Neutral Citation Number: [2013] EWHC 272 (Fam)

Case No: COP12230183

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 18/02/2013

Before :

THE HONOURABLE MR JUSTICE BAKER

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IN THE MATTER OF LDV
AND IN THE MATTER OF THE MENTAL CAPACITY ACT 2005

Between :

A PRIMARY CARE TRUST	**Applicant**
- and -	
LDV (by her guardian the Official Solicitor) (1)	
CC (2)	
B HEALTHCARE GROUP (3)	**Respondents**

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Susanna Rickard (instructed by **Bevan Brittan LLP**) for the **Applicant PCT**
Alex Ruck Keene (instructed by **CVC Solicitors**) for the **1st Respondent**
Michael Dooley (instructed by the **local authority solicitor**) for the **2nd Respondent**
Peter Mant (instructed by Radcliffes Le Brasseur) for the 3rd Respondent

Hearing dates:

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Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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THE HONOURABLE MR JUSTICE BAKER

This judgment is being handed down in private on 18th February 2013. It consists of 13 pages and has been signed and dated by the judge. The judge hereby gives leave for it to be reported.

The judgment is being distributed on the strict understanding that in any report no person other than the advocates or the solicitors instructing them (and other persons identified by name in the judgment itself) may be identified by name or location and that in particular the anonymity of the 1st respondent and adult members of her family must be strictly preserved.

The Honourable Mr. Justice Baker :

Introduction

1. These proceedings in the Court of Protection concern a woman, hereafter referred to as "L" who is currently residing at a private hospital, hereafter referred to as "WH", in Devon, run by a company hereafter referred to as "B Healthcare Group",. The proceedings give rise to a number of issues. This judgment addresses two preliminary matters, the remainder to be considered at a later date.

Background

2. L is a 33-year-old woman suffering from a learning disability. She has suffered years of traumatic experiences, not only at home but also in foster care and subsequently in a series of institutional settings, including Winterbourne View. She has also at different stages been diagnosed with an emotionally unstable personality disorder. It is unnecessary for the purposes of this short judgment to consider her background and diagnosis in any greater detail, although I anticipate that those matters will be the focus of much greater attention in the next hearing.

3. On 20th April 2011, L was transferred to a medium-secure unit at St Andrew's Hospital in Northampton and there detained under the provisions of s.3 of the Mental Health Act 1983 ('MHA')On 25th May 2012, however, a First Tier Tribunal (Mental Health) made an order for L's deferred discharge from hospital under s.72(3) of the MHA to take effect from 28th September 2012. The tribunal held inter alia that L "needs to be placed in a residential establishment in the community, equipped to meet the needs of a person suffering from mild learning disability with challenging behaviours, and supported by a package of aftercare comprising medical, nursing and social worker oversight and the provision of day-care."

4. The care coordinators, led by the PCT for her home area, therefore began the process of identifying a suitable community placement for L. As a preliminary step, however, L moved in early September 2012 to WH, a hospital within the meaning of paragraph 17 of schedule 1A of the Mental Capacity Act 2005 ("MCA"), situated closer to her home area. As described below, her accommodation at WH is under a considerable degree of restriction.

5. On 20th September, at around the time of her move to WH, two doctors at St. Andrew's approved under s.12 of MHA recommended that L be re-detained under s.3. As a result, a Mental Health Act Assessment was carried out by Ms Emma Goodall, an Approved Mental Health Professional employed by the local authority. She was, of course, aware of the tribunal decision to discharge L from detention and concluded that, as there had been no material change in her circumstances since that decision, it would be unlawful for L to be detained under the MHA, following the decision of the House of Lords in R v East London NHS Trust, ex parte Count Von Brandenburg [2004] 2 AC 280. In those circumstances, and for further reasons set out in her assessment report, she therefore declined to make an application under s.3. The deferred discharge therefore took place on 28th September. In fact, L did not leave the hospital on that date, and her status

thereafter was, and remains, that of a patient under an informal admission within the scope of s.131 of the MHA.

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

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

8. On 23rd October 2012, the PCT therefore made an urgent application to bring the matter before the Court of Protection. The application came before Parker J for directions on 25th October. The respondents to the proceedings were L herself by her litigation friend, the Official Solicitor, and the local authority. At that hearing, the learned judge gave directions and identified issues to be determined at the further hearing. That list of issues has been expanded on further analysis by the parties to encompass the following matters.

    (1) Does L have capacity (a) to conduct the litigation; (b) to make decisions as to her residence; (c) to make decisions about her care and treatment and (d) to consent to the restrictions imposed upon her during the currency of her admission at WH?
    (2) Does the current care regime for L amount to a deprivation of liberty?
    (3) If the answer to the above questions is yes, how can her deprivation of liberty be authorised? Specifically, is she eligible to be deprived of her liberty under the MCA 2005, whether under a standard authorisation in accordance with the provisions of Schedule A1 or pursuant to an order of the court under section 16(2)(a)? Alternatively, (in a further question posed by the local authority) may she be lawfully detained under the MHA?
    (4) If she lacks capacity, what order, if any, should the court make concerning her personal welfare?

9. These matters were listed for a hearing before me for two days in January 2013. B Healthcare Group was joined as third respondent. In the course of preparation for the hearing, it became apparent that the issues, in particular the assessment of

capacity, and the question of eligibility, are potentially complex. After time spent in further negotiations, it became plain that there was insufficient court time to resolve all the issues and that further evidence, analysis and argument would be required. It was therefore agreed that two preliminary issues would be considered and determined by the court at that hearing, the others being adjourned to a later date. The two questions considered at the hearing, which form the subject of this judgment, are

(1) Do L's current circumstances amount objectively to a deprivation of liberty?
(2) When assessing whether L has capacity to consent to her accommodation at WH, in circumstances which amount to a deprivation of liberty, what information is relevant to that decision?

Deprivation of Liberty

10. I do not propose in this short judgment to embark upon another exegesis of the current state of the law concerning deprivation of liberty in cases of mental capacity, which is considered at some length in my recent decision in *CC v KK* [2012] EWHC 2136 (COP) at paragraphs 76-96. The conjoined appeals in the cases of *Cheshire West and Chester Council v P* [2011] EWCA (Civ) 1257 and *P and Q v Surrey County Council* [2011] EWCA (Civ) 190 are to be heard by the Supreme Court in the Autumn of this year. Pending that appeal, the legal principles are as set out in the Court of Appeal decisions.

11. I am grateful, however, to counsel for their submissions on the law on this point, and in particular to Mr Alex Ruck Keene on behalf of the Official Solicitor for reminding me of the recent cases in the European Court of Human Rights. The starting point in determining whether or not circumstances amount to a deprivation of liberty is, of course, Article 5 of the European Convention for the Protection of Human Rights and Fundamental Freedoms. The analysis of Article 5 in the European Court has had a profound influence on the development of the law in this field, in particular the decisions in *Guzzardi v Italy* (1981) 3 EHRR 333, *Storck v Germany* (2005) 43 EHRR 96, and *HL v United Kingdom* (2005) 40 EHRR 32, the last-named being the decision which compelled the change in the law as set out in the amendments to the MCA 2005 which introduced the DOLS. In addition, there has, in recent months, been a series of further authorities of the European Court which has specifically addressed the issue of deprivation of liberty under Article 5 in the context of care homes, namely *Stanev v Bulgaria* (2012) 55 EHRR 22, *DD v Lithuania* (application 13469/06, decided 14th February 2012) and *Kedzior v Poland* (application 45026/07, decided 16th October 2012). No doubt these authorities will be considered and analysed by the Supreme Court in due course. I do not, however, think it would be helpful for this court to anticipate that analysis here.

12. The current law can be summarised briefly as follows.

13. When determining whether there is a 'deprivation of liberty' within the meaning of Article 5, three conditions must be satisfied, (a) an objective element of a person's confinement in a certain limited space for a not negligible time; (b) a subjective element, namely that the person has not validly consented to the confinement in

question, and (c) the deprivation of liberty must be one for which the State is responsible: see *Storck v Germany*, supra.

14. When determining whether the circumstances amount objectively to a deprivation of liberty, as opposed to a mere restriction of liberty, the court looks first at the concrete situation in which the individual finds herself, taking account of a whole range of criteria, including the type, duration, effects and manner of implementation of the measure in question, bearing in mind that the difference between deprivation, and restriction upon liberty is merely one of degree or intensity and not one of nature or substance. As Munby LJ observed in *Cheshire West*, supra, at paragraphs 34-35 and 102, 'account must be taken of the individual's whole situation...the context is crucial'.

15. At a more practical level, guidance as to the objective element is given in the Deprivation of Liberty Safeguards Code of Practice 2008. Chapter 2 of the Codes is entitled: "What is a deprivation of liberty?" At paragraph 2.5, there is what is described as a 'non-exhaustive' list of factors pointing towards there being a deprivation of liberty, namely where:

    (1) restraint is used, including sedation to admit a person to an institution where that person is resisting admission;
    (2) staff exercise complete and effective control over the care and movement of a person for significant periods;
    (3) staff exercise control over assessments, treatments, contacts and residence;
    (4) a decision has been taken by the institution that the person would not be released into the care of others, or permitted to live elsewhere, unless the staff in the institution consider it appropriate;
    (5) a request by carers for a person to be discharged to their care is refused;
    (6) the person is unable to maintain social contacts because risk of restrictions placed on their access to other people;
    (7) the person loses autonomy because they are under continuous supervision and control.

16. The court must also have regard to the following factors identified in the recent case law :

    (1) whether the person objects to their confinement: see paragraph 25 of the judgment of Wilson LJ (as he then was) in *P and Q v Surrey County Council* (supra);
    (2) the relative normality of the person's life: see paragraph 28 of the judgment of Wilson LJ in *P and Q* (supra);
    (3) the relevant comparator, having regard to the particular capabilities of the person concerned: see paragraphs 38, 39 and 102 (viii) to (xii) of the judgment of Munby LJ (as he then was) in the *Cheshire West* case, (supra);
    (4) as part of the overall assessment, the purpose for the placement: see judgment of Munby LJ at paragraphs 60 – 77 and 102 (vi) and (vii) in the *Cheshire West* case, as qualified for the reasons set out in *CC v KK*, supra, at paragraphs 94-96;
    (5) the extent to which it can be said that the managers of the establishment, in this case WH, exercise complete and effective control over the person in his

treatment, care, residence and movement: see the judgments of the European Court in *DD v Lithuania* (supra), at paragraph 146 and *Kedzior v Poland*, (supra) at paragraph 57.

17. In this case, the restrictions within L's care plan were reviewed by Ms Goodall with Dr. A., and are summarised by Ms Goodall in her report as follows::
    (1) WH is locked to visitors and its patients;
    (2) L must seek the permission of nursing staff if she wishes to leave;
    (3) in the community, L is supervised 1:1;
    (4) staff would prevent her leaving WH and entering the community if she is assessed to be at risk;
    (5) should L seek to leave WH, staff would seek to dissuade her from doing so using de-escalation techniques;
    (6) if she were to abscond from WH or staff, the police would be alerted;
    (7) there are restrictions of movement within the unit;
    (8) the level of observations of L are variable, ranging from level 3 (every 15 minutes) to level 2 (line of sight) to level 1 (i.e. 1:1 close). And observations are increased or decreased according to the assessed level of risk;
    (9) restraint is used where there is an assessed and immediate risk to herself or others;
    (10) staff may seek to remove L from the area to de-escalate the situation;
    (11) personal property may be searched when staff assess there to be a clear indicator or risk (e.g. ligatures, hoarding of medication, instruments for use to self-harm);
    (12) personal searches may also be conducted according to indicators of risk;
    (13) if required, sedative medication may be administered, if necessary intramuscular injection;
    (14) L's contact with her mother is to be supervised by staff in the community according to assessed need or risk;
    (15) no contact is permitted with her mother in the hospital.

18. In the opinion of both Dr. A and Ms Goodall, these restrictions amount to a deprivation of liberty.

19. The position of the parties on the question whether the circumstances of L's placement at WH amounts objectively to a deprivation of liberty can be summarised as follows.

20. On the behalf of the Official Solicitor, Mr RuckKeene, drawing on the description of the circumstances set out in Ms Goodall's statement, contends that the restrictions imposed upon L at WH amount to a deprivation of liberty. He states that the Official Solicitor considers that it is clear that the restrictions identified therein cross the threshold required to amount to a deprivation of liberty. In short, L is at a psychiatric hospital, under continuous supervision and control, and not free to leave.

21. Mr Ruck Keene acknowledges the narrowing of the definition of an objective deprivation of liberty in the Court of Appeal decision in the *Cheshire West* case,

but points out that Munby LJ was at pains to recognise that there was a spectrum of concrete situations and that those circumstances which fell clearly at the more restricted end would manifestly amount to a deprivation of liberty. Specifically, he reminds me that Munby LJ identified, amongst the cases that plainly fell in the category of a deprivation of liberty, the decision in *HL v United Kingdom*, itself, which involved someone who was, like L, an informal patient in a psychiatric hospital. As the European Court stated in that case, (at paragraph 91); 'the health care professionals treating and managing the applicant exercised complete and effective control over his care and movements...accordingly the concrete situation was that the applicant was under continuous supervision and control and was not free to leave.'

22. The Official Solicitor's position was supported by the local authority. On its behalf, Mr Dooley submitted that the restrictions in L's care plan were broadly in line with those factors identified in paragraph 2.5 of the Code of Practice as indicative of a deprivation of liberty. Mr Dooley submitted that it was not necessary for all of those factors to be present. In this case, he relied in particular on the fact that, as Dr A accepted, staff in this case exercised complete control over the care and management of L, and over her treatment and medication. As part of that complete control and management, it had been decided that she could not leave the premises.

23. On behalf of the Primary Care Trust, Ms Rickard, whilst not putting forward a strong contrary case, invited the Court to consider an alternative interpretation. In her written document, she suggested that, in light of the decision in *Cheshire West* , it was 'unlikely' that L's living arrangements at WH amounted to a deprivation of liberty. Expanding on this position in oral submissions, she argued that L's long history of mental disorder and institutional abuse, leading to her current presentation and needs, precluded any immediate move into a setting other than one with the level of medical input and expertise available at WH. The restrictions on her liberty would therefore need to be the same wherever she was placed. Ms. Rickard suggested that WH, as a community hospital, did fall within the tribunal's recommendation of 'a residential establishment in the community equipped to meet the needs of a person suffering from mild learning disability with challenging behaviours, and supported by a package of after-care comprising medical, nursing and social-worker oversight and the provision of day-care'. As a result, applying the tests of relative normality and the relevant comparator, her circumstances did not amount objectively to a deprivation of liberty.

24. In reply to Ms Rickard's submission, Mr Ruck Keene argued that, in assessing the relative normality of L, the court had to take into account the tribunal's findings as to L's needs summarised above. In light of those findings, Mr. Ruck Keene submitted that a person placed in a residential placement in the community of the nature recommended by the tribunal was the appropriate comparator in determining whether the current circumstances amounted to a deprivation of liberty, and that WH did not amount to such a placement.

25. With respect to Ms Rickard, it seems to me manifestly clear that L's current circumstances amount to a deprivation of liberty. It may well be the case that not all of the factors identified in paragraph 2.5 are satisfied in this case but I accept Mr

Dooley's argument that it is not necessary for every such factor to be present. As paragraph 2.5 itself makes clear, the factors listed therein 'can be relevant to identifying whether the steps taken involve more than restraint to amount to a deprivation of liberty.' In this case, a number of the factors are manifestly present as identified by Mr Dooley above. The plain fact is that in this case the care and movement of L is subject to the complete and effective control of the staff at WH. That control extends to treatment, contacts and residence. The treatment includes medication. It has been decided that she will not be released into the care of others or to live elsewhere, unless staff consider it appropriate. Her social contacts are subject to a degree of control.

26. I accept Mr. Ruck Keene's submission that the appropriate comparator is a person properly placed in a residential placement in the community, and that WH does not amount to such a placement. In any event, the concept of relative normality and relevant comparator were not intended by the Court of Appeal to be used to exclude cases such as this from the safeguards introduced into the MCA 2005 as a result of the decision in *HL v United Kingdom*. In *Cheshire West*, Munby LJ makes it crystal clear by his reference to the decision in *HL v United Kingdom* that such circumstances will continue to be seen as amounting to deprivation of liberty.

27. The restrictions included in the care plan, as summarised by Ms Goodall in the analysis set out above, are on any view at the more severe end of the spectrum. To my mind, this is, objectively, a plain case of deprivation of liberty.

Relevant information for consenting to a deprivation of liberty

28. I therefore turn to consider the second question. When assessing whether L has capacity to consent to her accommodation at WH, in circumstances which amount to a deprivation of liberty, what information is relevant to that decision? This is 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.

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.

30. When assessing capacity, the court applies the principles in sections 1, 2 and 3 of the MCA 2005, together with the relevant guidance in the Codes of Practice. In this context it is particularly important to note that:

(1) a person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success: section 1(3);
(2) a person must be assumed to have capacity unless it is established that he lacks capacity on the balance of probabilities: Section 1(2) and Section 2(4);
(3) a person is unable to make a decision for itself if he is unable (a) to understand the information relevant to the decision, (b) to retain that information, (c) to use or weigh the information as part of the presence of making the decision or (d) to communicate his decision: section 3(1).

31. The parties all submit that in light of the above provisions, it is necessary to identify as a preliminary step the 'information' which the person is required to understand, retain, use and weigh. In this context, they remind me of the observations of Macur J in ***LBL v RYJ*** [2010] EWHC 2664 (Fam) at paragraph 24 that 'it is not necessary for the person to comprehend every detail of the issue'. At paragraph 58, Macur J identified the question as being whether the person under review can 'comprehend and weigh the salient details relevant to the decision to be made'.

32. In this case, L is at present resident at WH as an informal patient. On behalf of the Official Solicitor, Mr Ruck Keene submits that, where the nature of the facility and the particular arrangements advised by those responsible for treating her amount objectively to a deprivation of liberty, analysis of the capacity of L to consent to such a placement includes identification of, firstly, information about the informal hospital admission and, secondly, the specific restrictions placed on her which amount objectively a deprivation of liberty.

33. Under the first category, Mr Ruck Keene identifies the following features:

(1) that the person is being admitted to hospital;
(2) that the admission has been proposed because they are considered to be suffering from a mental disorder;
(3) that they are being admitted for the purposes of receiving care and treatment;
(4) that the treatment that they will receive may include treatment for mental disorder;
(5) that they will be accommodated in the facility at least until such time as they change their mind and decide to leave;
(6) that if they decide to leave that they might nonetheless be subject to an application made under the statutory holding power under section 5 of the MHA so that they might not in fact be able to leave when they wanted to if those treating them thought they were too mentally unwell to be allowed to leave.

34. Under the second category, he submits that the 'salient details' in the current case include:

(1) the locked nature of WH;
(2) the fact that L must seek permission of the nursing staff to leave;
(3) that L is to be supervised when she goes out into the community;

(4) the circumstances under which she will be prevented from leaving if she wished to do so;
(5) that if she left without permission the police would be alerted;
(6) that her treatment plan includes the prescription of anti-psychotic drugs and sedative medication;
(7) that contact with family members would be supervised and limited.

35. On behalf of B Healthcare Group, Mr Mant submits that the specific consent is to the 'deprivation of liberty' not to the care or treatment as such. As a result, the focus of the analysis of the capacity to understand, retain use and weigh information is on deprivation of liberty rather than the care or treatment she receives per se. Having regard to the dicta of Macur J in ***LBL v RYJ*** (supra), he submits that the salient facts in this case are as follows:

(1) that WH is a psychiatric hospital;
(2) that L was admitted there to receive care and treatment;
(3) that care and treatment would include varying levels of supervision (including supervision in the community) use of physical restrain and the prescription of medication to control her mood, and
(4) if she insists on leaving with the intention of not returning to WH her situation would be reviewed and she may be prevented from leaving by legal means.

36. Mr Mant submits that, so long as L understands that she is prescribed medication that controls her mood, it is unnecessary for her to have the capacity to consent to the medication in terms of understanding all of the side effects, benefits and risks of such medication. Similarly, whilst L must understand the fact that she may not be permitted to leave, Mr Mant submits that it is unnecessary for her to have a full grasp of this specific legal mechanism by which she might be prevented from leaving. He points out that the questions of what provisions might be applied are issues which perplex lawyers and to require a person in the position of L to understand such issues would be to set the bar too high.

Discussion and Conclusion

37. It seems to me to be undesirable for the court in these circumstances to be asked as a matter of course to identify in advance and with precision the information which a person must be capable of understanding, retaining, using and weighing by a person in order to make a decision whether to consent to a placement which amounts to a deprivation of liberty. The evaluation of capacity is a complex process that engages the principles in sections 1, 2 and 3 of the MCA. The better course, in my judgment, is for the clinician to consider the concrete situation and assess the level of the person's understanding about that situation. The court will then, in the light of that assessment and all other relevant evidence, consider whether practicable steps to help him decide whether or not to give his consent have been taken and if so, whether it has been proved on a balance of probabilities that he lacks the capacity to make the decision. If the court were asked as a matter of routine to identify for the parties in advance the precise information necessary for making a decision, it would lead to an alarming amount of satellite litigation at great and unnecessary cost.

38. In expressing the following views, therefore, I am not seeking to set any sort of precedent, either as to the process to be followed or as to the type of information which is likely to be relevant in such cases, but merely to assist the parties in this case.

39. I consider that on the facts of this case, the clinicians and the court should ask whether L has the capacity to understand, retain, use and weigh the following information:

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

40. Whilst I accept Mr. Mant's submission that the specific consent under consideration is to the 'deprivation of liberty' and not to the care or treatment as such, it seems to me that the information which must be understood, retained, used and weighed extends to some information about the context in which the deprivation is being imposed.

41. I shall invite the parties to agree an appropriate formulation of words for a recital to be included in an order, together with directions for a further hearing to address the remaining issues.