IN THE UPPER TRIBUNAL **Case No. HM/1538/2013**
ADMINISTRATIVE APPEALS CHAMBER

AM v (1) SOUTH LONDON & MAUDSLEY NHS FOUNDATION TRUST and (2) THE SECRETARY OF STATE FOR HEALTH

[2013] UKUT 0365 (AAC)

Before: Mr Justice Charles (Chamber President)

Attendances

For the Appellant:	Chris Buttler instructed by Steel & Sharmash
For the 1st Respondent	Parishil Patel instructed by DAC Beechcroft, Solicitors
For the 2nd Respondent	Ben Hooper instructed by the Department of Health

Decision:

1. This appeal is allowed.
2. The case is remitted to a differently constituted First-tier Tribunal to consider, applying the approach set out below.

REASONS FOR DECISION

Introduction

1. This case gives rise to issues relating to the approach to be taken by the First-tier Tribunal (the FTT) and other decision makers under the Mental Health Act 1983 (the MHA) when treatment and authorisation of a deprivation of liberty of the relevant patient might be given under the Mental Capacity Act 1985 (the MCA). It does so in different circumstances to those that existed in both *J v Foundation Trust* [2010] Fam 70 and in *DN v Northumberland & Wear NHS Foundation Trust* [2011] UKUT 327. The circumstances that existed in those two cases also differed in that although in both the subject to the proceedings had mental and physical health problems:

   i) the first (*J v Foundation Trust*) concerned assessment and treatment in hospital and the validity of the authorisation given under the Deprivation of Liberty Safeguards ("DOLS") introduced into the MCA, of a patient who objected to being in hospital. I concluded that the authorisation was lawful because the patient was not ineligible to be deprived of his liberty under the DOLS because on a "but for" approach his admission and treatment was for his diabetes, and

   ii) the second (*DN*) related to the discharge of *DN* and whether arrangements that might be put in place under the MCA and DOLS concerning his placement in a Care Home were a relevant consideration and Upper Tribunal Judge Jacobs decided that in the circumstances of that case they could be.

Here, the circumstances do not raise issues relating to (a) treatment for mental and/or physical disorder or problems (as in *J v Foundation Trust*), or (b) discharge from hospital (as in *DN*). Rather, they relate to whether the Appellant should be discharged from detention under s. 2 because her assessment in hospital for the purposes identified in s. 2 MHA should be carried out and authorised under the MCA and its DOLS.

2. All decision makers who have to address the application of the provisions of the DOLS contained in Schedules A1 and 1A of the MCA are faced with complicated legislative provisions and their difficulties are compounded when they have to consider the relationship between the MHA and the MCA. Regular visitors to the provisions need to remember the daunting task they set for lawyers and non-lawyers who have to apply them. Such regular visitors will be aware that new points of interpretation and application regularly arise and this has caused me to make some comments in a postscript about what I said in *J v Foundation Trust* [2010] Fam 70.

Some background facts

3. This case concerns AM who is a 78 year old woman who until late 2012 had for many years been living in her own home with her daughter CM. She has another daughter VM. AM has had contact with mental health services from time to time since 1983, when she was first admitted to hospital with depression. Prior to the events leading to this appeal her last admission to hospital was an informal one in 2002 and no formal diagnosis was made at that time.

4. On 12 November 2012, AM was removed from her home by the community mental health team using a warrant issued under s. 135(1) MHA so that an assessment of her under s. 2 MHA could be undertaken. I understand that CM had refused the mental health team access to the home or other access to AM to enable them to carry out an assessment. On execution of the warrant AM was admitted to hospital under s. 2 MHA.

5. On 21 November 2012, the FTT considered an application for the discharge of AM. They ordered that she was not to be discharged and in paragraphs 13 and 14 of their Decision (the November 2012 FTT Decision) said:

> " 13. We are satisfied that if the order were discharged, [AM] would be taken home by her daughters although she appeared to be quite happy in the hospital environment herself. She would therefore be deprived of the benefit to her health which is likely to follow from the important assessment, which also needs to be done in the interests of her long-term mental health.
>
> 14. We are also satisfied that if the order were discharged [AM's] daughter, [CM], would not co-operate with medication or with the community team. There is a history of non-co-operation both in the past and recently. [AM's] poor insight is also relevant. Without her carer to cooperate on her behalf, we find that she would be completely unable to do so as she

> blatantly lacks capacity to understand what is happening and she lacks insight into her mental disorder. "

6. AM's detention in hospital under s. 2 MHA is continuing under s. 29(4)(a) MHA because proceedings to displace CM as her nearest relative have been issued on the basis of an assertion that CM has refused to agree to AM being detained in hospital pursuant to s. 3 MHA. No interim orders have been made in those proceedings because CM has given an undertaking to the court not to make an order for AM's discharge under s. 23 MHA.

7. At present AM is on s. 17 leave with her daughter VM.

8. A further application for AM's discharge came before a differently constituted FTT on 8 February 2013. AM attended part of that hearing. Her daughter CM attended the hearing and provided a written statement and her daughter VM gave oral evidence.

9. That FTT ordered that AM was not to be discharged and it is that decision (the FTT Decision) that is the subject of this appeal.

10. There is and was effective common ground that (a) AM has a mental disorder, (b) she needs a cognitive assessment, and (c) she needs treatment in the form of taking tablets. The way in which the case for discharge was put is not that AM should be discharged home but that she should be discharged from s. 2 detention in hospital. The argument is that, as she will stay there on a voluntary basis her s. 2 detention is not "necessary" and so it is not "warranted" (the word used in ss. 2 and 72 MHA) if those provisions are read compatibly with Article 5(1)(e) ECHR.

11. An essential factual issue therefore relates to AM's voluntary compliance with her assessment in hospital (and not anywhere else). Also, no question arises on whether her admission and stay in hospital is for anything other than an assessment (or an assessment followed by medical treatment) of her mental disorder.

12. It is argued on AM's behalf that if she is sufficiently compliant she can be assessed and treated at the hospital pursuant to s. 5 MCA and that if the objective assessment of her circumstances in hospital amounts to a deprivation of her liberty then this can be authorised under the DOLS provisions contained in the MCA. The question of whether she is ineligible (the statutory approach) to be the subject of a DOLS authorisation is covered by Case E in the table set out in paragraph 2 of Schedule 1A to the MCA.

The correct approach in law to the issue whether the compliance of a person to remaining in hospital for assessment (or treatment) leads to the conclusion that his or her detention under s 2 (or s. 3) MHA is or is not warranted

13. This heading focuses the analysis on the issues in this case. The most relevant provisions of the MHA, the MCA, the MHA Code of Practice, and the MCA Deprivation of Liberty Safeguards Code of Practice are set out in the Schedule hereto.

14. The status of the MHA Code of Practice is addressed by the House of Lords in *R(Munjaz) v Mersey Care NHS Trust*[2006] 2 AC 148 in particular at paragraph 21

(Lord Bingham) and paragraph 69 (Lord Hope). Those passages make clear that a decision maker must have cogent reasons for departing from the guidance in the MHA Code of Practice and that it must be given great weight. There is no similar authority in respect of other relevant Codes but here nothing turns on whether the guidance they give should be given different weight, or on the cogency of any reasons to depart from it. Clearly hospitals, the FTT and other relevant decision-makers should consider all of the relevant Codes with care.

The approach to determining whether detention in hospital is "warranted".

15. There was no dispute before me about this and all parties accepted, as submitted on behalf of AM, that to be compatible with Art 5(1)(e) ECHR, ss 2, 3 and 72 of the MHA have to be applied on the basis that for detention in hospital to be "warranted" it has to be "necessary" in the sense that the objective set out in the relevant statutory test cannot be achieved by less restrictive measures. As to that, I was referred to *Varbanov v Bulgaria* [2000] ECHR 31365/96 at paragraph 46, *Enhorn v Sweden* (2005) 19 BHR 222 at paragraph 44 and *R(Countryside Alliance) v A-G* [2008] 1 AC 719 at paragraph 156 (for the approval of the citation that to support the proposition that any restriction imposed on a Convention right must be proportionate to the legitimate aim pursued).

16. I agree and add that it seems to me that whether it is reasoned and classified in terms of proportionality, or by reference to promoting the best interests of the patient, the relevant aim is to seek to identify the least restrictive way of best achieving the proposed assessment or treatment (the aim). This is a judgmental exercise that involves the consideration and balancing of the relevant factors.

Categorisation of persons requiring assessment and/or treatment in hospital of the types defined in ss. 2 and 3 MHA.

17. The parties adopted a categorisation advanced on behalf of AM. I agree that it is helpful to do so as a background to the consideration of the issues in this case. The four categories were:

    i) The compliant capacitated.

    ii) The compliant incapacitated.

    iii) The non-compliant capacitated.

    iv) The non-compliant incapacitated.

18. In these categories the capacity being referred to is the capacity to agree to remain in hospital for the purposes of and in the proposed circumstances relating to the relevant admission. The capacity of a person to agree to so remain in hospital, or only to treatment or to anything else falls to be assessed by applying ss. 1, 2 and 3 of the MCA, and is "matter specific".

19. Section 131 MHA plainly contemplates that if a person with the capacity to agree to the arrangements referred to in that section, and thus to an informal admission, does so agree there is no need (or warrant) for him or her to be detained in hospital

pursuant to ss. 2 or 3. A case might arise where there was an issue whether the person's capacity covered the ability to consent to the circumstances of an admission that may amount to a deprivation of liberty as opposed to consenting simply to stay in hospital, and there can be an overlap between issues that are relevant to the capacity to stay in hospital and to agree to treatment. Such questions can give rise to finely balanced issues, but the conclusions on capacity give rise to hard edged answers, including the following:

i) the MCA cannot apply in respect of any matter which the relevant person has the capacity to decide for himself or herself,

ii) a person with the capacity to do so can consent to a deprivation of his or her liberty, and

iii) a person with the relevant capacity who is refusing to be admitted to hospital or is demanding to leave hospital (so a category (iii) person) can only be detained there pursuant to the MHA.

20. But, the position is not so hard edged in respect of a person with the relevant capacity who is agreeing to be admitted to and to stay in hospital. The position in respect of such a person (a category (i) person) is reflected in paragraphs 4.9 and 4.11 of the MHA Code of Practice. In short, this indicates and I agree that generally it will not be necessary to detain such a person (see paragraph 4.9) but there can be circumstances in which it will be (paragraph 4.11). This result flows from the nature of the "necessity test" set by ss. 2, 3 and 72 the MHA, and from the terms of s. 131 MHA because it provides that nothing in the MHA will prevent informal admission, rather than providing that in certain defined circumstances the admission is to be on an informal (voluntary) basis.

Assessment or treatment in reliance on the MCA.

21. If sections 5 and 6 of the MCA apply, they have the effect that the persons involved in the relevant assessment or treatment do not incur liability. However these sections:

i) do not exclude liability for depriving P of his liberty (see s. 4A MCA),

ii) do not affect the operation of ss. 24 to 26 (advance decisions to refuse treatment), and

iii) are qualified in respect of acts intended to restrain P, and such acts can trigger a consideration of whether P is being deprived of his liberty.

22. The DOLS provisions in the MCA apply only to persons who are in hospitals and care homes. Save in cases of life-sustaining treatment, or the doing of a vital act (see s. 4B MCA), any other authorisation of a deprivation of liberty under the MCA is based on the person responsible for it giving effect to a decision of the Court of Protection made by an order under s. 16(2)(a) MCA in relation to a matter concerning P's personal welfare (see s. 4A MCA).

23. No authorisation of a deprivation of liberty by the Court of Protection or DOLS is possible under the MCA if the relevant person is "ineligible to be deprived of his liberty" (see s. 16A MCA and paragraph 17 of Schedule A1 to the MCA).

24. The DOLS provisions provide for the giving of urgent and standard authorisations and the role of the Court of Protection in respect of them is given and governed by s. 21A MCA.

25. The provisions of the MCA relating to deprivation of liberty were added by amendment to address and fill the "*Bournewood Gap*" (see *R* v. *Bournewood Community and Mental Health NHS Trust, ex parte L (Secretary of State for Health and others intervening)* [1998] 3 All ER 289). In describing the *Bournewood Gap* I again with gratitude adopt a description used in lectures given by Professors Fennell and Clements. It is:

> "In *Bournewood* a mentally incapacitated man (HL) was admitted to hospital and retained there against the wishes of his carers, without the health care professionals using the powers of compulsory detention in the Mental Health Act 1983. HL was 48 and was suffering from severe autism. He lacked capacity to consent or dissent to being in hospital. For most of his adult life he had been an in-patient in a learning disability hospital, before being placed in the care of Mr and Mrs E under an adult fostering scheme. Whilst at the day centre which he attended on one day each week, he became disturbed and agitated, banging his head with his hands. According to Mr and Mrs E, he had one of these 'tantrums' about every four days, but the Es could cope with them and had never had to call the police or have him admitted to hospital. On this occasion the Es could not be contacted. A local doctor attended and sedated HL. His care worker arranged for him to be taken to the accident and emergency ward of the local hospital. Although initially calm and relaxed, while at the Accident and Emergency Unit he became increasingly disturbed, was again given sedation and was admitted 'informally' to the mental health behavioural unit at the hospital, under the care of the clinical director for learning disabilities, a consultant psychiatrist. Although incapable of consenting to admission, once in hospital he made no attempts to leave. He had no ability to express consent or dissent to treatment (although he could manifest unhappiness as to specific treatment). He was unable to express preference as to residing at one place rather than another. He did not resist admission, nor did he seek to leave. If he had, the doctor would have detained him using the compulsory powers in the Mental Health Act 1983. Because he had not been detained ('sectioned') under the 1983 Act, HL had no right to review of his detention by a Mental Health Review Tribunal. Through his next friends (Mr and Mrs E) he sought legal redress, via judicial review of the decision to detain him, habeas corpus and an action for damages for false

imprisonment. To obtain that redress it had to be established (1) that HL had been detained or subject to imprisonment, and (2) that the detention was unlawful.

So there were two central questions: (a) in what circumstances was an incapacitated patient detained in law? and (b) when should a patient who lacks capacity be detained using the powers in the Mental Health Act 1983 and when was it permissible to use common law to admit incapacitated patients? The House of Lords held that there was a common law power under the doctrine of necessity to detain and restrain patients who lack capacity and where detention was necessary in their own best interests. Five of the nine judges who considered HL's position at English law considered him to have been detained, and did so on the basis of the control assumed by the doctor over HL's treatment, residence, movement and contact with the outside world, a key point being that HL would have been prevented from leaving had he tried to do so. Despite the existence of an extensive case law on detention under the European Convention on Human Rights, the speeches in the House of Lords do not refer to the Convention. Lord Steyn, however, identified the existence of a lacuna, which has come to be known as 'the Bournewood Gap':

> "The common law principle of necessity is a useful concept but it contains none of the safeguards of the 1983 Act. It places effective and unqualified control in the hands of the hospital psychiatrists... [N]either habeas corpus nor judicial review are sufficient safeguards against misjudgements and professional lapses in the case of compliant incapacitated patients."

He also stated that 'the law would be defective if it failed to provide adequate protective remedies to a vulnerable group of incapacitated mental patients.'

HL's carers applied to the European Court of Human Rights, which held that HL had been deprived of his liberty and that there had been a breach of Article 5(4) in that the use by the doctor of the common law doctrine of necessity, instead of statutory powers to detain, did not meet the requirement in Article 5(1)(e) that such a detention must be carried out in accordance with a procedure prescribed by law. They won (*HL* v *The United Kingdom* (2004) 40 EHRR 761).

In relation to mentally incapacitated adults, the common law doctrine of necessity has largely been superseded in relation to acts of care and treatment by sections 5 and 6 of the MCA. However, it follows from the ECHR's ruling that because sections 5 and 6 of the MCA provide a defence to a battery action, rather than prescribe a procedure, they cannot satisfy the

> requirements of Article 5(1)(e) in relation to a detention on grounds of unsound mind. For that reason, the Government decided to implement the judgment and bridge '*the Bournewood Gap*' by way of amendments introduced to the Mental Capacity Act 2005 to provide for Deprivation of Liberty Safeguards in relation to adults who lack capacity to decide where they should reside."

26. More generally, a part of the relevant background to the issues that arise in this case relating to the application of the MHA and the MCA are the points that:

    i) compliance with Art 5(1) ECHR requires that if, the relevant person does not have the capacity to consent to it, a deprivation of his or her liberty is only implemented in accordance with a procedure prescribed by law,

    ii) before and after the amendments to the MCA, such procedures for the lawful authorisation of a deprivation of liberty are provided by the MHA 1983, when it applies, and

    iii) after the amendments to the MCA such procedures, in defined circumstances, are provided by the MCA and its DOLS which authorise, rather than direct, a detention or deprivation of liberty, on the basis that it is an aspect of the arrangements to be put in place to best promote the best interests of the relevant person.

27. So, the DOLS were introduced into the MCA to cover (amongst others) people in the situation of HL in the *Bournewood* case and thus the compliant incapacitated (category (ii) above).

28. To my mind, it follows that:

    i) in the circumstances defined therein the DOLS were intended to and do provide an alternative basis to that provided by the MHA to authorise the deprivation of the liberty of an incapacitated person for a range of purposes including his or her assessment or treatment for mental or physical disorders in hospital, and so

    ii) a decision maker under the MHA has to consider whether that alternative is available and, if it is, whether it should be used when he or she applies the "necessity test" set by the MHA.

    The qualification "in the circumstances defined thereby" in sub-paragraph (i) is important and means that the relevant decision maker has to consider the application of those provisions to the circumstances of the particular case.

29. *The decision –makers under the DOLS.* These include the NHS Foundation Trust for the hospital, as the managing authority. Only the managing authority may give an urgent authorisation and it may only do so if it is required to do so (see Schedule A1 paragraphs 74 to 77). A standard authorisation can only be given by the supervisory body, at the time of the FTT Decision the relevant Primary Care Trust (see Schedule AI paragraphs 21 and 180, as from 1 April 2013 para. 180(2) was amended with the

result that the supervisory body is now the local authority) and the supervisory body may not do so unless the managing authority has requested it or paragraph 71 of Schedule A1 applies (see Schedule A1 paragraph 22). The managing authority may not make the request unless they are required or permitted to do so (see Schedule A1 paragraph 23). The duty of the managing authority to give an urgent authorisation is linked to the duties imposed on it to request a standard authorisation imposed by paragraphs 24 and 25 of Schedule A1 and, for present purposes, the most relevant trigger to that duty is that it appears to the managing authority that the relevant person "is likely – at some time in the next 28 days - to be a detained resident in the relevant hospital (or care home)".

30. There are also 6 qualifying requirements that have to be satisfied before an authorisation can be given under the DOLs (see paragraph 12 of Schedule A1). These include the best interests and eligibility requirements and the decisions on whether they are met are made by a range of people.

Pausing there

31. At the stage that the matter is before the FTT, it is the FTT that is the relevant decision maker under the MHA.

32. In this case the function of the FTT was to consider and determine an application for the discharge of AM from detention under Part II of the MHA (in this case, s. 2 MHA). That decision making process is governed by the MHA and in particular s. 72 thereof and so the "necessity test".

33. In contrast, the FTT has no jurisdiction or power to make decisions under the MCA or its DOLS.

34. But the MHA "necessity test" means that, in the search for the best way to achieve the desired purpose (i.e. the assessment or treatment referred to in ss. 2 and 3 of the MHA) in the least restrictive way, the FTT (and other decision makers under the MHA) have to consider whether this result should be founded on a detention in hospital and if so whether that should be pursuant to the MHA, or whether the assessment or treatment in the proposed circumstances should be founded on the MCA and any deprivation of liberty it involves should be authorised under the DOLS. To do that, the FTT (and such other decision makers) have to consider whether the MCA and its DOLS alternative are applicable and available and, if so, whether and when they should be used.

35. This approach necessitates a progression of reasoning.

36. I agree with the SSH that a first stage for decision makers responsible for making decisions about a person's assessment or treatment for mental disorder (or other health problems) is to consider whether the admission of that person to hospital, as opposed to treatment or assessment in the community or as a day patient, is warranted. In this case, the argument before me and the FTT proceeded on the common ground that in AM's case admission to hospital was warranted. (However, I add that AM's daughters were not parties and I do not know whether they subscribe to that common ground).

37. Once it has been decided that an admission to hospital is required the progression of reasoning will generally give rise to the three questions set out and discussed in paragraphs 39 to 75 below.

38. The second of those questions covers the issue whether the relevant person is ineligible to be deprived of his liberty under the MCA, and as appears from for example paragraphs 33 to 36 and 75 of my judgment in *J v Foundation Trust*, once it has been decided that an admission to hospital is required:

    i) the first condition set by the gateway or test set out in paragraph 5(3) of Schedule 1A to the MCA for the application of Case E is engaged when the purpose of any authorisation under the MCA and its DOLS would be to authorise the accommodation of the relevant person as a mental health patient (as defined by paragraph 16(1) of Schedule 1A – a person accommodated in a hospital for the purpose of being given medical treatment (which as defined by s. 145(1) and (4) of the MHA includes nursing) for a medical disorder (as defined in paragraph 14 of Schedule A1 to the MCA)), and so as in my view here and generally this includes the medical treatment (as so defined) that would be given during an assessment for the purposes referred to in s. 2 MHA,

    ii) the second condition set out in paragraph 5(4), namely whether the relevant person objects to being a mental health patient or to being given some or all of the mental health treatment, determines the application of the paragraph 5 gateway or test.

    This means that the relevant person will only not be ineligible to be deprived of his or her liberty under the MCA, and so an authorisation under its DOLS could be given, if he or she does not so object.

The first question for the decision maker and thus the FTT in this case.

39. The analysis and discussion in paragraphs 13 to 20 above mean that the decision maker (and thus the FTT) should consider:

> "*Whether the relevant person has the capacity to consent to the arrangements referred to in s. 131 MHA*?"

40. That question 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.

41. I pause to add 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.

42. However, the answer to the issues of capacity set out in paragraph 40 above will set the progression of decision making.

43. If the person has that capacity the issue will become whether he or she has decided to be admitted to hospital and to remain there, in those circumstances, the MCA will be irrelevant and the tests set by the MHA will be determinative.

44. Whereas, if it is decided that the person lacks capacity to be the subject of an informal admission or to give a relevant consent relating to the relevant arrangements (or their effect) the jurisdiction under the MCA is engaged, and the decision maker is considering an incapacitated person in categories (ii) or (iv), namely a compliant or non-compliant incapacitated person.

The second question for the decision maker under the MHA and thus for the FTT in this case.

45. The analysis and discussion in paragraphs 21 to 38 above mean that the decision maker (and thus the FTT) should consider:

> "*Whether the hospital might be able to rely on the provisions of the MCA to lawfully assess or treat the relevant person?"*

46. The MCA can only apply when the relevant person lacks the relevant capacity and so it does not apply to categories (i) and (iii).

47. It was common ground that generally a hospital could not rely on the MCA to lawfully assess and treat persons in category (iv) – the non-compliant incapacitated. This is because such persons will generally be ineligible to be deprived of their liberty pursuant to s. 4A(5) (read with paras. 12(1)(e) and 17 of Schedule A1 to the MCA and paras 1, 2, 5 and 12 of Schedule 1A to the MCA as I construed them in *J v Foundation Trust*). To my mind sensibly, as it does not seem that it arises here, no point was taken as to whether the hospital could rely on the MCA if the objection was only to some elements of the care, assessment or treatment (see paragraph 4.20 of the MHA Code of Practice, which also refers to advance decisions). Any such distinctions are for another day, would engage the second condition set by paragraph 5(4) of Schedule 1A to the MCA and, as mentioned in paragraph 41 above, the factual premise for them may well be difficult to establish.

48. So, at this stage and in this case the second question relates to a person in category (ii) – the compliant incapacitated – because the answer to the first question is that the relevant person does not have the capacity to consent to the arrangements referred to in s. 131 MHA taken as a whole.

49. In those circumstances, the second question involves a consideration of:

    i) whether the relevant person will comply with all the elements of what is proposed concerning his or her assessment or treatment, which arises under s. 131 MHA (and paragraph 5(4) of Schedule 1A to the MCA - see paragraph 38 above), and

ii) the application of ss. 5 and 6 MCA and its DOLS if the proposed circumstances relating to the proposed assessment or treatment are such that the objective element of a deprivation of liberty is or is likely to be satisfied.

50. *Compliance.* This issue of fact will include an assessment of the degree of compliance, the risks of non-compliance or objection and what might trigger them. The conclusion on this "compliance issue" could render further consideration of this second question irrelevant and redundant, or they could inform the application of ss. 5 and 6 MCA or the third question (see paragraphs 62 and 73(ii) below).

51. *The DOLS.* There are two issues to be considered, when as here the proposed placement is in a hospital :

i) is the relevant person ineligible to be deprived of his or her liberty under the DOLS, and

ii) whether the circumstances are such that an authorisation under the DOLS is required.

52. The first of these issues engages the issue whether the relevant person is ineligible to be deprived of his or her liberty under the MCA and so a consideration of the provisions relating to this. Here, if the compliance issue is satisfied it was correctly common ground that AM would not be ineligible to be deprived of her liberty under the MCA.

53. As mentioned in paragraph 29 above the duty of the managing authority to give an urgent authorisation is linked to the duties imposed on it to request a standard authorisation imposed by paragraphs 24 and 25 of Schedule A1 and, for present purposes, the most relevant trigger to that duty is that it appears to the managing authority that the relevant person "*is likely – at some time in the next 28 days - to be a detained resident in the relevant hospital (or care home)*".

54. A "detained resident" is defined by paragraph 6 of Schedule A1 as a person detained in a hospital (or care home) – for the purposes of being given care or treatment – in circumstances that amount to a deprivation of that person's liberty.

55. In the context of a person who lacks capacity to consent to such circumstances the objective element or assessment of a deprivation of liberty is engaged. This objective assessment is fact sensitive and, for example, the distinction between a deprivation of, and a restriction upon, liberty is merely one of degree and intensity and not one of nature or substance (see paragraph 89 of the judgment in *HL v UK* and the discussion of the authorities in *A Primary Care Trust v LDV and others* [2013] EWHC 272 (Fam) at paragraphs 10 to 16, which also demonstrates the difficulties the courts have had in analysing and determining what is or is not objectively a deprivation of liberty). A decision of the Supreme Court is awaited on the subject, but it is likely that whatever analysis is given by the Supreme Court the position will remain that two decision makers applying the correct approach could lawfully reach different answers.

56. In paragraph 49(ii) above, I referred to the question as being whether the objective element of a deprivation of liberty is or is likely to be satisfied. The phrase "is likely" is used in the test to determine whether a managing authority has a duty to request a

standard authorisation and so by reference in the test governing its duty to give an urgent authorisation (see again paras 24 and 76 of Schedule A1).

57. As is demonstrated by the speeches in the House of Lords in *Re H and R (Child Sexual Abuse)* [1996] 1 FLR 80 the word "likely" can according to its context mean "probable" or "whether there is a real risk" (see Lord Nicholls at 94D to 95E). In my judgment, in the context of defining the duty on a managing authority to request a standard authorisation Parliament was using the word "likely" in the sense of whether, in the period referred to, there is a real risk or possibility that the relevant person will be a "detained resident" (as defined - see paragraph 54 above) and intended that the word "likely" was to relate to both that period and that status.

58. I am of this view because if Parliament had intended the word "likely" to mean "probable" or "more likely than not", or that it only related to the 28 day period referred to, the provisions enacted to fill the *Bournewood* gap would not cover cases where there was a real possibility that the relevant circumstances amounted to (and would later be held to be) a deprivation of liberty, and so would leave a gap, albeit a narrower one. That gap would mean that the procedure so prescribed by amendment to the MCA to provide safeguards would not do so for either (a) a person who lacks capacity and is put is such a situation, or (b) the persons who have done this. In my view, that result for a procedure designed to provide safeguards relating to the important issue of deprivation of liberty would fly in the face of the underlying protective purposes of the DOLS and the intention to fill the *Bournewood* gap particularly when it is remembered that in some circumstances there are real difficulties in determining whether a person is being deprived of his or her liberty and different people applying the right test can reach different answers.

59. So, I agree with the SSH's submission that the DOLS regime applies when there may be a deprivation of liberty in the sense that it 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.

60. I expressed the same view, in *A Local Authority v P and PB* [2011] EWHC 2675 (CoP) at paragraph 64(vi). There it was based on different, but in my view supportive, reasoning to that set out above based on the duty imposed by paras 24 and 76 of Schedule A1.

The third question for the decision maker under the MHA and thus for the FTT in this case.

61. Whether this question is reached depends on the answers to the first two questions and thus on whether the relevant person lacks the relevant capacity and the hospital might be able to rely on the MCA to lawfully treat or assess him.

62. However, if the MCA does apply because the person lacks the relevant capacity and the hospital might be able to rely on its provisions to assess or treat the relevant person, the question arises:

> "*How should the existence of a choice between reliance on the MHA and the MCA and its DOLS be taken into account?"*

63. Here the complications that arise when a person requires assessment or treatment for both mental and physical disorders, and so the situation in *J v Foundation Trust* does not arise, and the reality is that the choice of statutory route relates to whether (a) the relevant person should be detained under the MHA, or (b) his (possible) deprivation of liberty should be authorised under the DOLS. This is because the application of s. 131 MHA and ss. 5 and 6 of the MCA to the assessment and treatment of a compliant incapacitated patient work together.

64. It was argued on behalf of the Appellant that on a proper application of the "necessity test" set by the MHA to persons in category (ii) – the compliant incapacitated – and thus to the Appellant on her case, he or she must not be detained under ss. 2 or 3 MHA if:

    i) the relevant objective (namely the proposed assessment or treatment referred to in ss. 2 or 3 MHA pursuant to the proposed arrangements and circumstances relating to it) could be met under the MCA regime, and

    ii) the MCA regime would be less restrictive.

    The effect of that submission is that in those circumstances the MCA has priority (or effective priority) because the powers under the MHA could not properly be exercised and relied on.

65. In support of that argument the Appellant's counsel made the following points:

    i) This is, or effectively is, the situation identified as the *Bournewood* gap and so it reflects a situation that Parliament intended to cover when it amended the MCA to introduce the DOLS.

    ii) Inherent in the "necessity test" under ss. 2, 3 and 72 MHA is the requirement of proportionality and so any interference with a Convention right (here Article 5) has to be to the minimum necessary to meet the objective, and this is reflected in paragraph 1.3 of the MHA Code of Practice.

    iii) Although an authorisation under the DOLS will not inevitably be less restrictive:

        a) the perception of many is that detention under the MHA carries a stigma and this supports the view that generally it will be more restrictive than an authorisation of a deprivation of liberty under DOLS, and

        b) an authorisation under the DOLS can where appropriate be made under conditions that would render it less restrictive (e.g. in respect of family visits or to the community).

66. As appears above, I do not quarrel with any of the points set out in the last paragraph. Nor did the SSH.

67. However, in my judgment they do not found the submission made on behalf of the Appellant but support the conclusion that, as was submitted on behalf of the SSH and is recognised in paras. 1.3 and 4.22 of the MHA Code of Practice, it will generally but

not always be more appropriate to rely on DOLS in such circumstances and so, when on an objective assessment, there is a risk that cannot sensibly be ignored that a compliant incapacitated person will be being deprived of his liberty in hospital in the circumstances relating to his or her assessment or treatment for the purposes set out in ss. 2 or 3 MHA.

68. In my judgment, as submitted on behalf of the SSH, the Appellant's submission, even though:

    i) it is based on the proposition that the relevant objective could (rather than might or would) be met under the MCA regime, and

    ii) has the qualification that authorisation of a detention under DOLS will not inevitably be less restrictive, and so gives some flexibility,

    is too prescriptive or "hard edged" and the correct position is that there may be cases in which a compliant incapacitated person may properly and lawfully be admitted, assessed or treated and detained under Part II MHA when he or she could be assessed or treated pursuant to s. 131 MHA and ss 5 and 6 MCA and be the subject of the DOLS.

69. I agree with the SSH that examples of circumstances when this will be the case are found in paragraph 4.21 of the MHA Code of Practice and paragraph 4.48 of the Code of Practice to Supplement the Mental Capacity Act Code of Practice.

70. In posing the second question (see paragraph 45 above) for the FTT (and earlier decision maker) under the MHA I have used the word "might" and not "could". As appears from *J v Foundation Trust* the meaning to be given to the word "could" in paragraph 12(1) of Schedule 1A to the MCA gives rise to some uncertainty when a decision maker has to consider whether another statutory scheme (there s. 2 or 3 of the MHA) applies or could apply. In my second question I am using "might" in the sense of there being a possibility, because that approach fits with a progression of reasoning relating to establishing the existence of that alternative followed by a decision on its impact on the application of the "necessity test" set by the MHA.

71. In answering the second question, the FTT (and earlier decision maker) under the MHA has to consider whether the criteria for the application of the MCA and its DOLS exist and I consider, as I did in *J v Foundation Trust*, that the appropriate and practical course for them to take is to ask themselves what conclusion they would reach applying those criteria.

72. In my judgment, at the stage of addressing the third question, the FTT (and earlier decision maker) under the MHA needs to consider the actual availability of the MCA regime and then compare its impact, if it was used, with the impact of detention under the MHA.

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

i) consideration of what is in the best interests of the incapacitated person in line with the best interests assessment in the DOLS process, and so for example conditions that can be imposed under the DOLS, fluctuating capacity and the comparative impact of both the independent scrutiny and review and the enforcement provisions relating to the MHA scheme on the one hand and the MCA scheme and its DOLS on the other, and possibly

ii) as mentioned in paragraph 50 above a consideration of the likelihood of continued compliance and triggers to possible non-compliance and their effect on the suitability of the regimes, which links to the points made in paragraph 4.21 of the MHA Code of Practice and paragraph 4.48 Deprivation of Liberty Safeguards Code of Practice.

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

75. In my judgment, the rationale for this more flexible approach, is that in certain circumstances which it has defined in the MHA and the MCA Parliament has provided statutory regimes which may or do provide alternatives and so choices which fall to be considered by the relevant statutory decision makers under the two schemes. This is such a situation but it is one in which the FTT only has jurisdiction (and power) to make a decision applying the MHA. This has the results that:

i) the FTT (and earlier decision makers under the MHA) have to apply the statutory tests imposed by the MHA and the possible application of the MCA and its DOLS are relevant to that exercise,

ii) the FTT (and the earlier decision makers under the MHA) have to assess whether as a result of the identified risks the relevant person ought to be detained, or kept in hospital in circumstances which on a objective assessment give rise to a risk that cannot be ignored that they amount to a deprivation of liberty (see for example paragraph 22 of Upper Tribunal Judge Jacobs decision in *DN v Northumberland & Wear NHS Foundation Trust*),

iii) if the answer is "yes", this triggers a value judgment applying the "necessity test" as between the choices that are or will or may become available,

iv) the search applying the MHA "necessity test" is for the alternative that best achieves the objective of assessment or treatment of the type described in ss. 2 and 3 MHA in the least restrictive way. This potentially introduces tensions and so a need to balance the impact of detention under the MCA and an authorisation under the DOLS as the means of ensuring that a deprivation of

liberty to best achieve the desired objective is lawful and governed by a statutory regime, and

v) the theoretical and practical availability of the MCA regime and its DOLS is one of the factors that needs to be considered by the MHA decision maker in carrying out that search, as are their overall impact in best achieving the desired objective when compared with other available choices and so detention under ss. 2 or 3 MHA.

Postscript

76. In *J v Foundation Trust* [2010] Fam 70 I said:

> "*The relationship between the MHA 1983 and the MCA in the context of deprivation of liberty*
>
> 58. In my judgment, the MHA 1983 has primacy in the sense that the relevant decision makers under both the MHA 1983 and the MCA should approach the questions they have to answer relating to the application of the MHA 1983 on the basis of an assumption that an alternative solution is not available under the MCA.
>
> 59. As appears later, in my view this does not mean that the two regimes are necessarily always mutually exclusive. But it does mean, as mentioned earlier, that it is not lawful for the medical practitioners referred to in ss. 2 and 3 of the MHA 1983, decision makers under the MCA, treating doctors, social workers or anyone else to proceed on the basis that they can pick and choose between the two statutory regimes as they think fit having regard to general considerations (e.g. the preservation or promotion of a therapeutic relationship with P) that they consider render one regime preferable to the other in the circumstances of the given case."

77. These paragraphs are reflected in paragraph 132 of that judgment and, as I recall it, were in line with the arguments in that case which, as I mentioned in paragraph 1 above were directed to a different situation to that which exists in this case.

78. The argument advanced by the SSH and the parties in this case (and by the SSH as recorded in paragraph 18 of the decision of Upper Tribunal Judge Jacobs in *DN v Northumberland Tyne & Wear NHS Foundation Trust*), and the approach that I have decided should be taken by the FTT (and other MHA decision makers) to a compliant incapacitated person who only needs assessment or treatment for the purposes described in ss. 2 and 3 of the MHA (i.e. in respect of a mental disorder), have led me to the conclusions that:

i) general propositions in respect of issues that arise concerning the inter-relationship between the MHA and the MCA are dangerous,

ii) as a general proposition the second part of paragraph 58 in *J v Foundation Trust* is not correct, as in the circumstances of this case the regimes provide relevant and available alternatives,

iii) albeit that the legislative history that the DOLS provisions were added to the MCA to fill the *Bournewood* gap and thus something not covered by the well established regime under the MHA and much of the definition of "ineligibility" in the MCA relates to the applicability of the MHA, any analysis that is based on or includes the concept of primacy of the MHA in the sense used in paragraph 58 of *J v Foundation Trust* (or any other sense) should be case specific, and

iv) I agree with the point made by the SSH to Upper Tribunal Judge Jacobs that my references to the MHA having primacy in *J v Foundation Trust* were made in and should be confined to the application of Case E in that case, and I add that even in that confined context they need some qualification to expand on the point I made that the two statutory schemes are not always mutually exclusive and so to acknowledge the point set out above that in defined circumstances Parliament has created alternatives that are factors for the relevant decision maker to take into account.

79. In this case, there was general agreement that paragraph 59 of my judgment in *J v Foundation Trust* (and so the same passage in paragraph 45(2) thereof) are correct. To my mind, those paragraphs accord with my reasoning and conclusion in this case as they reflect the points that:

i) each decision maker has to apply his or her jurisdiction and powers and thus the provisions of the statute governing that decision making process (the "Determinative Statutory Test"), and

ii) as and when the existence and availability of an alternative under a different statutory scheme is relevant to the application of the Determinative Statutory Test, that factor and so the impact of that alternative must be assessed by the decision maker.

80. This accords with the conclusion set out above that an FTT exercising its jurisdiction under s. 72 MHA has to have regard to relevant alternatives to detention in hospital under the MHA when applying the "necessity test".

Did the FTT err in law in this case?

81. Understandably, the FTT did not go through the exercise I have set out above step by step.

82. It was argued on behalf of AM that the FTT failed to properly address the issue whether AM had capacity to consent to a voluntary admission for assessment but in my judgment if that challenge had stood alone it would fail because when they are read as a whole and fairly against the background known to the parties the reasons given by the FTT make it clear enough that it was of the understandable (and so far as I am aware not effectively disputed) view that AM lacked that capacity.

83. More difficult is the question whether the FTT addressed the question whether AM was or was likely to be compliant and so remain in hospital. It was argued on behalf of the First Respondent (the NHS Trust) (a) that when the reasons of the FTT are read with paragraphs 13 and 14 of the November 2012 FTT Decision (cited in paragraph 5 above) and the detaining authority's case, the conclusion of fact reached by the FTT was that AM would not remain voluntarily at the hospital because she would be influenced to object and to demand that she be permitted to be removed, or would be removed by one or both of her daughters, and (b) if that is right, such a finding of fact would mean that she would not be within category (ii) – compliant incapacitated – and the arguments based on the availability and application of the MCA scheme and its DOLS would not arise.

84. It was accepted in oral argument on behalf of AM that if I concluded that the FTT had not properly addressed and provided adequate reasons relating to this compliance issue I would have to remit the case to a differently constituted FTT to determine it. I agree because there is plainly an arguable case that AM would either on her own or as a result of the influence of others not be compliant throughout the proposed assessment (and any later treatment).

85. This factual issue relating to compliance relates and leads to the arguments before me concerning the applicability of the MCA and its DOLS. Like the FTT judge who refused permission to appeal, I have not found anything to indicate that this next step was raised before the FTT in the way it has been raised before me. There is therefore something in the view that the FTT is now being criticised for not properly identifying and dealing with a trigger issue of fact when it was not identified as such before them. This may also explain why, so far as I am aware, this factual issue was not addressed directly in the oral evidence with any of the witnesses and, as mentioned in paragraph 8 above AM's daughter and nearest relative CM did not give oral evidence.

86. But, as recorded in paragraph 7 of their reasons, the FTT were aware that AM's representative was asserting that AM would remain in hospital on an informal basis whilst further assessments took place before she could be successfully discharged into the community. It being submitted on her behalf that she was happy on the ward and wished to stay.

87. Although I see force in the view that the FTT held the view expressed in paragraphs 13 and 14 of the November 2010 FTT Decision and so the view that AM would not be compliant with a stay in hospital throughout the period of her assessment, I have concluded that the references to their acceptance of the nurse's view that she lacks the capacity to say yes and no (paragraph 13), their finding that AM's daughters have for some time been at odds with the treating team and have not agreed with their plans and CM's opposition to a detention under s. 3 MHA (paragraph 15), their conclusion that if AM is discharged her daughter CM may not encourage her mother to take her medication (paragraph 18) and their reference to the matters under investigation and the wish of her daughters to take AM out for increasing periods of time (paragraph 19) are not sufficient, when read in the context of the whole of the decision in the light of the background, to show:

    i) that the FTT properly addressed the factual issue raised on behalf of AM (see paragraph 86 above) by reference to that recorded submission, and/or s. 131 MHA and/or as a step in the application of the "necessity test", and/or as a

trigger factual issue in respect of the possible application of the MCA and its DOLS, or

ii) what conclusion they reached on that issue of fact and so, if it was the case, why they rejected the case put on behalf of AM that she was willing to remain in hospital on an informal basis whilst further assessments took place.

Rather the focus of the passages relied on by the First Respondent (and the FTT judge who refused permission to appeal) relate in large part to what the position would be after discharge from hospital, rather than whether AM would voluntarily remain in hospital (with or without the support and co-operation of her daughters) during the in-patient assessment.

88. Accordingly, and with some sympathy for the FTT because it seems that the relevance of the compliance issue was not flagged up in the way it was before me, I have concluded that the FTT erred in law by either not addressing the compliance issue or explaining with sufficient clarity what they decided on it and why.

(Signed on the Original)

Mr Justice Charles (Chamber President)

6 August 2013