psychiatric hospitals, including the following:

- The level of supervision and control
- Requirements for patients to be escorted in certain parts of the ward or site;
- Restrictions on access to parts of the ward such as limited access to bedrooms during the day;
- Locked doors or use of “baffle locks” unless the patients have the code and are able to come and go as they please;
- Limited visiting time;
- The prescription and administration of medication to a patient who lacks capacity to consent to it, in particular medication to sedate and/or to control the behaviour of the patient;
- Use of physical restraint, especially where such restraint is regular.

81. It is important to recall that the person’s compliance or lack of objection to remaining in hospital and continued care and treatment is no longer relevant to the question of whether a deprivation of liberty is occurring.

82. That it is necessary to err on the side of caution in this determination was emphasised by Charles J in [*AM v South London & Maudsley NHS Foundation Trust & Secretary of State for Health*](#),⁵¹ in which he confirmed that the DOLS regime “*applies when there may be a deprivation of liberty in the sense that [the regime] applies when it appears that judged objectively there is a risk that cannot sensibly be ignored that the relevant circumstances amount to a deprivation of liberty.*”⁵²

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

2.2 Assessment of capacity

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

85. Assuming that the patient is no longer eligible to be detained under the MHA 1983, the only basis for detaining the patient is under the MCA 2005. If the grounds for detaining a person under the MCA 2005

⁵⁰ Paragraph 5.13

⁵¹ [2013] UKUT 0365 (AAC); [2013] COPLR 510

⁵² Para 59.

are not made out then (subject only to the possible and very limited ‘emergency’ exception outlined above) there is no legal basis for holding the person as an informal patient.

86. It follows that, in order to avoid a gap in the legal basis for detention, steps should be taken to authorise a patient’s deprivation of liberty prior to a patient’s discharge. In this regard, it should be noted that there is nothing in the statutory regime to prevent a prospective application being made under the MCA 2005 in the expectation that the patient concerned will be discharged from detention under the MHA 1983. This is the effect of paragraph 12(3) of Schedule A1 which provides that, in determining whether a person meets the qualifying requirement in relation to the giving of a standard authorisation, those circumstances are to be taken into account as they are expected to be at the later time. It was emphasised by Charles J in *AM* that where the discharge from the provisions of the MHA 1983 of a compliant incapacitated patient is warranted, *“it should usually be deferred to enable the relevant DOLS authorisation to be sought (and I should add obtained).”*⁵³
87. The first step is to carry out a capacity assessment to determine whether the patient lacks capacity to consent to a deprivation of liberty. For guidance as to how to carry out capacity assessments, see this [note](#).
88. The assessment of an informal patient’s capacity should be approached with caution. If the assessment is being carried out with a view to making a prospective application to the Court of Protection, or the Supervisory Body, to authorise the deprivation of a patient’s liberty following discharge, this is presumably because the best interests assessor has determined that it is not in the patient’s best interests to return home or be permitted to leave hospital even though section under the MHA 1983 is no longer justified. There will be an understandable inclination to find that an objection on the part of the patient to remaining in hospital is unreasonable and evidence that the patient lacks capacity to make such a decision.
89. Approaching matters on the basis that a person whose views differ from those of the best interests assessor are more likely to lack capacity has always been a forbidden line of reasoning and one that must particularly cautioned against in this scenario.
90. The decision of Baker J in [CC and KK](#) [2012] EWCOP 2136 reinforces this point. It provides a very useful and detailed analysis of the approach to be taken to determining the functional limb of the capacity test. In short, it concerned an elderly dementia sufferer who in the face of the unanimous views of both the independent expert psychiatrist and all of the professionals asserted that she had capacity to make decisions concerning her residence. The court received evidence from her, not only in a written statement but also orally in court. Baker J helpfully set out the approach to be taken by the Court when addressing questions of capacity (paragraphs 17-25). Two points are particularly noteworthy in the present scenario.

⁵³ Para 74.

(1) First, Baker J emphasised that professionals and the court must not be unduly influenced by the “protection imperative”; that is, the perceived need to protect the vulnerable adult (*Oldham MBC v GW and PW* [2007] EWHC 136 (Fam); *PH v A Local Authority, Z Ltd and R* [2011] EWHC 1704 (Fam)) (para 25). After citing passages from Munby LJ’s lecture, ‘Safeguarding and Dignity: Protecting Liberties – When is Safeguarding Abuse?’ Baker J held that “67. *In this case, I perceive a real danger that in assessing KK’s capacity professionals and the court may consciously or subconsciously attach excessive weight to their own views of how her physical safety may be best protected and insufficient weight to her own views of how her emotional needs may best be met.*”

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

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

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

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

92. This judgment provides important lessons for the approach to be taken to determining the functional limb of the capacity test with respect of an informal patient following discharge. It serves as an important reminder that assessors should not allow a professional view that it is best for the patient to remain as an inpatient influence a decision as to patient's capacity. The wisdom and practicable steps principles in s.1 MCA 2005 are designed to guard against this danger. Baker J's emphasis on the need to take such steps – in this case, identifying the full details of the domiciliary care package that would or might be available to KK – is extremely important. Nobody can make an informed decision without being made aware of the salient details and it will often be the assessor that is in the position of providing the person with those details.
93. Identifying the information relevant to a decision can be a somewhat subjective exercise, with a real danger of capacity assessments being conflated with the assessor's views on best interests and identifying the particular steps required will of course differ in each case. The court's decision in *LDV*, discussed above, provides useful guidance on this question. Baker J noted that this was a preliminary issue to be resolved when considering whether the second condition of a deprivation of liberty under Article 5 is satisfied, namely the subjective element - whether or not the person has validly consented to the confinement in question. He noted that:

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

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

- (1) that she was in hospital to receive care and treatment for a mental disorder;
- (2) that the care and treatment would include varying levels of supervision (including supervision in the community), use of physical restraint and the prescription and administration of medication to control her mood;
- (3) that staff at the hospital would be entitled to carry out property and personal searches;

- (4) that she must seek permission of the nursing staff to leave the hospital, and, until the staff at the hospital decide otherwise, would only be allowed to leave under supervision;
- (5) that if she left the hospital without permission and without supervision, the staff would take steps to find and return her, including contacting the police.

95. Not least as this was the first case in which the Court considered the components of capacity to decide upon admission as an informal psychiatric patient, we would suggest that each of these matters are likely to be a relevant considerations in any scenario wherever the assessor is considering whether the person has the capacity to consent to an informal admission to a psychiatric hospital in circumstances amounting to a deprivation of their liberty.⁵⁴

2.3 Authorising a deprivation of liberty

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

97. It is important that any application for an authorisation under the MCA 2005 is made as soon as possible. It is clear following the *ZH* case discussed above that a deprivation of liberty can arise after only a relatively short period of time. In principle, an authorisation should be in place from the moment the patient is discharged. In a case, such as the *LDV* case, where it is likely that a patient will remain in hospital for a period of time after discharge, best practice would be for assessments to be carried out and any application for an authorisation under the MCA 2005 to be made prior to discharge. Although

⁵⁴ In *AM*, Charles J noted (at para 40) that the question of whether the relevant person has the capacity to consent to admission as an informal patient: "will be likely to include consideration of the person's capacity to agree (a) to the relevant admission to hospital for the relevant purpose, (b) to stay in hospital whilst its purpose is carried out and (c) to the circumstances relating to a possible deprivation of liberty that will prevail during that admission." He continued at para 41 that "it seems to me that whilst in theory distinctions between the elements of capacity described above could arise it is unlikely that they will do so with any regularity in practice. Also, it seems to me that it may well be difficult to assert that the person does not have the capacity to consent to the assessment or treatment but does have the capacity to agree to be admitted to and remain in hospital in the relevant circumstances and for the relevant period, and so whilst the assessment is carried out or the treatment is given that requires the person to be an in-patient."

a person cannot simultaneously be detained in hospital under the MHA 1983 and subject to a deprivation of liberty authorisation under the MCA 2005, there is nothing to prevent a prospective application being made. This point was emphasised in the Department of Health's letter (referred to above),⁵⁵ which stated as follows:

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

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

Resources

99. Useful free websites include:

www.39essex.com/resources-and-training/mental-capacity-law – database of case summaries and case comments from the monthly Thirty Nine Essex Street Mental Capacity Law Newsletter, to which a free subscription can be obtained by emailing marketing@39essex.com.

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 - Social Care Institute of Excellence, including good practice guidance in a number of areas relating to mental capacity and related law.

Other useful materials can be found in Chapter 11 of [Deprivation of Liberty: a Practical Guide](#).

⁵⁵ Reproduced in the Upper Tribunal judgment in *DN v Northumberland, Tyne and Wear NHS Foundation Trust* [2011] UKUT 327 (AAC) (Judge Jacobs).