Covid-19 Protocol: This judgment was handed down by the judge remotely by circulation to the parties' representatives by email and release to Bailii. The date and time for hand-down is deemed to be 10.30am on 9 November 2021

Neutral Citation Number: [2021] EWHC 2990 (Fam)

IN THE UPPER TRIBUNAL **HM/1606/2020**

ADMINISTRATIVE APPEALS CHAMBER

(ON APPEAL FROM THE FIRST TIER TRIBUNAL (MENTAL HEALTH)

AND

IN THE HIGH COURT OF JUSTICE **FD20F00078**
FAMILY DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 09/11/2021

Before :

MRS JUSTICE LIEVEN

- -

Between :

(1) CUMBRIA, NORTHUMBERLAND TYNE & WEAR NHS FOUNDATION TRUST
(2) SECRETARY OF STATE FOR JUSTICE

Applicants

and

EG

Respondent

- -
- -

Ms Victoria Butler-Cole QC (instructed by **DAC Beachcroft LLP**) for the **First Applicant**
Ms Fiona Paterson with Mr James Strachan QC and Ms Nicola Kohn following the hearing itself (instructed by **Government Legal Department**) for the **Second Applicant**
Mr Peter Mant and Mr Simon Garlick (instructed by **Hadaway & Hadaway**) for the **Respondent**

Hearing dates: **6 May 2021**

- -

Approved Judgment

....

MRS JUSTICE LIEVEN

This judgment was delivered in private. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of the children and members of their family must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

Mrs Justice Lieven DBE :

1. EG is a 49 year old man. He has diagnoses of pervasive developmental disorder (but not a learning disability), emotionally unstable personality disorder with some features on the autistic spectrum, and paedophilia. The issue in the case is whether he can lawfully remain in the community, rather than in hospital, but be deprived of his liberty in the community. This issue arises as a consequence of the Supreme Court decision in *Secretary of State for Justice v MM* [2019] AC 712 where the Court found that a restricted patient could not be discharged from hospital under the Mental Health Act 1983 ('MHA') on conditions that amounted to a deprivation of liberty. If EG cannot be deprived of his liberty, the Trust has indicated that it would recommend to the Secretary of State that EG should be recalled to hospital (in real terms rather than the theoretical recall which is currently in place) because if EG is to remain in the community it needs to be with the clear legal authority to deprive him of his liberty. The Secretary of State has made clear he would follow this recommendation.

2. The Trust was represented before me by Ms Butler-Cole QC, the Secretary of State by Ms Paterson, and EG by Mr Mant. I am very grateful to them all for their clear submissions in a difficult case. After the arguments concluded, the Supreme Court gave judgment in *Re T (A Child)* [2021] UKSC 35 concerning the scope of the inherent jurisdiction to deprive a child of his/her liberty. I gave the parties the opportunity to make further written submissions on the impact of *Re T* on the arguments in this case, and I refer to those submissions below.

3. In this case I sat both as the Upper Tribunal (Administrative Chamber) ('Upper Tribunal') to hear the appeal from the First Tier Tribunal (Mental Health) ('FTT') decision dated 31 August 2020, and as the Family Division of the High Court to hear an application under Part 8 for the Court to use its inherent jurisdiction to deprive EG of his liberty if the appeal from the FTT was refused and EG therefore could not be detained under the MHA.

4. The issues in the case are:

    a. Whether s.72 MHA can be construed to allow the detention of a restricted patient in a community setting pursuant to s.17(3) MHA where that person has not resided in, or been treated by, a hospital for a considerable period of time. That issue itself is in two parts:

        (i) Whether such a construction can be arrived at under a purely domestic statutory interpretation of the MHA alone;

        (ii) Whether reliance on s.3 of the Human Rights Act 1998 ('HRA') can allow such a construction.

    b. If the answer to (a) is no – then whether the patient, assuming he has capacity and therefore does not fall within the jurisdiction of the Court of Protection, can be subject to a conditional discharge and deprived of his liberty pursuant to the inherent jurisdiction of the High Court.

5. It can be seen from this summary that if the Court concludes that a domestic interpretation of s.72 does not allow EG to be deprived of his liberty in the community

pursuant to s.17(3), then the Court has two alternatives; either to rely on s.3 HRA, or to use the inherent jurisdiction to deprive EG of his liberty. If neither of these routes are possible, then the Claimant seeks a declaration of incompatibility under the HRA. For the reasons that I set out below, I consider it more legally appropriate in this case to rely on s.3 HRA than upon the inherent jurisdiction.

6. EG was first admitted to hospital in 1987 at the age of 16 and then had subsequent short admissions, including one following an assault on his GP who had been called to the family home because of his disturbed and aggressive behaviour. EG has a number of convictions for sexual assaults on girls, including on his sister. He was made the subject of an order pursuant to s.37/41 MHA on 31 January 1994 and has therefore been a restricted mental health patient for approaching 30 years. Between 1994 and 2014 he was detained at Northgate Hospital, a medium secure unit. During that time in hospital EG was aggressive and potentially violent on a number of occasions. His response to treatment and his progress in rehabilitation were, for lengthy periods, poor. There were a number of efforts made to move him to less secure placements, all of which failed, in part because of his lack of engagement with clinical teams, aggression and self-harm.

7. He was conditionally discharged by the FTT on 1 April 2014 to The Care Home situated in a remote rural area. The conditions included that he must live at The Care Home, which would undoubtedly amount to a deprivation of his liberty within the *Storck* tests (*Storck v Germany* [2006] 43 EHRR 6). He has never been recalled to hospital since being conditionally discharged (save for his technical recall following the *MM* decision). There was an incident in October 2019 when he threatened to rape a member of staff and he was given a warning, but since that time his behaviour has improved.

8. Since being at The Care Home, efforts have been made to move EG to a less restrictive placement akin to supported living. These efforts have been unsuccessful, largely due to EG's own anxiety about trying to manage without a high level of support and supervision. EG is aware that he poses a risk of harm to others and that he needs support to help him manage his behaviour. He is reported to have an exaggerated perception of risk to himself when in the community as a result of his previous offending behaviour.

9. Staff are required to be aware of EG's location at all times within The Care Home and its grounds, and he receives 1:1 support when accessing the community. He is closely supervised when using public toilets and staff are advised that he should use a disabled toilet where possible, or otherwise should first check there are no other members of public in the toilets, and then station themselves outside the toilet which EG is inside. EG is not allowed access to the internet unless staff supervise him. He is not permitted to buy a smart phone with a camera or internet access. Any parcels delivered to him are checked by staff. The care plan includes the following:

    a. *Staff are to be aware of EG's location at all times within the home and grounds. If staff are unable to locate EG at any time then a thorough search should be undertaken by all staff.*

    b. *If staff are still unable to locate EG then the POLICE should be called immediately. Staff are to inform the Police of EG's history and the potential risk this places on members of the public.*

c. *Staff are to contact the Home Manager/ Deputy Manager who will then notify the company Compliance Manager, EG's Care Manager and family members.*

d. *Staffing levels permitted, staff will then be required to search the local area to see if he can be located.*

e. *If EG is found by staff or police within the local area then the Home Manager/Deputy Manager, Compliance Manager, Care Manager and the Police should be notified of this.*

f. *If EG is not found then staff will take advice and guidance from the Police.*

g. *If EG has visitors who arrive with children then staff are to ensure that the responsible adult accompanying the children are aware of the need to maintain close supervision at all times. Staff will call in occasionally to carry out a visual check to ensure everything is alright.*

h. *If EG visits any other area of [The Care Home] he is aware that he needs to inform the staff that he is present. Staff must maintain visual observations of EG at all times to ensure the safety of other individuals.*

i. *If EG is invited to visit the XX, XX or the XX staff must continue with 30 minute observations to ensure he maintains appropriate communication with his peers at all times.*

10. Professionals responsible for EG's care and treatment in the community agree that the threat of recall is one that he understands, and which motivates him to comply with the restrictions that are imposed on him.

11. Importantly, in the period after his discharge in 2014, EG has never visited Northgate Hospital, or any other hospital, for his mental health condition. He has not therefore been an in-patient at hospital, nor an outpatient. Until his post-*MM* recall, EG's Responsible Clinician under the MHA was Dr Barrington, who is a community psychiatrist.

12. EG applied to the FTT for a review of his detention in May 2020, but following his technical recall, withdrew that application.

13. EG was recalled to hospital on 30 June 2020 as a result of the Supreme Court's decision in *MM*. The reasons given were that: *"The Secretary of State has reviewed the patient's case with his Responsible Clinician, and, based on the clinical assessment, the Secretary of State is of the view that if the unlawful requirement for [EG] to be constantly supervised in the community were to be removed, the patient's risk to the public, directly linked to his mental disorder, would be elevated."*

14. This has been referred to as a 'technical recall' as EG never actually went back to hospital. He was immediately granted s.17 MHA leave by the Secretary of State subject

to the same conditions as had been in place under his conditional discharge. The period of leave was the maximum available – 12 months, ending 30 June 2021. Since the recall, EG's Responsible Clinician has been Dr Swinglehurst, who is based at Northgate Hospital. In addition to structured clinical management sessions provided by the Secure Outreach Transitions Team in the community, Dr Swinglehurst's evidence said:

> *"[E] has ongoing input from his social worker, Alan Anderson, his inpatient clinical coordinator and Dr Swinglehurst, his responsible clinician since his recall. The role of responsible clinician of an in-patient is by definition a more involved one and whilst [E] remains on leave the responsibility to ensure the placement meets [E's] needs rests with the responsible clinician. It is my opinion that this involves having an overview to ensure that the appropriate treatment and therapeutic input of all staff working with him (whether [The Care Home], NHS or Local Authority) is being maintained, and to make any adjustments to this input to ensure that the treatment remains appropriate. It also involves more frequent direct review of [E] than would be usual for an outpatient conditionally discharged patient which has both a direct therapeutic component of providing stability and authority in [E's] management and ensuring he is aware of that as well as the monitoring component around the other input [E] is receiving described above. All of these professionals work both directly with [E] and with the staff team to help ensure that ongoing risk management at a high level is maintained and that complacency around risks is not allowed to creep in. [E] is also supported to manage his stresses around life events as they occur, such as the current police investigation which has been ongoing for around one year at the current time. All of the above are essential therapeutic components to manage the symptoms and manifestations of his mental disorder. As mentioned in paragraph 8 above, without this specialist treatment from professionals and specially trained support staff [E's] anxieties inevitably escalate and this results in an escalation of his forensic risk to others. Continuing availability of staff and regular contact with professionals to manage and maintain his mental wellbeing and prevent his anxieties spiralling out of control is an ongoing therapeutic need for [E]. In addition during working hours the above professionals are available for advice and input and out of hours there is the availability of an on-call specialist learning disability psychiatry service with Dr Swinglehurst is part of."*

15. The nursing report for the FTT noted that increased contact with the detaining hospital caused EG anxiety and had a negative effect upon him.

16. After the Supreme Court decision in <u>*MM*</u> the Secretary of State recalled EG to hospital on 30 June 2020. However, this was a "technical recall" because EG never actually went back to hospital. He was immediately granted s.17 MHA leave by the Secretary of State, subject to the same conditions as had been in place under his conditional discharge. Given the recall to hospital, there was an automatic reference to the FTT by the Secretary of State under s.75(1) MHA.

17. The skeleton argument on behalf of EG for the FTT hearing stated that his recall had been lawful and was not challenged. The Trust supported the Secretary of State's

position that EG should be technically detained, but his s.17 leave should continue since a conditional discharge with conditions amounting to a deprivation of liberty was not a lawful option after *MM*.

The First Tier Tribunal decision

18. The FTT on 27 August 2020 decided that EG should be conditionally discharged and made subject to the following conditions:

> *1. The patient shall reside at [The Care Home] (or as directed by the RC and agreed by the Secretary of State or the First Tier Tribunal) and conform with the accommodations' standard terms and conditions of residence in as far as they do not deprive him of his liberty.*
>
> *2. The patient shall comply with all agreed care and risk management plans in as far as they do not deprive him of his liberty.*
>
> *3. The patient shall accept and engage in all psychiatric and social supervision, including attending all appointments, as directed by his Responsible Clinician (currently Dr Swinglehurst), Social Supervisor (currently Alan Anderson) or any other members of the care team.*
>
> *4. The patient shall permit any member of the care team access to his place of residence when requested to do so.*

19. The FTT's stated grounds for its decision were:

> *1. The tribunal is not satisfied that the patient is suffering from mental disorder or from mental disorder of a nature or degree which makes it appropriate for the patient to be liable to be detained in a hospital for medical treatment.*
>
> *2. The tribunal considers that it is appropriate for the patient to remain liable to be recalled to hospital for further treatment.*
>
> *3. The tribunal considers that conditions are required.*

20. The FTT set out Dr Swinglehurst's evidence as follows:

> *"13. Dr Swinglehurst was clear that it was not possible to manage [EG] in the community without depriving him of his liberty. He said it was difficult to see an exit strategy.*
>
> *14. Dr Swinglehurst also confirmed that [EG] has not had any inpatient treatment or any treatment in hospital since his discharge in 2014. The team are actively keeping him out of hospital as they believe should be return his behaviour would deteriorate, and his risks escalate, making it difficult to discharge him to the community. They see the current treatment and care plan as the least restrictive alternative. They want his care plan to remain the same.*

15. In terms of the appropriate treatment [EG] is in a specialist placement with both learning disability and forensic specialism. The staff have become expert at caring for him. Dr Swinglehurst has seen him twice since his recall which we are told is more than usual for a community patient. He does have a notional bed in the hospital although were he to be recalled he may go to another service."

21. The FTT carefully recorded the evidence on EG's capacity to agree to the care plan (DL16-18) and whether his position was analogous with that of Cheshire West v PWK [2019] EWCOP 57. The FTT concluded that EG did have capacity to consent to the arrangements for his care (DL19).

22. The FTT then set out the law in respect of s.72(1)(b) in some detail. I will set out that law below and therefore not refer here to the FTT's record.

23. At DL31-32 the FTT said:

"31. Ms Kingston [for EG] also submitted that we should distinguish these cases as they were unrestricted cases. However, we do not see how that affects the fundamental point that a patient, whether restricted or not, is detained for the purposes of treatment in a hospital and that there must be some significant part of that treatment in a hospital however tenuous that connection is. We accept the proposition that these cases did not consider conditional discharge but cannot see how this changes the interpretation of the language in section 72 that we must apply. If anything, the option of conditional discharge would mean that evidence of inpatient treatment is more important as the Tribunal have the option of granting a conditional discharge with the liability to recall. Even if our interpretation of the law is wrong then we as a FTT cannot depart from the binding authorities above which UTJ Jacobs in SL found to have been correctly decided.

32. All witnesses were clear in their evidence that there was no element of treatment at or in a hospital. In [EG's] case the team were actively avoiding a readmission to hospital as they thought this would bring about a deterioration of his mental state. The recall was planned over weeks with all the specialist input available to ensure that [EG] understood that he would not return to hospital even overnight. This was so carefully planned to avoid deterioration in his mental state and consequent behaviour which may have increased the risk to himself and others. [EG's] conditions are life-long. There is no suggestion as in the cases above that the treatment which can include section 17 leave was progressive and leading towards eventual discharge. The proposition was that he remains on section 17 leave until the law is changed and that this was the device the Secretary of State was using to deal with the lacuna in the law. We have to apply the law as it is. It is up to Parliament to change that law."

24. At DL33 and 36 they said:

> *"33. Given our finding that there is no treatment in hospital at all, there has not been since 2014 and the RA is actively resisting any return to hospital or treatment therein we cannot be satisfied of the criteria in section 72(1)(b)(i) and therefore we must discharge. We are certain that the patient needs to remain liable to recall (section 73) and therefore we must conditionally discharge. We accept the evidence that he remains a risk to others because of his mental disorders and the power of recall is necessary. [EG] himself wants the position to remain the same and is not challenging this.*
>
> *…*
>
> *36. If we cannot be satisfied that there is any treatment in hospital at all then we must discharge. We cannot impose a condition that [EG] is deprived of his liberty as was made clear in the case of MM. But we must discharge as we cannot find any part of his treatment could be described as treatment in hospital. In fact, the opposite is true."*

25. The Tribunal therefore concluded that it had no choice but to discharge EG because the s.72(1)(b)(i) criteria were not met. They knew that granting a conditional discharge did not serve the interests of any party (including EG) or the public well (DL38) but felt they had no choice given the state of the law. They suspended their decision so that the matter could be appealed to the Upper Tribunal and granted permission to appeal to the Trust and the Secretary of State, saying:

> *"38. We are well aware that granting a conditional discharge to [EG] does not serve the interests of any party or the public well. It puts both [EG] and the RA in an invidious position. Dr Swinglehurst and his team have actively worked to ensure that [EG] is not actually recalled to hospital given the very significant length of time it took to discharge him in 2014. He was in hospital for 21 years before a discharge could be achieved. The written evidence is that he sabotaged his moves to lesser security during his inpatient stay. If he were actually recalled to hospital there is no reason to believe that this would not be the position again."*

26. Grounds of appeal were submitted by the Trust to the Upper Tribunal. Permission was granted on the ground the Tribunal erred in law because:

    a. It wrongly interpreted s.72(1)(b)(i) as requiring an element of EG's care plan to be treatment provided in hospital;

    b. It wrongly concluded on the facts that medical oversight and specialist support provided to EG could not satisfy the requirements of s.72(1)(b)(i); and

    c. It was not bound by the decision in <u>*SL v Ludlow Street Healthcare*</u> [2015] UKUT 398 (AAC) which did not address the application of s.72(1)(b)(i) in the context of a restricted patient in EG's position.

27. Permission was granted to the Trust on the basis that the issues require consideration by the Upper Tribunal, not because it appeared the FTT had erred in law. The second ground of appeal, namely that the FTT's decision was incapable of implementation as it was too vague and did not specify which elements of EG's care plan he was required to comply with, was not addressed.

28. The Secretary of State also sought and was granted permission to appeal on the ground that the FTT erred in law because it misdirected itself on the facts in respect of whether EG was receiving 'treatment' and whether that treatment was provided in a 'hospital'.

29. The Trust and the Secretary of State applied in December 2020 for a declaration that it is lawful under the inherent jurisdiction of the High Court for EG to be deprived of his liberty, if the FTT's decision could not be overturned, and EG therefore had to be conditionally discharged under the MHA but with no authorisation for the elements of his care plan that constituted a deprivation of his liberty.

The law

30. Section 72(1) of the MHA states:

> *"72 Powers of tribunals*
>
> *(1) Where application is made to the appropriate tribunal by or in respect of a patient who is liable to be detained under this Act or is a community patient, the tribunal may in any case direct that the patient be discharged, and—*
>
> *(a) the tribunal shall direct the discharge of a patient liable to be detained under section 2 above if it is not satisfied—*
>
> *(i) that he is then suffering from mental disorder or from mental disorder of a nature or degree which warrants his detention in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; or*
>
> *(ii) that his detention as aforesaid is justified in the interests of his own health or safety or with a view to the protection of other persons;*
>
> *(b) the tribunal shall direct the discharge of a patient liable to be detained otherwise than under section 2 above if it is not satisfied—*
>
> *(i) that he is then suffering from mental disorder or from mental disorder of a nature or degree which makes it appropriate for him to be liable to be detained in a hospital for medical treatment; or*
>
> *(ii) that it is necessary for the health of safety of the patient or for the protection of other persons that he should receive such treatment; or*
>
> *(iia) that appropriate medical treatment is available for him; or*

(iii) in the case of an application by virtue of paragraph (g) of section 66(1) above, that the patient, if released, would be likely to act in a manner dangerous to other persons or to himself.

….

[emphasis added]

31. Section 20 states:

"20 Duration of authority

(1) Subject to the following provisions of this Part of this Act, a patient admitted to hospital in pursuance of an application for admission for treatment, and a patient placed under guardianship in pursuance of a guardianship application, may be detained in a hospital or kept under guardianship for a period not exceeding six months beginning with the day on which he was so admitted, or the day on which the guardianship application was accepted, as the case may be, but shall not be so detained or kept for any longer period unless the authority for his detention or guardianship is renewed under this section.

(2) Authority for the detention or guardianship of a patient may, unless the patient has previously been discharged under section 23 below, be renewed—

(a) from the expiration of the period referred to in subsection (1) above, for a

further period of six months;

(b) from the expiration of any period of renewal under paragraph (a) above, for a further period of one year, and so on for periods of one year at a time.

(3) Within the period of two months ending on the day on which a patient who is liable to be detained in pursuance of an application for admission for treatment would cease under this section to be so liable in default of the renewal of the authority for his detention, it shall be the duty of the responsible clinician—

(a) to examine the patient; and

(b) if it appears to him that the conditions set out in subsection (4) below are

satisfied, to furnish to the managers of the hospital where the patient is detained a report to that effect in the prescribed form; and where such a report is furnished in respect of a patient the managers shall, unless they discharge the patient under section 23 below, cause him to be informed.

(4) The conditions referred to in subsection (3) above are that—

(a) 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

(b) . . . .

(c) it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and that it cannot be provided unless he continues to be detained; and

(d) appropriate medical treatment is available for him. . . .

32. The key issue for the Tribunal was whether the nature and degree of EG's mental disorder made it *"appropriate for him to be liable to be detained in a hospital for medical treatment",* under s.72(1)(b)(i). If that condition was not met then the Tribunal was obliged to discharge him, either absolutely or conditionally, subject to the application of s.73 MHA.

33. There are a number of cases which have considered this phrase and the similar, though materially different, phrase in s.20 whether *" 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"* (s.20(4)(a)). It can be seen that the two statutory provisions are importantly different. Ms Butler-Cole argues that the Tribunal erred by referring to caselaw on s.20. However, as I explain below, I do not consider this criticism of the Tribunal is correct as the principal case it relied upon, SL v Ludlow, was a case on s.72 rather than s.20.

34. The first case on the relevant part of s.72 is R (Epsom & St Hellier NHS Trust) v Mental Health Review Tribunal [2001] MHLR 8 which concerned a woman detained under s.3 but granted s.17 leave to a nursing home where she was fed through a PEG tube. She had monthly outpatient visits from her responsible clinician but did not visit the hospital. The Tribunal found that she was entitled to be discharged under s.72 because she was not receiving any in-patient treatment and was not likely to do so.

35. The Trust's application for judicial review was refused. Sullivan J held at [52]:

"52. The matter has to be looked at in the round, including the prospect of future in-patient treatment, but there will come a time when, even though it is certain that treatment will be required at some stage in the future, the timing of that treatment is so uncertain that it is no longer "appropriate" for the patient to continue to be liable to detention. It is the Tribunal's function to use its expertise to decide whether the certainty, or the possibility, of the need for in-patient treatment at some future date makes it "appropriate" that the patient's liability to detention shall continue."

36. In R (on the application of DR) v Mersey Care NHS Trust [2002] 8 WLUK 70 the patient was detained under s.3 and her detention was renewed under s.20 even though at the time she was on s.17 leave and only attended the hospital for occupational therapy

twice a week, and for the ward round once a week. She argued that renewal under s.20 was only possible where the treatment plan was for in-patient care. The Trust argued that there was a sufficient element of treatment in hospital to make the decision lawful. The Court rejected DR's claim and said at [30]:

> *"30. The question therefore in my judgment is whether a significant component of the plan for the claimant was for treatment in hospital. It is worth noting that, by s. 145(1) of the Act, the words "medical treatment" include rehabilitation under medical supervision. There is no doubt, therefore, that the proposed leave of absence for the claimant is properly regarded as part of her treatment plan. As para. 20.1 of the Code of Practice states, "leave of absence can be an important part of a patient's treatment plan". Its purpose was to preserve the claimant's links with the community; to reduce the stress caused by hospital surroundings which she found particularly uncongenial; and to build a platform of trust between her and the clinicians upon which dialogue might be constructed and insight on her part into her illness engendered. Equally, however, the requirement to attend hospital on Fridays between 9:00 am and 5:00 pm and on Monday mornings was also in my judgment a significant component of the plan. The role of occupational therapy as part of the treatment of mental illness needs no explanation. But the attendance at hospital on Monday mornings seems to me to be likely to have been even more important. Such was to be the occasion for the attempted dialogue; for monitoring; for assessment and for review. In the Barking case both Lord Woolf at 114E and Thorpe L.J. at 118B stressed the importance of the arrangements for weekly monitoring and assessment in the hospital."*

37. In CS v Mental Health Review Tribunal [2004] EWHC 2958 (Admin), the Court was concerned with a s.3 patient who was granted s.17 leave but returned to hospital for ward rounds every 2 weeks, which was then varied to every 4 weeks. The Tribunal held that CS met the criteria for detention and the Court upheld the decision. The Court held that the relevant question for the Tribunal was whether: *"CS's mental illness was of a nature or degree which made it appropriate for her to receive treatment, a significant and justified component of which was treatment in hospital?"* at [39]. It can be noted that this question does not entirely reflect the statutory test in s.72.

38. All these cases were considered by UTJ Jacobs in SL v Ludlow Street Healthcare [2015] UKUT 398 (AAC). The patient there was detained under s.3 and was on s.17 leave. He attended hospital fortnightly for psychology sessions and the monthly ward round. The Tribunal refused to discharge, and the UT upheld that decision. UTJ Jacobs said:

> *"35. There are two dangers that tribunals must bear in mind in applying the approach set out in the cases. First, the tribunal must not reason by analogy from the facts of those cases. It must apply the principles established by the cases, but their application can only be undertaken by reference to the facts and circumstances of the case before the tribunal. Even small differences may justify, or even require, a different analysis. Second, it is not sufficient merely to repeat the language of the principles. The tribunal must, of course, make sufficient findings of fact to support, and provide an explanation that justifies, its conclusion.*

…

39. The tribunal regarded the contribution of the ward round to the decision-making of the clinical team as particularly important. That tied in with the supportive and review nature of the oversight it provided in the case of a patient who was improving and moving closer to a community treatment order. Although the actual rehabilitation and care was delivered outside the hospital, the form that it took was under the ultimate control and supervision of the clinical team.

40. The tribunal might also have taken account of the definition of 'medical treatment'. As Wilson J pointed out in DR, this includes rehabilitation under medical supervision. That means that the patient's section 17 leave and the rehabilitation provided to him in his accommodation, both of which operated under medical supervision, were themselves part of his treatment plan. The Code of Practice makes the same point."

39. DB v Betsi Cadwaladr University Health Board [2021] UKUT 53 (AAC) (3 March 2021) (after the FTT decision in the present case), again concerned a patient detained under s.3 and on s.17 leave. The FTT recorded that he *"had not set foot in hospital"* for almost a year. The Tribunal found that he should remain liable to be detained having met the s.72 criteria. However, UTJ Jacobs overturned the decision. He said at [11-12]:

"11. The tribunal's answer was that he needed the discipline of liability to detention in view of the risk that he would not take his medication and that his mental health and judgement would deteriorate as a result. But that cannot overcome the need for a significant component of his treatment to be in hospital. The tribunal found, and was entitled to find on the evidence, that the patient would not take his medication unless he were liable to be detained. And it was undoubtedly the case that the administration of medication was a significant component of his care plan. But the point was where the medication was being delivered, not whether it was necessary or whether it was being delivered. The tribunal should have analysed the components of the patient's treatment, which is broadly defined in section 145, and then decided the extent to which they were being delivered in hospital.

12. This may appear to create a dilemma. The patient is complying with his treatment regime while on leave without the need to attend a hospital, but that is only on account of the discipline provided by the possibility that the leave will be revoked if he does not. If that means that he has to be discharged, he will then disengage from treatment, leading to deterioration and the inevitable new admission. And so on in an unending cycle of discharge and admission. In practice, that situation can be avoided by using some of the other options available under and outside the Act. A community treatment order is an obvious possibility, but the clinical team ruled that out in this case. In the case of a restricted patient, which this patient is not, there is also the option of a conditional discharge. Outside the Act, there is the possibility of using the Mental Capacity Act 2005."

40. Ms Paterson argues that that DB can be distinguished on its facts because DB was receiving far less therapeutic input than EG, DB's symptoms being largely controlled through medication. However, I note that in terms of treatment in hospital, neither patient was being treated in hospital.

The Ministry of Justice Guidance and the White Paper

41. In 2019, in the light of the Supreme Court decision in *MM*, the Ministry of Justice produced guidance entitled "Discharge Conditions that amount to deprivation of liberty". The guidance provides that where a patient was already in the community, conditionally discharged in circumstances that constituted a deprivation of liberty, there were four options that the Secretary of State would consider:

    a. *Exercise the Secretary of State's power to revoke or amend a condition to remove the illegality, if it is considered that the public would remain adequately protected without that condition (or with an amended condition);*

    b. *Recall the patient to hospital on the grounds that the clarification of the law constitutes a material change of circumstance. In these circumstances, the Secretary of State will at the same point consider granting immediate consent to the use of long-term escorted leave of absence under section 17(3) MHA to enable the patient to remain in the community, where this appears to be in the patient's best interests and where any risk to the public can be safely managed during the patient's period of leave. Where this option is appropriate, the Secretary of State will generally only give consent to long-term escorted leave of absence for up to 12 months and the recall will only be a technicality (i.e. the patient should not actually be physically returned to hospital). Both considerations and decisions will be made concurrently to enable the patient to remain where they are currently placed while a decision is made. The Secretary of State could extend consent to a longer-term escorted leave of absence on the application of the responsible clinician after 12 months, but it will be necessary to review the continued appropriateness of such a leave of absence before extending it;*

    c. *Absolutely discharge the patient, if it is considered that the public would remain adequately protected without restrictions (including the power to recall to hospital at a later date);*

    d. *Refer the case to the Tribunal to consider amending or removing the relevant condition, or to consider absolute discharge.*

42. Also in the light of the Supreme Court decision in *MM*, on 30 January 2021 the Government produced a White Paper in which is it is proposed to fill the gap left by *MM* for restricted patients whom it would be appropriate to conditionally discharge, with the introduction of a new power of "supervised discharge". The White Paper states:

    "As with all patients detained under the Act, restricted patients should be supported to progress through their pathway of care, while taking care to

safely manage the potential risk they pose. This risk, including potentially violent, dangerous, or inappropriate sexual behaviour, would require continuous supervision to be managed safely in the community.

There is currently no effective legislation mechanism by which this small number of patients could be discharged from hospital by either the Justice Secretary or the tribunal with the necessary care and supervision needed to protect the public from this risk. As found by the Supreme Court Judgment in the case of MM, where such measures amount to a deprivation of liberty they properly and lawfully be imposed.

We want the reformed Act to support these few patients, who have very distinct needs and risks, to progress through their pathway of care, and to be supported so that their risk is managed in the most appropriate and least restrictive way – including in the community where it is appropriate.

Following the Supreme Court judgment in MM, an interim operational policy was implemented to allow a number of patients, who would otherwise have had to immediately return to hospital, to remain in a community setting on a long-term section 17 leave. This provides a temporary operational solution while legislative change is considered.

We are proposing the introduction of a new power of 'supervised discharge' which would enable discharge of a restricted patient with conditions amounting to a deprivation of that person's liberty, in order to adequately and appropriately manage the risk they pose. We propose that this type of order would be subject to annual review by the tribunal in line with the Court of Protection decisions on similar cases. The use of this new discharge power would be closely monitored to ensure that conditions amounting to deprivation of liberty were only applied when necessary and proportionate. This supervised discharge would be applicable only to restricted patients, and available irrespective of decision-making capacity. It would be applicable only where such a patient:

- *is no longer therapeutically benefitting from hospital detention under the Act, but*

- *continues to pose a level of risk which would require a degree of supervision and control amounting to a deprivation of their liberty; and so, could not be managed via a conditional discharge. Therefore,*

- *this would be the only least restrictive alternative to hospital.*

We are continuing to consider the appropriate threshold in relation to risk and how this power would be operated. We will consider suitable oversight of these patients in the community alongside proposals to strengthen the role of the social supervisor, as outlined above."

43. The Secretary of State produced a witness statement from Stephen O'Connor, Deputy Director for Vulnerable Offenders. He explained that the consultation on the White

Paper closed on 21 April 2021 and the Government expected to publish a response later this year. The intention is to introduce a Bill to Parliament as soon as Parliamentary time allows.

The submissions on Issue One – the domestic interpretation

44. Ms Butler-Cole for the Appellant Trust, and Ms Paterson for the Secretary of State, argue that the Tribunal erred in law by misconstruing s.72(1)(b)(i) and misapplying the caselaw, and therefore that I should set aside the FTT decision and decide that EG did meet the criteria for continued detention in the sub-section.

45. They submit that the Tribunal erred because it applied caselaw on s.20 and failed to properly take into account the different test under s.72 to that under s.20. Thus, the test of "a significant element" of the treatment having to be in hospital they argue does not apply under s.72. Further, any focus on in-patient treatment derives from the more restrictive wording in s.20 and should not be applied to s.72.

46. Ms Butler-Cole focused on the words "liable to be detained" in s.72 to suggest that there was a key difference from s.20 because the patient does not actually have to be in hospital, merely that s/he should be liable to be detained there. Therefore, a broader interpretation is possible under s.72 than under s.20.

47. Ms Paterson emphasised that on the facts of the case, once EG was recalled to hospital, his treatment was under the supervision and control of Dr Swinglehurst and he was receiving frequent input and monitoring from hospital-based professionals, even though he was not actually attending the hospital. That treatment was aimed at preventing a deterioration of his condition and, as such, his case could be differentiated from those where the Tribunal found that the care plan did not satisfy the requirements for ongoing detention. Ms Paterson therefore argued that even though EG did not physically attend the hospital, whether as an in-patient or out-patient, he did still meet the requirements of s.72 and therefore the FTT had been wrong to discharge him.

48. Mr Mant, who appeared for EG made clear that he did not mind what legal route was found to allow EG to remain in the community but subject to effective supervision. He focused his legal submissions on the Human Rights Act argument, as set out below.

Conclusions on Issue One (a) – the domestic interpretation of s.72

49. In my view it is not possible to conclude, applying domestic principles of construction absent s.3 of the Human Rights Act 1998, that the Tribunal erred in law. The Upper Tribunal can only overturn the FTT on the grounds of error of law. The caselaw referred to above shows that the Upper Tribunal (or previously the Administrative Court on judicial review) will be slow to interfere with the judgment of a specialist tribunal considering whether the treatment in question fell within the terms of s.72.

50. I accept that the test of a "significant component" of the treatment needing to be given by the hospital is one that originally emerged from the wording of s.20, rather than s.72. However, it has subsequently frequently been applied in cases concerning the lawfulness of detention under s.72. There is some tension between holding that a significant component of the treatment needs to be provided from or by the hospital and holding that the connection between the patient and the treatment need only be

"gossamer thin". However, what is clear is that the statutory words must be applied. That requires that the patient must be liable to be detained "in" a hospital "for medical treatment". Therefore, firstly there has to be an element of the treatment which needs to be in hospital (whether as an in-patient or outpatient visiting hospital); and secondly, the liability for detention in hospital must be because the patient needs the treatment. In other words, the fact that he needs to be liable to be detained in hospital cannot simply be a legal device, it must be for treatment.

51. I do not accept that the difference in wording between s.72 and s.20 has the effect that Ms Butler-Cole and Ms Paterson argue. Although s.20 requires directly that it must be appropriate for the patient to be detained in hospital, on any natural meaning of the words, the requirement for the patient to be liable to be detained, is to the same or very similar effect.

52. In EG's case he does not need to be detained in hospital for treatment. He has been receiving treatment with no connection whatsoever to a hospital for 7 years. The evidence shows that being in hospital, even as an out-patient, is positively counter-therapeutic for EG. As such, it is not merely that his treatment has no significant connection with hospital, rather it had and has, no connection at all. It is true that since his technical recall, his treatment has been supervised from hospital. But that is not because it is appropriate for him to be liable to be detained in a hospital for medical treatment, it is because that is the only way he can be deprived of his liberty after the Supreme Court's decision in ***MM***. Therefore, the liability that is being created is not because his mental disorder makes it appropriate for him to be detained in hospital for treatment.

53. In my view, the FTT applied the caselaw impeccably. They did not confuse the tests under s.20 and s.72. They applied that caselaw to the facts of EG's case and the evidence that not merely did he not need to be in hospital for treatment, but that it was actually harmful for him to receive treatment in hospital. It is noteworthy that in all the cases where the s.72 test was met, the patient was receiving some treatment in hospital, including some visits to hospital. For these reasons, in my view there was no error of law in the Tribunal's analysis of s.72, absent applying s.3 of the Human Rights Act.

Issue 1 (b) section 3 of the Human Rights Act 1998

54. All parties agree that the Court should seek to avoid the outcome by which EG is forced to return to hospital. Mr Mant argues that pursuant to s.3 of the HRA I should read s.72 in such a way as to avoid that outcome. He argues that to force EG to return to hospital would breach his Article 5, 8 and 14 rights and therefore the interpretative duty under s.3 comes into play. Ms Butler-Cole and Ms Paterson argue that rather than rely on s.3, if I reject their construction of s.72 under domestic interpretative principles, I should instead use the High Court's inherent jurisdiction to allow EG's detention in the community alongside the conditional discharge ordered by the FTT. Having rejected issue 1(a), this case comes down to whether I should rely on s.3; use the inherent jurisdiction; or if I conclude that I can do neither, then make a declaration of incompatibility.

55. I deal first with EG's rights under the European Convention of Human Rights ('ECHR'). Mr Mant argues that to detain EG in hospital would breach his Article 5, 8 and 14 rights.

Article 5(1)(e)

56. Article 5(1)(e) states:

> *"1. Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:*
>
> *(e) the lawful detention ... of persons of unsound mind…This requires the deprivation of liberty to be lawful as a matter of domestic law and free from arbitrariness."*

57. The minimum conditions that must be satisfied for detention of a person of unsound mind to be lawful under Article 5(1)(e) are those set out in Winterwerp v Netherlands (Application 6301/73) (1979) 2 EHRR 387, namely that:

   a. It must be established through objective medical evidence that the person is of unsound mind;

   b. The mental disorder must be of a kind or degree warranting compulsory confinement; and

   c. The validity of the continued confinement depends upon the persistence of the mental disorder.

58. In Ashingdane v United Kingdom (Application 8225/78) (1985) 7 EHRR 528 the European Court of Human Rights ('ECtHR') held that a delay in transferring a patient from a high security hospital to an ordinary psychiatric hospital with a more liberal regime did not breach the requirements of Article 5(1). At paragraph [44] it said:

> *"Certainly, the 'lawfulness' of any detention is required in respect of both the ordering and the execution of the measure depriving the individual of his liberty. Such 'lawfulness' presupposes conformity with domestic law in the first place and also, as confirmed by Article 18, conformity with the purposes of the restrictions permitted by Article 5(1). More generally, it follows from the very aim of Article 5(1) that no detention that is arbitrary can ever be regarded as 'lawful'. The Court would further accept that there must be some relationship between the ground of permitted deprivation of liberty relied on and the place and conditions of detention. In principle, the 'detention' of a person as a mental health patient will only be 'lawful' for the purposes of sub-paragraph (e) of paragraph 1 if effected in a hospital, clinic or other appropriate institution authorised for that purpose. However, subject to the foregoing, Article 5(1)(e) is not in principle concerned with suitable treatment or conditions."* [emphasis added]

59. In the light of the last line of [44] of Ashingdane, the generally accepted position has been for many years that there would not be a breach of Article 5(1)(e) by reason of the suitability of the treatment or the conditions of detention relative to the patient's condition, see Lady Hale in MM at [24]:

> *"24. It is, of course, an irony, not lost on the judges who have decided these cases, that the Secretary of State for Justice is relying on the protection of liberty in article 5 in support of an argument that the patient should remain detained in conditions of greater security than would be the case were he to be conditionally discharged into the community. It is, however, difficult to extract the principle of the "least restrictive alternative" from the case law under article 5 . This has not concerned itself with the conditions of the patient's detention (which may raise issues under article 3 or 8), as long as the place of detention is appropriate to the ground upon which the patient is detained: thus, in Ashingdane v United Kingdom (1985) 7 EHRR 528 , the court rejected a complaint that the patient should have been transferred from Broadmoor to a more open hospital setting much earlier than he was."*

60. However, that understood position has now been materially changed by the decision of the Grand Chamber in *Rooman v Belgium* [2020] MHLR 250. The Court was concerned with a convicted sex offender who was placed in a "social protection" facility where psychiatric care was available. However, he was from a German speaking minority, but the treatment provided was not in German and that language barrier effectively undermined his chance of progressing and reintegrating into society. The Grand Chamber undertook an extensive review of its previous caselaw before "clarifying and refining" the applicable principles. Crucially the Court said at [208] and [211]:

> *"208. Analysis of the Court's case-law, particularly as developed over the past fifteen years, shows clearly that it should now be considered that there exists a close link between the "lawfulness of the detention of persons suffering from mental disorders and the appropriateness of the treatment provided for their mental condition. While this requirement was not yet set out in the first judgments delivered in this area (see Winterwerp, § 51, and Ashingdane, §§ 47 and 48, cited above), from which it appeared that the therapeutic function of compulsory confinement was not as such guaranteed under Article 5, the current case-law clearly indicates that the administration of suitable therapy has become a requirement in the context of the wider concept of the "lawfulness" of the deprivation of liberty. Any detention of mentally ill persons must have a therapeutic purpose, aimed specifically, and in so far as possible, at curing or alleviating their mental-health condition, including, where appropriate, bringing about a reduction in or control over their dangerousness. The Court has stressed that, irrespective of the facility in which those persons are placed, they are entitled to be provided with a suitable medical environment accompanied by real therapeutic measures, with a view to preparing them for eventual release.*
>
> *…*
>
> *211. Lastly, the Court considers that potential negative consequences for the prospects of change in an applicant's personal situation would not necessarily lead to a finding of a breach of Article 5 § 1, provided that the authorities have taken sufficient steps to overcome any problem that was hampering the applicant's treatment."*

61. Mr Mant argues that in the light of *Rooman*, any outcome which has the effect of requiring EG to be detained in hospital would breach his rights under Article 5(1)(e). He submitted that the evidence shows beyond any doubt that hospital is not a "suitable medical environment" for EG and is positively harmful and counter-therapeutic to his needs and his ability to progress. The Secretary of State therefore cannot argue that the authorities have taken sufficient steps to overcome any problem hampering his treatment, (*Rooman* [211]). This is not a case which concerns limited resources or unavailability of treatment, which would prevent the placement of EG in a suitable therapeutic environment, this is rather a case of EG being caught in a legal lacuna which the Secretary of State and Parliament have failed to remedy after the decision in *MM*.

62. Ms Butler-Cole argues that *Rooman* does not create a duty under Article 5(1)(e) to detain only in the least intrusive way. Therefore, there is no necessary breach of Article 5(1) if EG is returned to hospital.

63. Ms Paterson also argues that there would be no breach of Article 5(1). She argues, in a Note produced after the hearing, that although EG has made greater progress at The Care Home, there is no concession that treatment there would be of no therapeutic value. Therefore, there would be sufficient link between the reason for his detention and the circumstances of his detention as for there to be no breach of Article 5. Further, she argues that his continued detention following recall could be justified under Article 5(1)(a) as following a conviction of a competent court. Therefore, the detention would be justified on the basis of risk to the public, not therapeutic benefit.

64. In my view there would be a breach of Article 5(1)(e) if EG was forced to return to hospital. The evidence is entirely clear that it is strongly against his therapeutic interests for him to be treated in hospital, even by going there as an outpatient. As the FTT record at paragraph 32 of its decision, the clinical team have been actively avoiding readmitting EG because it would bring about a deterioration of his mental health. This is not a situation where the State cannot meet EG's therapeutic needs because of lack of resources, or the way services are organised. An appropriate therapeutic milieu is available, but the law, as construed above, does not allow EG to be detained there.

65. I accept Ms Butler-Cole's broad proposition that *Rooman* does not require a person to be detained in the least intrusive way. The focus of paragraph 208 is on the situation where a person's detention is being justified under Article 5(1)(e), but they are not receiving suitable therapy. Here, the evidence shows that in hospital EG would not be being given suitable therapy, however broadly one interprets that phrase. The situation EG would find himself in if he was returned to hospital would fall within the terms of [208] of *Rooman*.

66. Ms Paterson now seeks to rely on Article 5(1)(a). That reliance does not in my view work in law. The detention of EG is under s.72 of the Mental Health Act. He was made subject to a s.37/41 MHA order in January 1994 and was conditionally discharged to The Care Home by the FTT in April 2004. It is not now open to the Secretary of State to say that the tests in the MHA do not apply and the Court should consider the matter under Article 5(1)(a) instead.

67. For these reasons I conclude that if EG had to return to hospital and be detained there, such a detention would be a breach of Article 5(1). The next issue is whether I should apply the interpretative power in s.3 of the HRA 1998 to construe the Mental Health

Act so as to be compatible with Convention rights. Mr Mant also pursued arguments under Article 8 and 14. In the circumstances it is not necessary for me to deal with those.

68. In Gilham v Ministry of Justice [2019] 1 WLR 5905 the Supreme Court held that a district judge was not a "worker" for the purposes of the Employment Rights Act 1996. This in turn would have led to a breach of Article 14 of the Convention. The Court held that the relevant statute should be read, pursuant to s.3, in such a way as to achieve a Convention compliant outcome. Baroness Hale addressed the correct approach to s.3 HRA at [39]:

> *"39. In Ghaidan v Godin-Mendoza [2004] UKHL 30; [2004] 2 AC 557 , the House of Lords held that the interpretive duty in section 3 of the Human Rights Act 1998 was the primary remedy. Section 3(1) reads: "So far as it is possible to do so, primary legislation ... must be read and given effect in a way which is compatible with the Convention rights". In Ghaidan v Godin-Mendoza it was also established that what is "possible" goes well beyond the normal canons of literal and purposive statutory construction. Philip Sales QC, for the Government, argued (at p 563) that section 3(1) required a similar approach to the duty to interpret domestic legislation compliantly with EU law, so far as possible, citing Litster v Forth Dry Dock Engineering Co Ltd [1990] 1 AC 546 . Both Lord Steyn (paras 45 and 48) and Lord Rodger (paras 118 and 121) agreed that what was possible by way of interpretation under EU law was a pointer to what was possible under section 3(1) , citing Litster as well as Pickstone v Freemans Plc [1989] AC 66 . Lord Nicholls referred to the "unusual and far-reaching character" of the obligation (para 30). He also emphasised that it did not depend critically on the particular form of words used, as opposed to the concept (para 31). Lord Rodger, too, said that to attach decisive importance to the precise adjustments required to the language of the particular provision would reduce the exercise to a game (para 123). The limits were that it was not possible to "go against the grain" of the legislation in question (para 121) or to interpret it inconsistently with some fundamental feature of the legislation (Lord Nicholls, at para 33, echoing In re S (Minors) (Care Order: Implementation of Care Plan) [2002] UKHL 10; [2002] 2 AC 291)."*

69. A Convention compliant outcome on the present case is one that allows EG (and others in his position) to be made lawfully liable to a deprivation of their liberty when they are in the community, so that there is no breach of Article 5(1)(e) as construed above. Mr Mant argues that to allow a restricted patient to be deprived of their liberty in the community on long term s.17 leave, without any part of their care plan involving treatment in hospital, is possible without straining the legislation beyond that permitted in Gilham.

70. In my view it is possible here to adopt the same logical approach that was taken in Gilham. The natural construction of s.72(1(b)(i) is that set out above. However, that leads to a Convention non-compliant outcome as I have explained. It is therefore possible to read the sub-section that makes "liable to be detained" mean liable in law to be detained for treatment, even where that treatment is being provided in the community, so long as it could lawfully be provided in hospital.

71. In my view, such a construction would not go against the grain of the legislation. The grain of this part of the statute might be said to be two-fold. Firstly, to allow the patient to be detained in a less restrictive setting, and secondly, to ensure that the protection of the public and an appropriate level of detention can be met. By construing the sub-section in this way, both purposes are met.

72. It is important to bear in mind that the very nature of the s.3 exercise is that the court is reaching an interpretation which does not accord with the meaning of the statute applying normal domestic canons of construction. The caselaw makes clear that is a broad power which allows something very close to re-writing as long it does not cut across "the grain".

73. It is therefore possible to construe s.72 as to not require the Tribunal to discharge, even where the link to the hospital is tenuous (as here), where such a construction is necessary in order to avoid a breach of Article 5. I will leave the parties to formulate a declaration that achieves this effect.

The Inherent Jurisdiction

74. All parties argue that if EG cannot be detained under the Mental Health Act by reason of there being no power to do so under s.72(1)(b)(i) and s.17(3), then he can be deprived of his liberty in the community under the High Court's inherent jurisdiction. As I have found above that I can read s.72 to allow for the deprivation of liberty in the community under s.17(3), this issue does not strictly arise. However, the issue was fully argued and is of very considerable importance. It is therefore appropriate that I should set out my conclusions.

75. The scope of the inherent jurisdiction to deprive adults with capacity of their liberty has been a matter of some judicial controversy. All parties agree that EG has capacity in respect of where he lives, and as such cannot be detained by the Court of Protection under the Mental Capacity Act.

76. That the inherent jurisdiction to make decisions in respect of "incompetent" adults has survived the passing of the Mental Capacity Act was established by the Court of Appeal in *A Local Authority v DL* [2012] 3 All ER 1064 and is not therefore in dispute. However, the scope of those to whom it can be applied, and whether it can be used to deprive a capacitous adult of their liberty, is rather less clear. The starting point is the judgment of Munby J (as he then was) in *Re SA (Vulnerable Adult with Capacity; Marriage)* [2005] EWHC 2942. At [77] Munby J said:

> *"77. It would be unwise, and indeed inappropriate, for me even to attempt to define who might fall into this group in relation to whom the court can properly exercise its inherent jurisdiction. I disavow any such intention. It suffices for present purposes to say that, in my judgment, the authorities to which I have referred demonstrate that the inherent jurisdiction can be exercised in relation to a vulnerable adult who, even if not incapacitated by mental disorder or mental illness, is, or is reasonably believed to be, either (i) under constraint or (ii) subject to coercion or undue influence or (iii) for some other reason deprived of the capacity to make the relevant decision, or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent."*

77. This passage appears to describe the category of persons who are "vulnerable" and thus fall within the scope of the jurisdiction as being unlimited, and equally the width of the jurisdiction as being unlimited. McFarlane LJ further considered who could fall within the term "vulnerable" in *Re DL* at [64]:

> *"64. For the reasons given by Munby J at paragraph 77 and elsewhere in Re SA, it is not easy to define and delineate this group of vulnerable adults, as, in contrast, it is when the yardstick of vulnerability relates to an impairment or disturbance in the functioning of the mind or brain. Nor is it wise or helpful to place a finite limit on those who may, or may not, attract the court's protection in this regard. The establishment of a statutory scheme to bring the cases in this hinterland before the Court of Protection would (as Professor Williams described) represent an almost impossible task, whereas the ability of the common law to develop and adapt its jurisdiction, on a case by case basis, as may be required, may meet this need more readily."*

78. In *O v P* [2015] EWHC 935 (Fam) Baker J (as he then was) referred to this caselaw and referred to the inherent jurisdiction being a *"sufficiently flexible remedy to evolve in accordance with social needs and social values."* When referring to the scope of the inherent jurisdiction, he said that he did not intend to define the reach of the jurisdiction as *"new problems will generate demands and produce new remedies… Indeed, there is probably no theoretical limit to the jurisdiction."*

79. In *Wakefield DC v DN* [2019] EWHC 2306 Cobb J was considering the use of the inherent jurisdiction to deprive a vulnerable adult of his liberty. At [24] the Judge summarised the key messages from *DL* and its predecessor authorities:

> *"i) [T]he inherent jurisdiction can be exercised in relation to a vulnerable adult who, even if not incapacitated by mental disorder or mental illness, is, or is reasonably believed to be, either (i) under constraint or (ii) subject to coercion or undue influence or (iii) for some other reason deprived of the capacity to make the relevant decision, or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent" (emphasis by underlining added) (Munby J in Re SA at [77]: this description was expressly endorsed by McFarlane LJ in Re DL at [53]);*
>
> *ii) The inherent jurisdiction should be "targeted solely at those adults whose ability to make decisions for themselves has been compromised by matters other than those covered by the 2005 Act" (McFarlane LJ in Re DL at [53]);*
>
> *iii) The inherent jurisdiction can be used to "supplement the protection afforded by the Mental Capacity Act 2005 for those who, whilst 'capacitous' for the purposes of the Act, are 'incapacitated' by external forces – whatever they may be – outside their control from reaching a decision" (Macur J as she then was in LBL v RYJ [2010 EWCOP 2665 [2011] 1 FLR 1279 at [62]). Macur J added (op cit.), materially: "… the relevant case law establishes the ability of the court, via its inherent jurisdiction, to facilitate the process of unencumbered decision-making by*

those who they have determined have capacity free of external pressure or physical restraint in making those decisions" (also at [62]: emphasis added);

iv) The inherent jurisdiction can be used to authorise intrusions into the human rights of the individual (esp. under article 8 ECHR) where it is necessary and proportionate to protect the health and well-being: see McFarlane LJ in Re DL at [66] and Davis LJ (ibid.) at [76]."

80. The first issue is whether the concept of vulnerability extends to someone in the position of EG. I accept that the category of who can be found to be "vulnerable" within the meaning of *Re SA* is not closed, and the nature of changing social conditions and situations mean that it would be wrong to seek to categorise those who could fall within the scope of the power, see the caselaw referred to above. However, it cannot be the case that a power as extensive, intrusive and wide ranging as the inherent jurisdiction can be used to interfere in the lives of any member of the public without some principled limit, see Lady Arden in *Re T (A Child)* [2021] UKSC at [188]. McFarlane LJ set out the proper extent of those potentially covered in *Re DL* at [53], namely those adults whose ability to make decisions is compromised by matters other than those set out in the Mental Capacity Act.

81. That description cannot sensibly be applied to EG. His ability to make decisions is not compromised, whether by undue influence, pressure or any similar reason. He is not vulnerable because of an inability to freely make a decision. The problem for EG is that the law has placed him in an exceptionally difficult and unfortunate position, because of the legal inability to deprive him of his liberty if he is conditionally discharged. That does not give rise to any vulnerability on his part and, in my view, he thus falls outside the principles set out *Re SA* and *Re DL*.

82. Therefore, if I were to find that EG could be deprived of his liberty under the inherent jurisdiction, it would have to be on a wholly different analytical basis to that in *Re SA*. The Trust and the Secretary of State argue that there is a lacuna in the statutory provisions, and it would be positively beneficial to EG for him to be deprived of his liberty in the legally unusual position of his case.

83. They rely on the decision of the Supreme Court in *Re T (A Child),* which was handed down after the end of oral argument in this case. In *Re T* the Supreme Court held that the inherent jurisdiction could be used to deprive a child of his/her liberty where such an outcome is essential for the protection of the very vulnerable children in question, see Lady Black at [141] and where the deprivation of liberty is necessary for the State to meet its positive operational duty under Article 2 and 3 ECHR, see Lord Stephens at [175]. It follows from this judgment that the inherent jurisdiction can be used to deprive certainly a child of their liberty where there is a lacuna in the statute and it is necessary to use the inherent jurisdiction to meet the State's obligations under the ECHR.

84. However, it is in my view quite a different thing to use the inherent jurisdiction to deprive a capacitous adult of their liberty through the use of the inherent jurisdiction. This issue was very carefully and thoroughly analysed by Cobb J in *Wakefield* at [48]. The fundamental problem with the use of the inherent jurisdiction for deprivation of liberty was explained by the Strasbourg Court in *HL v United Kingdom* (2005) 40 EHRR 32 (the *Bournewood* judgment), as Cobb J said at [48] of *Wakefield*:

"48. The second issue : As is apparent from my rehearsal of the parties' arguments above, in fact it was not in issue on the facts of this case that the inherent jurisdiction should not be used to deprive DN of his liberty, and rightly so. For my part: i) This accords with the same concerns expressed by the European Court of Human Rights in HL v United Kingdom (2005) 40 EHRR 32 (the Bournewood case) which referred (at [120]) to the "striking" lack of any fixed procedural rules under the common law by which the admission and detention of compliant incapacitated persons was conducted. In concluding that the use of the inherent jurisdiction to achieve a deprivation of liberty in these circumstances was too "arbitrary" 14 (i.e. without procedural control or limits, and the lack of any formalised admission procedures which indicate who can propose admission, for what reasons and on the basis of what kind of medical and other assessments and conclusions) it expressed its disquiet about the absence of a:

"...requirement to fix the exact purpose of admission (for example, for assessment or for treatment) and, consistently, no limits in terms of time, treatment or care attach to that admission. Nor is there any specific provision requiring a continuing clinical assessment of the persistence of a disorder warranting detention. The nomination of a representative of a patient who could make certain objections and applications on his or her behalf is a procedural protection accorded to those committed involuntarily under the 1983 Act and which would be of equal importance for patients who are legally incapacitated and have, as in the present case, extremely limited communication abilities".

ii) There are strong judicial dicta to the effect that the inherent jurisdiction should be used for "facilitative rather than dictatorial" reasons (McFarlane LJ in Re DL at [67] citing Macur LJ in LBL). As McFarlane LJ had earlier explained in his judgment (Re DL at [54]) the jurisdiction is:

"... in part aimed at enhancing or liberating the autonomy of a vulnerable adult whose autonomy has been compromised by a reason other than mental incapacity because they are ... (a) under constraint; (b) subject to coercion or undue influence; or (c) for some other reason deprived of the capacity to make the relevant decision or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent".

iii) For the reasons set out at [27] and [37] above, no support for the use of the inherent jurisdiction to deprive someone of their liberty can be derived in this context from Re PS ; on the contrary, the opposite conclusion should be reached from the judgment."

85. HL was plainly focusing on the limitations on detention set out in Article 5, and in particular the requirement that any detention be "in accordance with law". However, very similar constraint or limitation would arise under the common law in relation to constraining the power to deprive a capacitous individual of their liberty without a clear legal framework, whether in statute or common law. The mere fact that a court might

consider that it was in that individual's "best interests" (or those of the public) to have their liberty deprived, cannot of itself give a legal basis for such an order. The Supreme Court in *Re T* considered that the lack of a statutory procedural framework did not deprive the Court of the power to use the inherent jurisdiction. However, that was in circumstances where, firstly, there was a duty on the State which could not otherwise be met; and secondly, where there was evidence about the procedural protections that would in practice be in place.

86. To give the court the power to deprive an individual, with capacity, of their liberty without any clearly stated limitation, solely because the court had determined that it would be in their interests to do so, would be a significant intrusion into the most fundamental principles of liberty of the subject. In my view the position in *Re T* is materially different for the following reasons. Firstly, the case concerned children and the very particular duties that arise both in common law and under the ECHR fall upon the State. Secondly, I have found above that s.72(1)(b)(i) can be construed to allow EG to be deprived of his liberty in the community pursuant to s.17(3). It therefore is not necessary to use the inherent jurisdiction to the same effect as there is no lacuna. Thirdly, if I am wrong in respect of the s.3 HRA interpretation, then to use the inherent jurisdiction would cut across the statutory scheme in the clearest way. The conclusion would be that despite the exceptionally detailed scheme set out by Parliament in the Mental Health Act, by which EG could not be deprived of his liberty in the community either under a conditional discharge or pursuant to s.17(3), the inherent jurisdiction could be used to go directly counter to that position. That would, in my view, be an inappropriate use of the inherent jurisdiction.

87. In *Hertfordshire CC v AB* [2018] EWHC 3103 Gwynneth Knowles J authorised the deprivation of liberty of a vulnerable adult under the inherent jurisdiction. She rejected the argument that she could do so on the basis of *Re DL*, see [32], however she did approve the deprivation of liberty on the grounds of AB's best interests:

> *"39. In circumstances where AB is subject to a plan which has been very carefully designed for his particular benefit and also to protect members of the public, the choice for him if that plan is ruled unlawful is stark; indeed, that choice amounts to either consenting to his return to confinement in hospital or indeed a consent to a relaxation of the restrictions in that care plan so that they would no longer amount to a deprivation of his liberty. That would, in my view, place AB in an invidious position. He would not receive the support which he clearly needs and which all the professionals involved in his care consider that he needs which would keep him safe and, indeed, importantly, keep members of the general public safe from his behaviour.*
>
> *40. In those circumstances, where the Court of Appeal has said that AB's consent to a deprivation of liberty is not lawful, the applicant invited me, both in AB's interests and in the interests of the general public as a whole, to authorise the extension of the inherent jurisdiction so as to regularise that care plan and to do so (a) by declaring that it involved a deprivation of liberty and (b) by providing for a regular court review of that plan.*
>
> *41. It seems to me that, in these particular circumstances this is precisely the use to which the inherent jurisdiction should be put, exercised*

> *cautiously and in the manner prescribed by Peter Jackson J (as he then was). Having given the matter a great deal of careful thought, having decided that I am able to do so."*

88. Like Cobb J in *Wakefield* at [49] I note that the use of the inherent jurisdiction to deprive a capacitous adult of their liberty does not appear to have been fully argued and no respondent to the application attended. I do however also note that the deprivation was in accord with AB's will and preferences, see [2] and [20]. I am in the position whereby Cobb J and Gwynneth Knowles J have differed on this legal issue, and for the reasons set out above, I prefer to follow the reasoning of Cobb J.

89. The question of whether the inherent jurisdiction could be used to deprive a capacitous, but vulnerable adult of their liberty was raised in *Mazhar v Birmingham Community Foundation Trust* [2021] 1 WLR 1207, see [30-37]. However, ultimately the Court of Appeal did not need to determine that issue because the Court allowed the appeal on other grounds in any event. Baker LJ (who gave the judgment of the Court) recorded that the preponderance of first instance decisions suggested that there was such a power, but referred to Cobb J's judgment in *Wakefield* as reaching the opposite conclusion, see [33] and [52].

90. In my view the inherent jurisdiction does not extend to depriving a person with capacity of their liberty for two fundamental reasons. Firstly, whether under Article 5 or the common law, the right to liberty is jealously protected and should only be removed in carefully understood and constrained circumstances. This has recently been reflected by the Grand Chamber in *Ilnseher v Germany* (Application No 10211/12) [2019] MHLR 278, drawing together dicta from earlier decisions of the court, stated (at para 129):

> *"the permissible grounds for deprivation of liberty listed in article 5(1) are to be interpreted narrowly. A mental condition has to be of a certain severity in order to be considered as a 'true' mental disorder for the purposes of sub-paragraph (e)"*

91. Although the legal issue being considered in *Ilsenher* at [129] concerned the scope of the grounds for lawful deprivation of liberty under Article 5, the underlying point that Article 5 rights have to be carefully protected, and any interference with those rights must be strictly construed, are relevant to the issue before me. The problems outlined by the Grand Chamber in *HL v United Kingdom* in respect of the lack of clear principles and appropriate legal safeguards to the use of the inherent jurisdiction continues to be the case. If anything, the breadth of the use of the inherent jurisdiction in the light of *Re SA* and the wide and potentially unlimited categorisation of a "vulnerable adult" serves to increase the concern about the unprincipled extension of the inherent jurisdiction into the area of deprivation of liberty. This analysis is not undermined by *Re T*, both because that case concerned children, and because of the role of the positive obligations under Articles 2 and 3.

92. A further reason for rejecting the argument that EG can be deprived of his liberty under the inherent jurisdiction is that the domestic caselaw, principally stemming from *DL*, shows that the use of the inherent jurisdiction in respect of vulnerable adults is a facilitative rather than a dictatorial one. It is to be used to allow the vulnerable person to have the space, away from the factor which is overbearing their capacitous will, to

make a fully free decision. An order which deprives that person of their liberty is a dictatorial order which severely constrains their freedom, however well meant, rather than allowing them the space to reach a freely made decision.

93. As such in my view it would be wrong to use the inherent jurisdiction here to deprive EG of his liberty.

IN THE UPPER TRIBUNAL **HM/1606/2020**

ADMINISTRATIVE APPEALS CHAMBER

(ON APPEAL FROM THE FIRST TIER TRIBUNAL (MENTAL HEALTH)

AND

IN THE HIGH COURT OF JUSTICE **FD20F00078**

BETWEEN

(1) CUMBRIA, NORTHUMBERLAND TYNE & WEAR NHS FOUNDATION TRUST
(2) SECRETARY OF STATE FOR JUSTICE

Appellants and applicants

and

EG

Respondent

ORDER

Before Mrs Justice Lieven sitting at the Royal Courts of Justice, the Strand, London, on 9 November 2021

UPON handing down judgment in the above matter

IT IS DECLARED THAT:-

1. Pursuant to section 3 of the Human Rights Act 1998 ("HRA"), where it is necessary to do so in order to avoid a breach of a patient's Convention rights, the words "liable to be detained in a hospital for medical treatment" under section 72(1)(b)(i) of the Mental Health Act 1983 ("MHA") should be read to mean "liable in law to be detained for treatment" even where that treatment is being provided in the community.

2. The First Tier Tribunal's ("FTT") decision, dated 31 August 2020, involved the making of an error on a point of law, in that the FTT failed to read section 72(1)(b)(i) of the MHA in a way that was consistent with EG's Convention rights.

3. The court is satisfied that, on a Convention compliant reading of section 72(1)(b)(i) of the MHA, the FTT was not required to discharge EG (absolutely or conditionally) under section 72(1) and section 73(1) or (2) of the MHA.

IT IS ORDERED THAT:-

4. The appeal against the decision of the FTT, dated 31 August 2020 is allowed.

5. The decision of the FTT that EG be conditionally discharged is set aside.

6. There shall be substituted for the decision of the FTT, a decision that EG is not discharged from liability to be detained under the MHA.

7. The application under the inherent jurisdiction is dismissed.

8. Any application for permission to appeal shall be made in writing to the court by no later than 4pm on 16 November 2021. Any response shall be filed by 4pm on 19 November 2021.

9. There shall be no order as to costs save that there shall be a detailed assessment of the EG's legally aided costs.