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IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

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FAMILY DIVISION
OFFICE OF CARE AND PROTECTION

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Between:

A HEALTH AND SOCIAL CARE TRUST

Plaintiff

and

MR O

and

MR R

Defendants

_____

Mr Potter (instructed by DLS Solicitors) for the Applicant Health Trust
Mr Lavery QC with Ms Kyle (instructed by Wilson Nesbitt Solicitors) for Mr R
Mr Heraghty (instructed by Higgins Holywood Deazley) for Mr O
Mr Sands (instructed by the Crown Solicitor's Office) for the Department of Justice and the Department of Health
Ms Connolly QC with Ms Murphy (instructed by the Official Solicitor) as amicus
Mr Simblet QC (instructed by the Human Rights Commission of Northern Ireland) as intervenor (in writing)
The Attorney General of Northern Ireland, Ms Brenda King, as intervenor (in writing)

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KEEGAN J

Nothing must be published which would identify the persons who are the defendants in this case as they are patients. The case has been anonymised on that basis.

Introduction

[1] This case arises in the context of mental health law. I, by agreement of the parties, heard the two cases together given that they both raise similar issues which are of a complicated nature. In broad terms both Mr O and Mr R were made the subject of hospital orders with a special restriction pursuant to the Mental Health (Northern Ireland) Order 1986 ("the Mental Health Order"). In the case of both patients their detention has been examined before the Mental Health Tribunal. In both cases the Mental Health Tribunal (now called the Review Tribunal) has determined that a conditional discharge would be appropriate but has adjourned a finalisation of the cases due to a perceived difficulty in achieving this within the law. The difficulty flows from a decision of the Supreme Court in *MM v Secretary of State for Justice* [2018] UKSC 60 which determined that a tribunal could not impose terms as part of a conditional discharge which amounted to a deprivation of liberty pursuant to Article 5 of the European Convention on Human Rights ("ECHR"). This has led to an impasse which affects each patient in different ways. Mr O remains in Muckamore Hospital and urgently seeks transfer to a community placement. Mr O has brought a *habeas corpus* application during the course of this application which is pending before another court. Mr R has left Muckamore under temporary leave provisions and has been living in a community based setting for the past eighteen months.

[2] This case has come to me after a judicial review brought by Mr O. That was directed at the Trust's failure to bring a declaratory application. Paradoxically, now Mr O does not support a declaration being granted. The representatives for Mr R query the court's jurisdiction under the inherent jurisdiction but in final submissions; "welcome any initiative that would preserve his position in his current placement." The Department of Justice appeared and was represented in these proceedings. Given the issues at play I also joined the Department of Health. I asked the Official Solicitor to act as amicus. The Human Rights Commission applied to intervene in Mr O's case and have done so on paper. Finally, the Attorney General of Northern Ireland has appeared as an intervenor and filed a written argument. I am very grateful to all for assisting the court. I was asked to determine this case on the basis of the papers put before me and the legal submissions.

[3] From the outset I have encouraged a solution focussed approach but as will become apparent that has not yielded any fruit as yet and so the issue remains whether I should exercise my inherent jurisdiction in the case of Mr O and Mr R who on the evidence currently available have capacity to consent to care arrangements in the community which amount to a deprivation of liberty.

Mr O's Case

[4] This applicant was born in 1988. He was made the subject of a hospital order by the Crown Court on 2 March 2018 having been found to suffer from a severe mental impairment pursuant to Article 49, 49A and 50A of the Mental Health

(Northern Ireland) Order 1986("the Mental Health Order"). It was also pursuant to Article 47 of the Order, having regard to the offence, the antecedents of the defendant and the risk of the defendant committing further offences if set at large that it was necessary for protection of the public for him to be subject to the further special restrictions set out in Article 47 without limit of time. The offences were found proven after a factual hearing as Mr O was found unfit to be tried. These were sexual offences of gross indecency with or towards a child x 2 (a male cousin when Mr O was aged 11-13); indecent assault on a male x 1 (the same male cousin when Mr O was aged 11-13); sexual assault of a child under 13 x 1 (a female cousin (2 years younger) when Mr O was 11-20); indecent assault on a female x 7 and threats to kill x 2 (a female cousin when Mr O was 26).

[5] There is some history set out in the reports which I have found useful as follows. The first assessment of this patient in January 1994 raised issues of learning disability and query epilepsy. A test of functioning was undertaken in November 1997 which produced an IQ of 53 but it was thought that this may be low due to a lack of interest in the testing. Mr O was reported to suffer from a speech impediment. There is a previous history in 2008 of arson and other offences and in 2008 issues of self-harm are recorded. There was an attendance at Muckamore Hospital in October 2008 as a result of the arson offence which resulted in discharge. The overall diagnosis was one of borderline learning disability. There are also issues of cannabis and drug misuse noted in the papers. A diagnosis of global developmental delay is provided. Mr O is noted to have been co-operative and active in engagement with psychotherapeutic work and sexual behavioural work. I also note the description of Mr O as vulnerable and reference to him being bullied in the community due to the nature of his offences and the potential for him to suffer abuse.

[6] Mr O made an application for discharge subsequent to this Order being made. The hearing at the Mental Health Review Tribunal ("the Tribunal") took place on 12 June 2020. Evidence was heard from the Responsible Medical Officer ("RMO") and a consultant forensic psychiatrist. Following this Mr O was considered to have capacity to decide issues in relation to his living arrangements. The decision of the Tribunal chaired by Ms Fenton has been made available to me and it states that the decision of the panel was that the applicant was suffering from a mental impairment but it was not of such a nature to warrant continued detention. However, the Tribunal decided that conditions were appropriate given the issues in this case and a conditional discharge was the preferred option because that would allow for a recall to hospital. No decision was actually reached until the deprivation of liberty issue was determined as all parties agreed that the current care plan represented a deprivation of liberty. The case was adjourned on that basis and that remains the current position.

[7] The reports in this case from the Consultant Psychiatrist, Dr Milliken, date back to February 2019. I extract some salient details as follows. The first report refers to good engagement. Mr O was reported to have a severe mental impairment

but it was opined that treatment in the community should be progressed with a robust community plan. By July 2019 Mr O clearly had some time out of the hospital attending Extern. The community based plan remained the recommendation but no placement was identified. In the October 2019 report, reference is made to utilising the leave of absence provision if the Secretary of State agreed. In a report of 3 January 2020 it is noted that a community placement that had been identified was not suitable. By March 2020 a placement was identified and the risks are described as low to moderate. In a report of June 2020 an issue is flagged about children living in proximity to the proposed placement. The final report of 14 October 2020 from Dr Milliken which I asked for in these proceedings determines that Mr O does not have litigation capacity but he has capacity in relation to living arrangements applying the tests contained within the Mental Capacity (Northern Ireland) Act ("the Mental Capacity Act").

[8] There are also reports available from the treating psychologist Ms Keating. From reading these reports it is quite clear that the patient undertook therapy and other work under the auspices of a clinical psychologist to deal with his issues. Even at that stage the opinion of the multi-disciplinary team was that Mr O could transition to a community placement and that the issue was risk management. There is also a report from a Dr Frances Caldwell which appears to deal with the proximity issues as regards the proposed placement. A striking part of the expert reports is the opinion that a failure to progress to the community would undermine the treatment plan and progress. However, it is recognised in the report that this person will require a high level of supervision.

[9] Finally, the social work reports and care plan were provided to me. The draft carer support plan which was agreed on 26 May 2020 and put forth to the tribunal recommended Mr O living with four other individuals with learning disability in a supported environment in the community. The plan provides that this would be locked accommodation and that Mr O would be escorted at all times and that there would be constant supervision.

[10] I should say that there is an ongoing issue about the actual placement which is pursued by the Department of Justice. It argues that a small community based placement with others in a private home could be problematic due to the presence of children nearby. In any event the reports indicate that Mr O needs essential supportive accommodation that meets his identified needs but that it is not overly restricted.

[11] At the Tribunal hearing the Department of Justice contended that medical treatment was still warranted and that there should not be any form of discharge. I also note that the Department of Justice referenced the Article 15 leave provisions, however this was not seen to be suitable by the Tribunal.

Mr R's case

[12] Mr R was born in 1985. He is reported to suffer from a severe mental impairment. He was made subject to a hospital order with restrictions in November 2015 for offences of common assault and attempted wounding. These occurred whilst he was in Muckamore and involved assaults on other patients and suffocation. He sought review of his detention and his case was heard on 5 December 2019 and on 11 February 2020 after which the case was ultimately adjourned by the Tribunal given the deprivation of liberty issue. Mr R also was detained in hospital at Muckamore until 5 December 2018 when he obtained the benefit of Article 15 leave with agreement of the Secretary of State. This had been recommended by the psychiatrist.

[13] Mr R is noted to have severe mental impairment and marked autistic spectrum disorder. His IQ is recorded as 53. He has lived in a supported environment in the Community for a considerable period of time as a result of agreed temporary leave. He was recalled to hospital due to incidents of aggression and agitation between 22 May and 17 June 2019. However, Mr R has been settled since then. The multi-disciplinary team states that he has capacity to consent to restrictive aspects and continues to work co-operatively. From the reports it is evident that the offences that occurred when he was an inpatient in Muckamore were extremely concerning in that he entered another patient's room and put a pillow over their face and on another occasion stabbed another patient. He was clearly not fit to plead and therefore obtained the hospital order. Subsequent to his detention there is a worrying picture of staff attacks and self-injury which are extreme and high in number. These incidents seem to have reduced according to the most recent report which was filed on 14 June 2020 and are now not so frequent certainly in terms of attacks on staff but there remain issues in relation to self-harm.

[14] It is clear that this is a man who without care and supervision is susceptible to self-harm illustrated by attempts to consume batteries on an ongoing basis. He is described as a vulnerable man. In the past his behaviour towards staff was unmanageable at times, extremely aggressive with little trigger and involved damage to furniture and injury to staff. It is important to note that since the age of 4 social services were involved with Mr R and his parents had difficulties with alcohol. He seems to have a history in various institutions including Forster Green, Glenhill and Lindsay House and he first became placed in Muckamore at age 14. There is an issue raised in the papers about his mother dying in 1997 and her possibly having been abused by him.

[15] The picture provided is by Dr Milliken that Mr R has a life-long issue which will require ongoing support and supervision in the community. In a report of November 2018 Dr Milliken recommended leave of absence as test to see if Mr R could settle in the community. There was recall after that which is unsurprising given the chronology of significant incidents that has been provided in the papers which were particularly frequent during 2019. In his report of November 2019

Dr Milliken refers to Mr R's ongoing mental disorder, abnormal and aggressive behaviour and that he exhibits seriously irresponsible behaviour at times directed at himself and others. The reports of January and June 2020 support ongoing management in the community. No updated report was provided in these proceedings. Mr Lavery who appeared for Mr R frankly said that there were difficulties in any communication with Mr R and that further assessment could cause upset.

[16] The care plan is explained in the social work reports of 15 January 2010 and 14 June 2020. It is clearly a plan of continuous supervision and control in a placement where Mr R is not free to leave.

[17] This case was referred to the Tribunal for review under the legislation given the period on temporary leave. I have been provided with a copy of two decisions of Ms Lavery of 5 November 2019 and 29 January 2020 the outcome of which is that the Tribunal has effectively adjourned proceedings given the deprivation of liberty issue.

Legal context

i. Response to MM

[18] In response to my queries the Department of Justice confirmed that there were 39 conditional discharges made in Northern Ireland from 2003 to the present. I have no more detail about the cases but at least I know there is a relatively small number which averages as just over 2 per year.

[19] In paragraph 26 and 27 of *MM* the Supreme Court raised the possibility of utilising the Mental Capacity Act as follows:

> "26. The Court of Protection cannot authorise the deprivation of liberty of an incapacitated person who is "ineligible" within the meaning of Schedule 1A to the Mental Capacity Act, section 16A of the Mental Capacity Act (as inserted by section 53 of, and Schedule 8 to, the 2007 Act). A restricted patient who is actually detained in hospital is ineligible (falling within Case A in para 2 of Schedule 1A). A restricted patient who is conditionally discharged from hospital falls either within Case B or Case C and is not wholly ineligible. A deprivation of liberty whose purpose consists wholly or mainly in medical treatment in hospital cannot be authorised, but a deprivation for other purposes can be authorised, provided that it is not inconsistent with the requirements of their MHA regime.

> 27. Whether the Court of Protection could authorise a future deprivation, once the FtT has granted a conditional discharge, and whether the FtT could defer its decision for this purpose, are not issues which it would be appropriate for this court to decide at this stage in these proceedings. Assuming that both are possible, and therefore that there might be an incompatibility with article 14, read either with article 5 or with article 8, it would make no difference to the outcome of this case."

[20] Also, in response to this case, guidance was issued by the Secretary of State in January 2019. This guidance is not a legally binding document but it is guidance nonetheless and I note it was before the Tribunals in the two cases I have to deal with and it was put to me as well.

[21] The observation made at the outset of the document is that the independent review of the Mental Health Act published on 6 December 2018 included a recommendation which is recommendation No: 136 in relation to this issue of discharge of a restricted patient subject to conditions which amount a detention or deprivation of liberty as follows:

> "The government should legislate to give the Tribunal the power to discharge patients with conditions that restrict their freedom in the community, potentially with a new set of safeguards."

[22] This guidance states that relevant government leads, including the Ministry of Justice and the Department of Health and Social Care are currently considering all recommendations in the MHA Review's Final Report. There is a recommendation for legislative reform. However, Mr Sands who represented the Department of Justice and the Department of Health could not give any timeline for this.

[23] In the meantime, the aim of the operational policy I have referred is to ensure that, where appropriate, restricted patients do not need to remain in hospital beds and can continue their rehabilitation in a community based setting, while on long-term escorted leave of absence under Section 17.3 of the Mental Health Act. It is stated that this will ensure affected patients are managed safely, detained in an appropriate setting, detained in accordance with the procedure prescribed by law and are subject to the safeguards of a detained patient.

[24] In relation to patients with capacity paragraph 3 of the guidance states as follows:

> "Where the patient has capacity to decide whether or not he/she should be accommodated at the relevant discharge placement with a care plan that includes

> arrangements that amount to a deprivation of liberty (DOL), the placement cannot be authorised under the provisions of the Mental Capacity Act 2005 (the MCA) and the patient cannot validly consent to the arrangements. If a patient is being considered for discharge and the responsible clinician considers that they no longer require treatment in hospital, but are not yet suitable for discharge without constant supervision, the Secretary of State can consider providing his consent to a long term escorted leave of absence under Section 17(3) MHA.
>
> The Secretary of State is aware of the case of *Hertfordshire County Council v AB* [2018] EWHC 3103 Fam where the High Court used its inherent jurisdiction to make an order authorising the DOL that arose from the patient's care plan. The Secretary of State does not consider that this is the correct approach. Where a patient continues to present such a risk to public protection, linked to his mental disorder, the Secretary of State considers that his treatment is best managed under the provisions of the MHA so that either the Secretary of State or the Tribunal can consider the public protection aspect of detention under the MHA. If further treatment and rehabilitation could be given in a community setting for such a patient then a Section 17.3 long-term escorted leave approach would be more appropriate than to conditionally discharge with a care plan that required a DOL authorisation under the inherent jurisdiction of the High Court."

[25] I referred the parties to the case *of Birmingham CC v SR; Lancashire CC v JTA* [2019] EWCOP 28 as I noted that Lieven J had made orders under the Mental Capacity Act in relation to two patients who were to be conditionally discharged. In these cases there was no dispute as to capacity and it is to be noted that neither patient raised any objections or participated in the hearing. The Judge referred to the government guidance which distinguished between (a) those whose best interests require a care plan depriving liberty to help them perform daily living activities or self-care, and (b) those who deprivation of liberty is primarily to protect the public. The guidance suggested using the MCA to authorise the former and MHA s.17(3) escorted leave for the latter. Lieven J decided that both patients would fall within the Mental Capacity Act pertaining in England and Wales as category B cases because when the order would come into effect they would not be detained and so there was no conflict with the Mental Health Act. Lieven J also deals with the issue of protection of the public at paragraphs 41 and 42:

> "41. In the case of SR, it might be argued that the purpose of the deprivation of liberty and some of the other elements of the care package is the protection of the public, rather than the care of SR. However, for the reasons given by Moor J in ZZ I think that is a false dichotomy. It is strongly in SR's best interests not to commit a further offence, or to place himself at risk of recall under the MHA, if the Secretary of State were to conclude that the risk of other offences was too great. In those circumstances the provisions of the care plan in terms of supervision and ultimately deprivation of liberty is, as Moor J put it, "to keep him out of mischief" and thereby assist in keeping him out of psychiatric hospital. This is strongly in his best interests, as well as being important for reasons of public protection.
>
> 42. It is for this reason that I am not convinced that the division the Secretary of State makes in the Guidance between patients whose care plan is in the patients' best interests, and those where the deprivation of liberty is primarily for the purpose of managing risk to the public, is one that stands up to close scrutiny. However, on the facts of this case I have found that both patients would fall into the first category in any event."

[26] *In MC v Cygnet Behavioural Health Ltd and the Secretary of State for Justice* [2020] UKUT 230 (ACC) Judge Jacobs also decided that there could be a coordinate jurisdiction between the Mental Health Act and the Mental Capacity Act regime. It is interesting that in saying so he pointed out that there was a difference in view among judges of the First Tier Tribunal which he hoped would resolve by virtue of his decision.

[27] These cases deal with persons who lack capacity. I have not been referred to any decision in relation to a restricted patient seeking conditional discharge who has capacity, following *MM*.

ii. Mental health and mental capacity legislation in Northern Ireland

[28] In Northern Ireland the relevant statutory provisions are found in the Mental Health (Northern Ireland) Order 1986. Also, after a period of review Northern Ireland has The Mental Capacity Act 2016. Mental Health review has been on the agenda for quite some time here following the Bamford Review which proposed a comprehensive legal framework as far back as 2002. The Mental Health Order was ripe for reform and the review process recommended fusion legislation which would be non-discriminatory. This drive has found expression in the Mental Capacity Act which is a comprehensive piece of legislation designed to overtake and

bring together the issues of capacity and mental health and amend and eventually repeal the Mental Health Order. The Mental Capacity Act has 15 parts and 308 sections and 11 schedules. This legislation is partially enacted from December 2019 in relation to deprivation of liberty authorisation. The system in Northern Ireland is therefore somewhat different from that in England and Wales. The Mental Health Review Tribunal has been renamed The Review Tribunal and it will hear deprivation of liberty applications in certain circumstances. This legislation does not establish a Court of Protection in Northern Ireland but there is provision for High Court jurisdiction in a limited number of cases. Pending the enactment of the other sections the Mental Health Order will continue to deal with detention on the basis of mental disorder. It is to that piece of legislation that I now turn.

[29] Under Article 44 of the Mental Health Order where a person is convicted of offences punishable with imprisonment the court may make a hospital order but before doing so must be satisfied on the oral evidence of a medical practitioner appointed by the Mental Health Commission for Northern Ireland and on the written oral evidence of one or other medical practitioner that the offender is suffering from mental illness or severe mental impairment of a nature or degree which warrants his detention in hospital for medical treatment. The court must also be of opinion, having regard to all the circumstances, including the nature of the offence and the character and antecedents of the offender, and to the other available methods of dealing with them, that the most suitable means of dealing with the case is by way of a hospital order.

[30] In Article 3(1) of the Mental Health Order severe mental impairment is defined as meaning a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.

[31] If it appears to the court making a hospital order that having regard to the nature of the offence, the antecedents of the person and the risk of his committing further offences if set at large, that it is necessary for the protection of the public from serious harm to do so, it may order that the person shall be subject to the special restrictions set out in Section 47 of the Mental Health Order either without limited time or during such period as may be specified in the order. This is known as a restriction order.

[32] In both the cases I have to deal with the Crown Court made a hospital order under Article 44 of the Mental Health Order having established severe mental impairment and in each case a Section 47 Order was made, namely a restriction order without limit of time.

[33] Article 15 of the Order deals with leave of absence from hospital and reads as follows:

"15.—(1) The responsible medical officer may grant to any patient who is for the time being liable to be detained in a hospital under this Part leave to be absent from the hospital subject to such conditions, if any, as that officer considers necessary in the interests of the patient or for the protection of other persons.

(2) Leave of absence may be granted to a patient under this Article either on specified occasions or for any specified period; and where leave is so granted for a specified period, that period may be extended by further leave granted in the absence of the patient.

(3) Where it appears to the responsible medical officer that it is necessary to do so in the interests of the patient or for the protection of other persons, he may, upon granting leave of absence under this Article, direct that the patient remains in custody during his absence; and where leave of absence is so granted the patient may be kept in the custody of any officer of the responsible authority, or of any other person authorised in writing by that authority.

(4) Where leave of absence is granted to a patient under this Article or where a period of leave is extended by further leave and the leave or the extension is for a period of more than 28 days, it shall be the duty of the responsible authority to inform RQIA within 14 days of the granting of leave or of the extension, as the case may be, of the address at which the patient is residing and, on the return of the patient, to notify RQIA thereof within 14 days.

(5) Where—

(a) a patient is absent from a hospital in pursuance of leave of absence granted under this Article; and

(b) it appears to the responsible medical officer that it is necessary to do so in the interests of the patient's health or safety or for the protection of other persons or because the patient is not receiving proper care;

that officer may, subject to paragraph (6), by notice in writing given to the patient or to the person for the time

being in charge of the patient, revoke the leave of absence and recall the patient to the hospital.

(6) A patient to whom leave of absence is granted under this Article shall not be recalled under paragraph (5) after he has ceased to be liable to be detained under this Part."

[34] Article 48 of the Order contains powers of Secretary of State in respect of patients subject to restriction orders as follows:

"48.—(1) If the Secretary of State is satisfied that in the case of any patient a restriction order is no longer required for the protection of the public from serious harm he may direct that the patient shall cease to be subject to the special restrictions set out in Article 47(2); and where the Secretary of State so directs, the restriction order shall cease to have effect, and Article 47(4) shall have effect accordingly.

(2) At any time while a restriction order is in force in respect of a patient, the Secretary of State may, if he thinks fit, by warrant discharge the patient from hospital, either absolutely or subject to conditions; and where a patient is absolutely discharged under this paragraph, he shall thereupon cease to be liable to be detained by virtue of the relevant hospital order, and accordingly the restriction order shall cease to have effect.

(3) The Secretary of State may at any time during the continuance in force of a restriction order in respect of a patient who has been conditionally discharged under paragraph (2) by warrant recall the patient to such hospital as may be specified in the warrant; and thereupon—

(a) if the hospital so specified is not the hospital from which the patient was conditionally discharged, sub-paragraph (b) of paragraph (2) of Article 46 shall have effect as if the hospital specified in the warrant were substituted for the hospital designated by the Department under sub-paragraph (a) of that paragraph; and

(b) in any case, the patient shall be treated for the purposes of Article 29 as if he had absented himself

without leave from the hospital specified in the warrant, and if the restriction order was made for a specified period, that period shall in any event be deemed not to have expired until the patient returns to hospital or is returned to hospital under that Article.

(4) If a restriction order in respect of a patient ceases to have effect after the patient has been conditionally discharged under paragraph (2), the patient shall, unless previously recalled under paragraph (3), be deemed to be absolutely discharged on the date when the order ceases to have effect, and accordingly shall cease to be liable to be detained by virtue of the relevant hospital order.

(5) The Secretary of State may, if satisfied that the attendance at any place in Northern Ireland of a patient who is subject to a restriction order is desirable in the interests of justice or for the purposes of any public inquiry, direct him to be taken to that place; and where a patient is directed under this paragraph to be taken to any place he shall, unless the Secretary of State otherwise directs, be kept in custody while being so taken, while at that place and while being taken back to the hospital in which he is liable to be detained."

[35] Article 75 refers to applications to the Tribunal concerning restricted patients:

"75. A patient who is a restricted patient within the meaning of Article 84 and is detained in a hospital may apply to the Review Tribunal—

(a) within the period of 6 months beginning with the date of the relevant hospital order or transfer direction;

(b) within the period between the expiration of 6 months and the expiration of 12 months beginning with the date of the relevant hospital order or transfer direction; and

(c) within any subsequent period of 12 months."

[36] Article 76 refers to references by the Secretary of State concerning restricted patients:

"76.—(1) The Secretary of State may at any time refer the case of a restricted patient to the Review Tribunal.

(2) The Secretary of State shall refer to the Review Tribunal the case of any restricted patient detained in a hospital whose case has not been considered by the tribunal, whether on his own application or otherwise, within the last 2 years.

(3) The Secretary of State may by order vary the length of the period mentioned in paragraph (2)."

[37] The next section of the legislation deals with discharge of patients. Article 77 reads:

"77.—(1) Where application is made to the Review Tribunal by or in respect of a patient who is liable to be detained under this Order, the tribunal may in any case direct that the patient be discharged, and shall so direct if—

(a) (except in relation to detention for assessment), the tribunal is not satisfied that he is then suffering from mental illness or severe mental impairment or from either of those forms of mental disorder of a nature or degree which warrants his detention in hospital for medical treatment; or

(aa) in relation to detention for assessment, the tribunal is not satisfied that the patient is then suffering from mental disorder of a nature or degree which warrants the patient's detention in a hospital for assessment (or for assessment followed by medical treatment); or

(b) the tribunal is not satisfied that his discharge would create a substantial likelihood of serious physical harm to himself or to other persons; or

(c) in the case of an application by virtue of Article 71(4)(a) in respect of a report furnished under Article 14(4)(b), the tribunal is satisfied that he would, if discharged, receive proper care.

(1A) In paragraph (1) "detention for assessment" means detention by virtue of any report under Article 9.

(2) A tribunal may under paragraph (1) direct the discharge of a patient on a future date specified in the direction; and where the tribunal does not direct the discharge of a patient under that paragraph the tribunal may—

(a) with a view to facilitating his discharge on a future date, recommend that he be granted leave of absence or transferred to another hospital or into guardianship; and

(b) further consider his case in the event of any such recommendation not being complied with."

[38] Article 78 refers to power to discharge restricted patients subject to restriction orders:

"78.—(1) Where an application to the Review Tribunal is made by a restricted patient who is subject to a restriction order, or where the case of such a patient is referred to the tribunal, the tribunal shall direct the absolute discharge of the patient if—

(a) the tribunal is not satisfied as mentioned in paragraph (1)(a) or (b) of Article 77; and

(b) the tribunal is satisfied that it is not appropriate for the patient to remain liable to be recalled to hospital for further treatment.

…

(3) Where a patient is absolutely discharged under this Article he shall thereupon cease to be liable to be detained by virtue of the relevant hospital order, and the restriction order shall cease to have effect accordingly.

(4) Where a patient is conditionally discharged under this Article—

(a) he may be recalled by the Secretary of State under paragraph (3) of Article 48 as if he had been conditionally discharged under paragraph (2) of that Article; and

(b) the patient shall comply with such conditions (if any) as may be imposed at the time of discharge by the tribunal or at any subsequent time by the Secretary of State.

(5) The Secretary of State may from time to time vary any condition imposed (whether by the tribunal or by him) under paragraph (4).

(6) Where a restriction order in respect of a patient ceases to have effect after he has been conditionally discharged under this Article the patient shall, unless previously recalled, be deemed to be absolutely discharged on the date when the order ceases to have effect and shall cease to be liable to be detained by virtue of the relevant hospital order.

(7) The tribunal may defer a direction for the conditional discharge of a patient until such arrangements as appear to the tribunal to be necessary for that purpose have been made to its satisfaction; and where by virtue of any such deferment no direction has been given on an application or reference before the time when the patient's case comes before the tribunal on a subsequent application or reference, the previous application or reference shall be treated as one on which no direction under this Article can be given."

[39] Article 79 also is relevant:

"79.—(1) Where an application to the Review Tribunal is made by a restricted patient who is subject to a restriction direction, or where the case of such a patient is referred to the tribunal, the tribunal—

(a) shall notify the Secretary of State whether, in its opinion, the patient would, if subject to a restriction order, be entitled to be absolutely or conditionally discharged under Article 78; and

(b) if it notifies him that the patient would be entitled to be conditionally discharged, may recommend that in the event of his not being discharged under this Article he should continue to be detained in hospital.

(2) If in the case of a patient not falling within paragraph (4)—

(a) the tribunal notifies the Secretary of State that the patient would be entitled to be absolutely or conditionally discharged; and

(b) within the period of 90 days beginning with the date of that notification the Secretary of State gives notice to the tribunal that the patient may be so discharged,

the tribunal shall direct the absolute or, as the case may be, the conditional discharge of the patient.

(3) Where a patient continues to be liable to be detained in a hospital at the end of the period referred to in paragraph (2)(b) because the Secretary of State has not given the notice there mentioned, the responsible authority shall, unless the tribunal has made a recommendation under paragraph (1)(b), transfer the patient to a prison or other institution in which he might have been detained if he had not been removed to hospital, there to be dealt with as if he had not been so removed."

[40] Article 80 refers to applications and references concerning conditionally discharged restricted patients:

80.—(1) Where a restricted patient has been conditionally discharged under Article 48(2), 78 or 79 and is subsequently recalled to hospital—

(a) the Secretary of State shall, within one month of the day on which the patient returns or is returned to hospital, refer his case to the Review Tribunal; and

(b) Article 75 shall apply to the patient as if the relevant hospital order or transfer direction had been made on that day.

(2) Where a restricted patient has been conditionally discharged as aforesaid but has not been recalled to hospital he may apply to the Review Tribunal—

(a) within the period of 12 months beginning with the date on which he was conditionally discharged; and

(b) in any subsequent period of 12 months.

(3) Articles 78 and 79 shall not apply to an application under paragraph (2) but on any such application the tribunal may—

(a) vary any condition to which the patient is subject in connection with his discharge or impose any condition which might have been imposed in connection therewith; or

(b) direct that the restriction order or restriction direction to which he is subject shall cease to have effect;

and if the tribunal gives a direction under sub-paragraph (b) the patient shall cease to be liable to be detained by virtue of the relevant hospital order or transfer direction."

[41] Regulation 46 of the Mental Capacity Deprivation of Liberty No: 2 Regulations (Northern Ireland) 2019 reads as follows:

> "For the purposes of Section 307(4) of the Act until the coming into force of paragraphs 6 and 10 of Schedule 8 to the Act the provisions of the Act that are included in the Schedule to the Mental Capacity 2016 Act Commencement No: 1 Order (Northern Ireland) 2019 and which are commenced by Article 2 of that Order do not apply in any circumstances in which a deprivation of liberty may instead by authorised by virtue of the provisions contained in Part II or Part III of the Mental Health (Northern Ireland) Order 1986."

iii. The European Convention on Human Rights, ECHR

[42] Article 5 reads as follows:

> "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: (a) the lawful detention of a person after conviction by a competent court; (b) the lawful arrest or detention of a person for non-compliance with the

lawful order of a court or in order to secure the fulfilment of any obligation prescribed by law; (c) the lawful arrest or detention of a person effected for the purpose of bringing him before the competent legal authority on reasonable suspicion of having committed an offence or when it is reasonably considered necessary to prevent his committing an offence or fleeing after having done so; (d) the detention of a minor by lawful order for the purpose of educational supervision or his lawful detention for the purpose of bringing him before the competent legal authority; (e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants; (f) the lawful arrest or detention of a person to prevent his effecting an unauthorised entry into the country or of a person against whom action is being taken with a view to deportation or extradition.

2. Everyone who is arrested shall be informed promptly, in a language which he understands, of the reasons for his arrest and of any charge against him.

3. Everyone arrested or detained in accordance with the provisions of paragraph 1 (c) of this Article shall be brought promptly before a judge or other officer authorised by law to exercise judicial power and shall be entitled to trial within a reasonable time or to release pending trial. Release may be conditioned by guarantees to appear for trial.

4. Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.

5. Everyone who has been the victim of arrest or detention in contravention of the provisions of this Article shall have an enforceable right to compensation."

[43] The clear aim of Article 5 of the Convention is to ensure that no one should be deprived of their right to liberty and security of person in an arbitrary fashion. This is a core right of fundamental importance in a democratic society hence the need to carefully consider its application. Article 5 is not concerned with mere restrictions on liberty of movement, which are governed by Article 2 of Protocol No. 4. The difference between restrictions on movement serious enough to fall within the ambit

of a deprivation of liberty under Article 5(1) and mere restrictions of liberty which are subject only to Article 2 of Protocol No. 4 is one of degree or intensity, and not one of nature or substance.

[44] The case of *Cheshire West and Chester City Council v P* [2014] UKSC 19 explains the objective and subjective elements of Article 5 and is the "acid test" in our law. The objective element requires a person to be subject to continuous supervision and control and be not free to leave. The subjective element is valid consent. The decision in *Cheshire West* was in part based upon the judgment of the ECtHR in *Storck v Germany* (Application number 61603/00) delivered on 16 June 2005. This was predated by a decision of De Wilde, *Ooms and Versyp (Vagrancy) v Belgium (Applications 2832/66, 2835/66 and 2899/66)* [1970] 1 EHRR 373 and *Buzadji v Moldova (App No 23755/07*. In *Storck* the Court said that:

> "However, the notion of deprivation of liberty within the meaning of Article 5 (1) not only comprises the objective element of a person's confinement to a certain limited place for a not negligible period of time. A person can only be considered of being deprived of his or her liberty if, as an additional subjective element, he has not validly consented to the confinement in question."

[45] The consent argument was drawn in aid by counsel in *MM* however at paragraph 23 the Supreme Court states as follows:

> "The same formulation was repeated by the Grand Chamber in *Stanev v Bulgaria* (2012) 55 EHRR 22, para 117. Hence, in *Storck*, although there was a deprivation of liberty in respect of one period of detention in a psychiatric clinic, there was no such deprivation in respect of another, as the patient had consented to being there. But it is also clear from *Storck* that an initial consent can be withdrawn, for example, where the patient attempts to leave the hospital. And it is clear from later decisions, such as *Buzadji v Moldova* (Application No 23755/07), Grand Chamber Judgment of 5 July 2016, that consent given in circumstances where the choice is between greater and lesser forms of deprivation of liberty - there between detention in prison and detention under house arrest - may be no real consent at all."

[46] The protection that Article 5(1) provides is absolute, subject only to the cases which fall within (a)-(f). In *Winterwerp v The Netherlands* [1979] 2 EHRR 387 the court determined that an individual cannot be deprived of his liberty as being of unsound mind unless the following three minimum criteria are satisfied:

(i) The individual must be reliably shown, by objective medical expertise, to be of unsound mind, unless emergency detention is required;

(ii) The individual's mental disorder must be of a kind to warrant compulsory confinement.

(iii) The validity of continued detention must depend upon the persistence of the disorder.

[47] The Guide to Article 5 provided by the ECtHR provides some further assistance in relation to these requirements and developments in the law which I set out in some detail as follows:

> "110. The term "a person of unsound mind" does not lend itself to precise definition since psychiatry is an evolving field, both medically and in social attitudes. However, it cannot be taken to permit the detention of someone simply because his or her views or behaviour deviate from established norms (Rakevich v. Russia, § 26). The term must be given an autonomous meaning, without the Court being bound by the interpretation of the same or similar terms in domestic legal orders (Petschulies v. Germany, 74-77). It is not a requirement that the person concerned suffered from a condition which would be such as to exclude or diminish his criminal responsibility under domestic criminal law when committing an offence (Ilnseher v. Germany [GC], § 149).
>
> 111. An individual cannot be deprived of his liberty as being of "unsound mind" unless the following three minimum conditions are satisfied (Ilnseher v. Germany [GC], § 127; Stanev v. Bulgaria [GC], § 145; D.D. v. Lithuania, § 156; Kallweit v. Germany, § 45; Shtukaturov v. Russia, § 114; Varbanov v. Bulgaria, § 45; and Winterwerp v. the Netherlands, § 39): the individual must be reliably shown, by objective medical expertise, to be of unsound mind, unless emergency detention is required; the individual's mental disorder must be of a kind to warrant compulsory confinement. The deprivation of liberty must be shown to have been necessary in the circumstances; the mental disorder, verified by objective medical evidence, must persist throughout the period of detention.
>
> 112. No deprivation of liberty of a person considered to be of unsound mind may be deemed in conformity with

Article 5 § 1 (e) of the Convention if it has been ordered without seeking the opinion of a medical expert (Ruiz Rivera v. Switzerland, § 59; S.R. v. the Netherlands (dec.), § 31). Where no other possibility exists, for instance because of a refusal of the person concerned to appear for an examination, at least a medical expert's assessment on the basis of the case file of the actual state of that person's mental health must be sought, failing which it cannot be maintained that the person has reliably been shown to be of unsound mind (Constancia v. the Netherlands (dec.), § 26, where the Court allowed other existing information to be thus substituted for a medical examination of the applicant's mental state).

113. As to the second of the above conditions, the detention of a mentally disordered person may be necessary not only where the person needs therapy, medication or other clinical treatment to cure or alleviate his condition, but also where the person needs control and supervision to prevent him, for example, causing harm to himself or other persons (Ilnseher v. Germany [GC], § 133; Hutchison Reid v. the United Kingdom, § 52). Article 5 § 1 (e) authorises the confinement of a mentally disordered person even where no medical treatment is envisaged, but such a measure must be duly justified by the seriousness of the person's state of health and the need to protect the person concerned or others (N. v. Romania, § 151).

114. A mental condition must be of a certain gravity in order to be considered as a "true" mental disorder (Glien v. Germany, § 85). To be qualified as a true mental disorder for the purposes of subparagraph (e) of Article 5 § 1, the mental disorder in question must be so serious as to necessitate treatment in an institution appropriate for mental health patients (Ilnseher v. Germany [GC], § 129 Petschulies v. Germany, § 76).

115. In deciding whether an individual should be detained as a person "of unsound mind", the national authorities are to be recognised as having a certain discretion since it is in the first place for the national authorities to evaluate the evidence adduced before them in a particular case (Ilnseher v. Germany [GC], § 128; Plesó v. Hungary, § 61; H.L. v. the United Kingdom, § 98).

and security European Court of Human Rights 26/60 Last update: 31.08.2020 The competent domestic authority must subject the expert advice before it to a strict scrutiny and reach its own decision on whether the person concerned suffered from a mental disorder (Ilnseher v. Germany [GC], § 132).

116. The relevant time at which a person must be reliably established to be of unsound mind, for the requirements of sub-paragraph (e) of Article 5 § 1, is the date of the adoption of the measure depriving that person of his liberty as a result of that condition (Ilnseher v. Germany [GC], § 134; O.H. v. Germany, § 78). However, changes, if any, to the mental condition of the detainee following the adoption if the detention order must be taken into account (Ilnseher v. Germany [GC], § 134). Medical expert reports relied on by the authorities must therefore be sufficiently recent (Kadusic v. Switzerland, §§ 44 and 55).

117. When the medical evidence points to recovery, the authorities may need some time to consider whether to terminate an applicant's confinement (Luberti v. Italy, § 28). However, the continuation of deprivation of liberty for purely administrative reasons is not justified (R.L. and M.- J.D. v. France, § 129).

118. The detention of persons of unsound mind must be effected in a hospital, clinic, or other appropriate institution authorised for the detention of such persons (L.B. v. Belgium, § 93; Ashingdane v. the United Kingdom, § 44; O.H. v. Germany, § 79).

119. By contrast, a person can be placed temporarily in an establishment not specifically designed for the detention of mental health patients before being transferred to the appropriate institution, provided that the waiting period is not excessively long (Pankiewicz v. Poland, §§ 44-45; Morsink v. the Netherlands, §§ 67-69; Brand v. the Netherlands, §§ 64-66).

120. In view of an intrinsic link between the lawfulness of a deprivation of liberty and its conditions of execution, the detention of a person of unsound mind on the basis of the original detention order can become lawful once that person is transferred from an institution unsuitable for

mental health patients to a suitable institution (Ilnseher v. Germany [GC], §§ 140-141).

121. The administration of suitable therapy has become a requirement of the wider concept of the "lawfulness" of the deprivation of liberty. Any detention of mentally ill persons must have a therapeutic purpose, aimed at curing or alleviating their mental-health condition, including, where appropriate, bringing about a reduction in or control over their dangerousness (Rooman v. Belgium [GC], § 208).

122. The deprivation of liberty under Article 5 § 1(e) thus has a dual function: on the one hand, the social function of protection, and on the other a therapeutic function that is related to the individual interest of the person of unsound mind in receiving an appropriate and individualised form of therapy or course of treatment. Appropriate and individualised treatment is an essential part of the notion of "appropriate institution" (Rooman v. Belgium [GC], § 210).

123. Article 5 § 1 (e) of the Convention also affords procedural safeguards related to the judicial decisions authorising a person's involuntary hospitalisation (M.S. v. Croatia (no. 2), § 114). The notion of "lawfulness" requires a fair and proper procedure offering the person concerned sufficient protection against arbitrary deprivation of liberty (V.K. v. Russia, § 33; X. v. Finland, § 148, concerning the lack of adequate safeguards in respect of the continuation of the applicant's involuntary confinement.

124. The proceedings leading to the involuntary placement of an individual in a psychiatric facility must thus provide effective guarantees against arbitrariness given the vulnerability of individuals suffering from mental disorders and the need to adduce very weighty reasons to justify any restriction of their rights (M.S. v. Croatia (no. 2), § 147).

125. It is essential that the person concerned should have access to a court and the opportunity to be heard either in person or, where necessary, through some form of representation. This implies Guide on Article 5 of the Convention – Right to liberty and security European

> Court of Human Rights 27/60 Last update: 31.08.2020 that an individual confined in a psychiatric institution should, unless there are special circumstances, receive legal assistance in the proceedings relating to the continuation, suspension or termination of his confinement (ibid., §§ 152 and 153; N. v. Romania, § 196). 126. The mere appointment of a lawyer, without that lawyer actually providing legal assistance in the proceedings, could not satisfy the requirements of necessary "legal assistance" for persons confined as being of "unsound mind". An effective legal representation of persons with disabilities requires an enhanced duty of supervision of their legal representatives by the competent domestic courts (M.S. v. Croatia (no. 2), § 154; see also V.K. v. Russia concerning a failure of a court-appointed lawyer to provide effective legal assistance and a manifest failure of the domestic courts to take that defect into consideration)."

[48] From the above it is clear that any deprivation of liberty must be premised on a person meeting the "unsound mind" requirement, it must be based upon evidence which should be scrutinised, there must be an identified purpose which can include protection as stated in *Ilnseher v Germany* and there must be proper safeguards.

[49] In this case the emphasis has obviously been upon Article 5 however Mr Simblet also references Article 8 which undoubtedly has an application to this case. He also raises Article 3 should the current *impasse* continue citing *Aerts v Belgium* (61/1997/845/1061) and *Rooman v Belgium* (application 18052/11).

[50] Finally, I mention The United Nations Convention on the Rights of Persons with Disability (CRPD) which whilst not incorporated is nonetheless an important instrument which provides a framework to address the rights of people with disability in relation to decision making. I do so recognising the tensions between this Convention and the law in this area. Article 14(1)(b) of CRPD is a non-discrimination provision and provides that the existence of a disability shall in no case justify a deprivation of liberty, the CRPD Committee's guidelines on the right to liberty and security of persons with disabilities reaffirm that liberty and security of the person is one of the most precious rights to which everyone is entitled and all persons with disabilities are entitled to liberty pursuant to Article 14. According to the Committee, it permits of no exceptions thus Article 14(1)(b) prohibits the deprivation of liberty on the basis of actual or perceived impairment even if additional factors or criteria are also used to justify the deprivation of liberty. Paragraph 9 of the Guidelines goes on to state:

> "Through all the reviews of state party reports, the Committee has established that it is contrary to Article 14 to allow for the detention of persons with disabilities

> based on the perceived danger of persons to themselves or to others. The involuntary detention of persons with disabilities based on risk or dangerousness, alleged need of care treatment or other reasons tied to impairment or health diagnosis is contrary to the right to liberty and amounts to arbitrary deprivation of liberty."

iv. The inherent jurisdiction

[51] Sir Jack Jacob's authoritative work on the inherent jurisdiction of the court 1970 23 CLP explains the historical development of the inherent jurisdiction and points out that it has proceeded along two paths, firstly, by way of punishment for contempt of court and, secondly, as a means of regulating the practice of the court and preventing abuse of its process. On the latter aspect Sir Jack said at page 27 that:

> "The essential character of a superior court of law necessarily involves that it should be invested with a power to maintain its authority and to prevent its process being obstructed and abused."

[52] Prior to statutory schemes the inherent jurisdiction was utilised as "the great safety net" in relation to medical treatment of mentally incapacitated adults flowing from the case of *Re F* (Mental Patient: Sterilisation) [1992] AC 1. Of course the Mental Capacity Act has replaced the inherent jurisdiction in respect of mentally incapacitated people but the inherent jurisdiction has survived in an attenuated form and continues to protect a group of vulnerable adults for certain reasons. The source of this development in the law is a forced marriage case of *Re SA* (Vulnerable Adult with Capacity: Marriage) [2006] 1 FLR which was approved by the Court of Appeal in *DL v A Local Authority* [2012] EWCA Civ 253. In *SA* Munby J did not define the categories but said that the issue of vulnerability should be (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.

[53] The use of the inherent jurisdiction has been discussed in two recent cases which have pushed the boundaries. In *FS v RS & JS* [2020] EWFC 63 which was described as an unusual case Sir James Munby rejected a claim by a man for maintenance against his parents. In doing so, he found that the application clearly contradicted the statutory scheme. In dismissing the claim under the inherent jurisdiction he said it was a "safety net and not a springboard". The court was clear that there was no power to award maintenance under the inherent jurisdiction, maintenance being a creature of statute and not the common law. Sir James discusses the jurisdiction regarding vulnerable adults which he developed in *SA* thus:

> "It is important at the outset to appreciate that, (1) precisely because they do not lack capacity, those subject to this branch of the inherent jurisdiction are fully autonomous adults; and (2) that, fundamentally, the jurisdiction exists to protect and to facilitate their exercise of that autonomy."

[54] Sir James also refers to the decision of Macur J in *LBL v RYJ and VJ* [2010] EWHC 2665 (COP), [2011] 1 FLR 1279, para 62:

> "I do not doubt the availability of the inherent jurisdiction 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 ... However, I reject what appears to have been the initial contention of this local authority that the inherent jurisdiction of the court may be used in the case of a capacitous adult to impose a decision upon him/her whether as to welfare or finance ... 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."

[55] Ultimately, in *FS* the court decided against the claim as it was far outside the accepted parameters of the inherent jurisdiction used to protect the autonomy of adults who while having capacity are vulnerable (see paragraphs 114-122). Also he said that the inherent jurisdiction could not be used to compel an unwilling third party to provide maintenance (paragraphs 123-130). Finally, Sir James said that the inherent jurisdiction cannot be used to reverse an outcome under a statutory scheme which deals with the actual issue (paragraph 132-138.)

[56] *Re T (A Child) (Secure Accommodation Order)* [2018] EWCA Civ 2136 is another case which has just been argued before the Supreme Court. This case concerns the exercise of the inherent jurisdiction to authorise a restriction of liberty for a child when no secure accommodation placements are available. The young person consented however the Court of Appeal determined that there was no requirement for a lack of valid consent. At paragraphs 23-40 Sir Andrew McFarlane deals with the consent issue in the context of Article 5 and there he examines the authorities post *MM*. In relation to the use of the inherent jurisdiction Sir Andrew records at paragraph 6:

> "In the present appeal, no party takes issue with the use of the inherent jurisdiction to meet the needs of the group

> of vulnerable young people, who would otherwise be the subject of a CA 1989, s25 secure accommodation order, but who fall outside the statutory scheme solely as a result of the lack of available approved secure children's homes. Indeed, as a primary justification for the continued use of the inherent jurisdiction with respect to children in modern times is to provide protection for young people when their welfare demands it, it would be difficult to argue against the assumption of jurisdiction in such cases. The issue in the present appeal, therefore, relates to the manner in which that jurisdiction is to be exercised and, in particular, the approach to be taken as a matter of law and in relation to the exercise of the court's discretion when, as here, the young person is *Gillick* competent and consents to the proposed care regime, notwithstanding that it significantly restricts her liberty that would otherwise require authorisation by a CA 1989, s25 order if the placement was in a unit registered as secure children's home."

[57] At paragraphs 78-82 of *RE T* the court sets out the purpose of an order authorising the placement of a child in the equivalent of secure accommodation namely to accord with Parliamentary intention that only a court can authorise such a placement and he explained that the authorisation means that the requirements of Article 5 will have been fulfilled.

[58] In Northern Ireland orders have been granted authorising deprivation of liberty under the court's inherent jurisdiction pending the enactment of the Mental Capacity Act. For instance, I have utilised this jurisdiction in the case of *Re NS* [2016] NI Fam 9; see also *Belfast Health and Social Care Trust in PT and the Official Solicitor to the Court of Judicature (Northern Ireland)* [2017] NI Fam 1. In these cases the court mirrored the procedural safeguards which are part of the mental capacity regime. Of course, in these cases the persons before the court was deemed not to have capacity and therefore it was a natural step for the court to step in and make decisions for the person. In *X v the Official Solicitor* [2019] NI Fam 9, O'Hara J heard competing arguments about the use of the inherent jurisdiction and decided that he would have utilised it notwithstanding the provisions of the Mental Health Order in relation to guardianship.

[59] The Trust relies on the case of *Hertfordshire County Council v AB* [2018] EWHC 3103 Fam. The patient in this case AB was a 28 year old man who was subject to a restriction order under the Mental Health Act 1983 following convictions for two counts of rape and one count of sexual assault of a child. AB's IQ was assessed at 71 which amounted to a mild learning disability. He was conditionally discharged from hospital in June 2016 by the First Tier Tribunal which included a requirement to comply with his care and risk management plan. AB had the capacity to

understand and consent to his care support and accommodation arrangements and was duly discharged. It is noted in the judgment that his compliance with the care and treatment plan was good. However, it is also apparent that the care plan for this person involved supervision at all times across a 24 hour period including when he was visited by his family. These were uncontroversial conditions as far as AB was concerned. However, the question was whether or not this amounted to a deprivation of liberty and therefore whether it could be authorised within the mental health law structure. The judge was satisfied that AB was a vulnerable adult even though he did not, she felt, fall into any of the three established categories. She therefore recognised this was an extension of the inherent jurisdiction and she thought that this would solve a situation where there was a legislative void but that it may come to pass that it was short lived. Ultimately, the court was persuaded to grant an order under the inherent jurisdiction authorising the deprivation of liberty which arose from the terms of AB's community care plan to run alongside the conditional discharge.

[60] The use of the inherent jurisdiction also arose in *Wakefield Metropolitan District Council, v DN and MN* [2019] EWHC 2306 Fam a decision of Cobb J. This case involved DN who was 25 years old, he had a severe form of autistic spectrum disorder together with a general anxiety disorder and traits of emotionally unstable personality disorder. That said it is clear that this person was not significantly intellectually impaired and was capable of clear thinking. He was treated in the past under the Mental Health Act and was in receipt of aftercare support under Section 117 of the Mental Health Act. In April 2019 DN was sentenced in the Magistrates' Court in respect of a range of public order offences and received a community order with a two year mental health treatment requirement under Section 207 of the Criminal Justice Act 2003. As a result of this he was bailed to supported living accommodation and the issue arose in relation to that. As the judge observed, a community order imposed by the criminal courts is to have power only to restrict and not to deprive a person of their liberty. However, the conditions of the regime in the supported accommodation appeared to deprive DN of his liberty pursuant to Article 5 of the ECHR hence the applicants who were the Health Authority issued an applicable to the High Court seeking the court's approval under the inherent jurisdiction for ensuring DN's need for care was delivered under a lawful framework and authorisation of the deprivation of liberty. In this judgment Cobb J explains why he disagrees with the *AB* decision where she authorised the deprivation of liberty of a vulnerable adult under the inherent jurisdiction but that cases ultimately may turn on their own facts.

[61] I was also referred to a number of decisions from the bail context as follows. In *Re Corry* [2013] UKSC 76 a decision of the Supreme Court. This case related to a bail decision which was made by the High Court following a judicial review but pending consideration of the release by the relevant statutory body, the commissioners. It was held that although the High Court in Northern Ireland had an inherent jurisdiction to ensure effective enforcement of its decisions, even in matters regulated by statute, it was precluded from exercising that jurisdiction

where to do so would run counter to the purpose or spirit of the legislation; that where the decision in question was a finding of unfairness in a review of the need for a life sentence prisoners continued detention, in breach of the prisoners' rights under Article 5(4) of the Convention, a full remedy lay in an order for a fresh review, making recourse to the inherent jurisdiction unnecessary and inapt; that, moreover, the use of the inherent jurisdiction in such circumstances to grant bail to the prisoner pending the rehearing ran directly counter to legislation, in that Article 6(4)(b) of the Life Sentences (Northern Ireland) Order 2001 provided that such a prisoner was to be released only when detention was no longer necessary for the protection of the public and paragraph 1 of Schedule 4 to the Criminal Justice (Northern Ireland) Order 2008 which provided that any decision to that effect was to be made by the specialist practitioner specified therein; and that, accordingly, the finding of a breach of the applicant's Article 5(4) rights during the review had not been ground for his release on bail.

[62] The second case referred to me in this context is a decision of McCloskey J in *Juana Chaos v Spain* [2010] NIQB 68. This was in the context of extradition and the exercise of the inherent jurisdiction in relation to bail. In that case the judge determined that there was no inherent jurisdiction for the High Court to revoke bail. There were three factors militating against the High Court having inherent jurisdiction. First, there was no authority for the proposition that the powers of revoking bail could be exercised by a court other than that which had granted bail, second, the historic statutory intervention in the sphere of bail in extradition proceedings clearly weakened any suggestion that the High Court possessed any residual inherent jurisdiction. Third, since Article 5 of the European Convention required that any procedure of law which deprived someone of their liberty was accessible and foreseeable any inherent jurisdiction would manifestly lack these essential qualities per *Winterwerp v Netherlands* [1979] 2 EHRR.

[63] I note a recent decision of the Court of Appeal of Baker LJ in *Mahzar v Birmingham Trust* [2020] EWCA Civ 1377 which raised the question of whether the inherent jurisdiction can be utilised to deprive a vulnerable adult of their liberty. Baker LJ said that:

> "This question has never arisen for consideration before this Court. There are a number of decisions at first instance in which it has been held that the jurisdiction can be exercised to deprive a vulnerable adult of their liberty, provided the exercise of the jurisdiction is compatible with Article 5 of ECHR: *Re PS (Incapacitated or Vulnerable Adult)* [2007] EWHC 623 (Fam), [2007] 2 FLR 1083, (Munby J), *An NHS Trust v Dr A* [2013] EWHC 2422 (Fam), [2014] Fam 161, (Baker J), *Guys and St Thomas' NHS Foundation Trust, South London and Maudsley NHS Foundation Trust v R* [2020] EWCOP 4, [2020] 4 WLR 96, (Hayden J), and see also my summary of the law when

> refusing permission to appeal in *A Local Authority v BF* [2018] EWCA Civ 2962, [2019] COPLR 150. On the other hand, Cobb J in *Wakefield MDC v DN* [2019] EWHC 2306 (Fam), [2019] COPLR 525, reached a contrary conclusion, relying in part on the observation of McFarlane LJ in *DL* (at paragraph 67) that the inherent jurisdiction should be used for "facilitative rather than dictatorial" reasons."

The Court of Appeal did not need to answer the question however it raised the divergence of views and complexity of the issue.

[64] Of course I recognise that any development of the inherent jurisdiction must be approached with extreme caution for obvious reasons explained in cases such as *Spencer v Anderson* [2018] EWCA Civ 100. The court must be mindful of the principle of legality, the need for certainty in law and the potential wider consequences. It is not enough to think that a remedy would be desirable.

The Arguments

[65] After significant reticence as to viability of this application, the Trust's legal arguments filed by Mr Potter presented a more definitive case in favour of declaratory relief. In relation to Mr O he pointed out that in its decision of 20 June 2020 the Tribunal found that the patient's detention in hospital pursuant to Article 77(1) of the Mental Health Order was that he should remain liable to recall pursuant to Article 78(1)(b). He stated that where a Tribunal decides the Article 77(1) question as here there are two options, namely conditional discharge and absolute discharge. A conditional discharge can be deferred, an absolute discharge cannot. Following from the *MM* case the Tribunal could not make the conditional discharge it wanted as it could not impose conditions which amounted to a deprivation of liberty so the case was adjourned. I pause to observe that the Tribunal had the benefit of legal submissions in relation to this and were directed along this line.

[66] As Mr Potter said that means that Mr O remains in Muckamore and has not been discharged to the community placement recommended for him. There is now an issue raised by the Department of Justice about proximity to children at the suggested accommodation, however that appears to be a practical rather than a substantive issue about the principle of moving to the community. The evidence is clear that a community placement is preferred with protections which amount to a deprivation of liberty. That is in the context of both protection to the public and protection to Mr O. As Mr Potter says in his argument, there were judicial review proceedings brought in mid-June which were against the Trust for failing to bring an application for a declaratory order and failure to comply with directions. However, the Trust maintained these proceedings were premature prior to the 20 June 2020 decision regarding detention. Mr Potter points out both the Department of Justice

and Mr O criticised the Trust for failing to act. It is paradoxical that having done so both parties now say that the court should not make such a declaration.

[67] Mr Potter explained that in Mr R's case the situation is somewhat different as he has been granted a leave of absence for some 18 months and subject to one recall has lived in the community placement with his liberty deprived. That case went to the Tribunal pursuant to a Secretary of State review in accordance with the provisions of the Mental Health Order. Mr Potter made similar submissions about the legal issues in this case as the Tribunal adjourned proceedings as it felt it could not make a conditional discharge which amounted to a deprivation of liberty. Of course in both Mr Potter highlights the fact that both persons have capacity.

[68] I convened a review on 7 September after hearing the case on 26 June by way of legal submissions because I wanted to raise a number of points myself. That led to revised submissions from Mr Potter. In respect of the issues raised, firstly as regards capacity the Trust lodged a further report and care plans but also reiterated that in Dr Milliken's opinion capacity was established in relation to both patients to make decisions and that specific capacity reports would take some time. Mr Potter reiterated his view that leave of absence is not an option in either case because the Tribunal found the statutory criteria for detention does not apply, i.e. neither patient is "liable to be detained in a hospital" for the purposes of Article 15.

[69] Mr Potter maintained that the High Court inherent jurisdiction is the only option to "plug the gap." In answer to my questions regarding the equivalent Section 117 provision the Trust refer to Article 112 of the After Care Provision read in conjunction with the Health and Personal Social Services Order (Northern Ireland) 1972 and the Health and Social Care Reform Act (Northern Ireland) 2009. As regards legislative reform, Mr Potter points out that the Mental Capacity Act is not yet fully in force but Sections 167, 192, 232 and 235 provide recall provisions when public protection orders are in place (these will replace hospital orders).

[70] Both representatives for the patients argued that the court did not have jurisdiction to make a declaratory order for a person with capacity. Both argued that the leave of absence provisions were also unlawful once the tribunal has established that the conditions for detention are not met pursuant to Article 15. Mr Lavery also raised a quality of law point *viz a viz* the exercise of the inherent jurisdiction and he relied on *Re Corry's Application* and the *Chaos* case in a bail context to highlight the jurisdictional impediments. Mr Heraghty also raised *habeas corpus* as a route being considered by Mr O.

[71] Mr Sands on the part of the Department of Justice referred me to the guidance in England and Wales and said leave of absence was the answer here. In response to my queries the Department of Justice said that there were 39 conditional discharges made in Northern Ireland from 2003 to the present. Mr Sands could not materially assist me regarding the numbers or current practice in England and Wales. In his

supplementary submissions, Mr Sands confirmed that the Mental Capacity Act has not been fully commenced. The provisions under Part II in Schedule 1 of the Mental Capacity Act relating to deprivation of liberty were commenced on 2 December 2019.

[72] Upon my seeking some clarification, Mr Sands referred me to Regulation 46. The wording of this is not easy to comprehend but Mr Sands' interpretation is at paragraph 6 of his revised submissions as follows:

> "Regulation 46 could be interpreted to mean that the DOL provisions in the 2016 Act cannot be used in respect of all patients, i.e. anyone who may be deprived of their liberty under the 1986 Order. Alternatively, and more probably, it may refer only to the narrower cohort of cases of patients who are detained in hospital, leaving open the possibility that incapacitous patients who are conditionally discharged (and who could not be deprived of their liberty by the review tribunal as a result of *MM*) could be deprived of their liberty under the newly commenced 2016 Act."

[73] This issue was raised by me as I had read and provided to the parties the decision of Lieven J in *Birmingham City Council v SR* [2019] EWCOP 28 a decision relating to two restricted patients in which the care plans proposed by the local authorities amounted to a deprivation of liberty. Mr Sands stressed that the court was prepared to consider the protection of the public as a ground for the exercise of the inherent jurisdiction on the basis that it was inter-related with the patient's own interests and obviously important in the context of the hospital order. In *SR* the judge decided that it was in the patient's best interest not to commit a further offence or place himself at risk of recall. So the judge considered that the Mental Health Act was complemented by the Mental Capacity Act and that permitted her to authorise the deprivation of liberty of a conditionally discharged patient. This case, as Mr Sands says, deals with incapacitous patients and so the issue remains regarding capacitous patients in the same position.

[74] Now the Department of Health have intervened I have some further information on the basis of the legal argument also filed by Mr Sands on its behalf. In the argument the Department of Health explain that Article 15 is designed as a step down from detention in hospital but not as an alternative to detention. The Department also explains the 2019 transitional arrangements contained within the Mental Capacity (Deprivation of Liberty) (No2) Regulations 2019. At paragraph 8 and 9 the argument reads that:

> "The purpose of the transitional arrangements is to ensure that only one regime for the deprivation of liberty will apply in any given circumstance. Where, a patient is

> deprived of his liberty under the 1986 Order, then the 2016 Order may not be used for that purpose. In the circumstances of the present cases, if the patients were to be conditionally discharged by the Review Tribunal, it would no longer be possible to authorise the deprivation of their liberty under the 1986 Order. Accordingly, it would then by possible to authorise a deprivation of liberty under the 2016 Act provided the necessary criteria were met. Also the Department states that if the patient lacked capacity, then a Trust panel may authorise a detention of liberty following conditional discharge. It would be possible for the Review Tribunal to defer any direction for conditional discharge under art 78(7) of the 1986 Order until such an authorisation was put in place by the Trust as a necessary arrangement. Drawing on *Birmingham City Council v SR* [2019] EWCOP 28, the Department asserts that there is "no inconsistency between these two orders."

[75] Paragraph 24 of the Department's argument states that those responsible for drafting the mental capacity bill which became the 2016 act were of the view that where serious public protection issues arose as a direct result of a person's severe mental impairment then it was likely that such a person would lack capacity as the severe mental impairment would impact on their ability to make a decision for the purposes of section 4 of the 2016 Act. The Department therefore raises an independent assessment. In terms of future legalisation the Department states that no date has yet been fixed for the commencement of the remainder of the 2016 Act. A considerable amount of preparatory work remains to be done. The commencement of Part 10, Criminal Justice will not in any event alter the core issue in this case; namely it will not provide authority for the deprivation of liberty in the community of a person with capacity."

[76] In the submission from the Human Rights Commission it is contended that the fundamental basis of the argument is flawed and requires the court to over reach the limits of its authority under the inherent jurisdiction. The argument invokes various provisions of the Convention but ultimately concludes that the plaintiff's solution is, on analysis no real solution. Whilst recognising that the *MM* decision does not leave the court with an easy task this argument suggests that the court may want to consider the extent to which the plaintiff's responsibilities include putting services in place that would enable it to protect the patient and facilitate release. The argument concludes that "to grant the plaintiff's proposed order would wrongly look back to detention rather than forward into how the discharge is to be put into effect." The Commission also stated that the Secretary of State's solution of temporary leave is no solution since the Tribunal has determined that the basis of discharge has been established.

[77] The Official Solicitor in her argument submitted that the essential function of the court is to determine capacity and were the court to determine that one or other lacked capacity this application would be redundant. The Official Solicitor points to the presumption in favour of capacity however she references the issues in relation to each patient. The Official Solicitor raised a query about Mr O in particular given the recent report which opines that he lacks litigation capacity. The Official Solicitor therefore invited the court to consider an independent assessment, or hear evidence. She points out that whilst exploring capacity interim declarations can be made pursuant to authority particularly *Redcar & Cleveland BC v PR & Others* [2019] EWHC 2305.

[78] Should the case remain that the patients have capacity, the Official Solicitor states that the role of the High Court narrows. The argument states that:

> "It is difficult to rationalise the judgement of Knowles J in Hertfordshire CC v AB with the overarching principle that any deprivation of liberty placement, regardless of the adult involved, must fall within one of the narrow list of exceptions encompassed in Article 5 ECHR Wakefield MDC v DN pars 48-50. Whilst the vulnerable adult category of adults may be able to seek and obtain a wide range of relief in circumstances where this is in their best interests, it is difficult to see how a deprivation of their liberty can ever be lawfully authorised in the absence of lack of capacity or the establishment of unsound mind."

[79] The Attorney General refers to McBride J's dicta in *Belfast HSC Trust v PT* [2017] NIFam 1 to the effect that (a) the inherent jurisdiction can be invoked in respect of adults who lack capacity, or vulnerable adults flowing from *RE SA* [2015] EWHC 2902 (b) the jurisdiction can only be exercised where gaps exist in the legislation (c) the test governing the operation of the inherent jurisdiction is best interests and (d) the inherent jurisdiction must be exercised in accordance with law and in a manner compatible with the ECHR. At paragraph 12 of the argument the Attorney states that the applicable question of law is a consideration of whether there is lawful justification for what would otherwise be false imprisonment. The Attorney also highlights a potential conflation of the power to declare and the power to authorise. Helpfully, the Attorney referred me to a recent case of Munby J, *FS v RS* and *JS* [2020] EWFC 63, in which he said that, fundamentally, the jurisdiction exists to protect and to facilitate this exercise of that autonomy. On the suggestion of two other judges that the jurisdiction may extend further, Sir James Munby expresses doubt at paragraph 122. The Attorney has referred to this as a "trend of judicial caution."

[80] The Attorney General has also referred me to the law in relation to Article 5 and opined that the conditions in *Winterwerp* may be met in these cases. She also points out that flowing from the *Rooman* case the Trust must be able to verify

whether an individualised programme has been put in place, taking account of the specific details of the detainee's mental health with a view to preparing him or her for possible future reintegration into society." In terms of the way forward the Attorney in common with the Official Solicitor, suggests that the capacity assessments should be revisited as the starting point. Finally, the Attorney contends that various steps could be considered under the Mental Capacity Act. In a supplementary note the Attorney refers to the absence of consent as a *sine qua non* for deprivation of liberty and references the case of *In the matter of D (A Child)* [2019] UKSC 42. The Attorney suggests exploration of issues of consent initiated by the Trust rather than the Tribunal which would remove pressure.

[81] After all of this legal analysis the problem remains for this court to determine in the absence of legislative change what, if anything, the court can do. As counsel have said this places the court in an invidious position and also raises issues which are of considerable importance in relation to the Mental Health/Mental Capacity regime.

Consideration

[82] I have had the benefit of substantial argument but I have still found this a difficult case to resolve. That is because of the *MM* decision and the consequences which flow from it. It is also because unlike many of the other cases I have read, there is an objection to me exercising my jurisdiction in a way that might facilitate a conditional discharge at this time. I respect the arguments made in that regard and so I have taken some time to review the law.

[83] In *MM* the Supreme Court recognised that its decision could result in people staying detained in hospital longer. Against that, the decision reinforced the fact that community based detention, potentially for long periods can offend the Convention rights of disabled persons. Since the decision there has been no legislative change. However, these cases illustrate that on the ground issues continue to arise. The court is being asked to find a solution but as all parties recognise this is not a simple or straightforward matter. There are also a number of interests engaged including those of the care provider (the Trust), the patient who has Convention rights and the public interest given issues of public protection (represented by the Secretary of State).

[84] No one has suggested that the conditional discharge is defunct and to my mind that is right given the middle ground it serves. Clearly there are cases that fall between ongoing detention and absolute discharge. The purpose of conditional discharge is worth repeating as it is to enable the patient to make a safe transition from the more institutional setting of a hospital to a less institutional setting in the community. As Lord Bingham put it in *R(H) v Secretary of State for the Home Department* [2004] 2 AC 253:

> "The conditional discharge regime, properly used, is of great benefit to patients and the public and conducive to the Convention object of restricting the curtailment of personal liberty. … If there is any possibility of treating and supervising a patient in the community, the imposition of conditions permits that possibility to be explored and, it may be, tried."

[85] The question is whether Mr O and Mr R can avail of this option. The Trust has taken the initiative as the care provider and I do not fault it. Obviously the Trust has social care obligations and it also wants to act in a Convention compliant way and to avoid any liability. And, as Mr Potter has said, in reality both Mr O and Mr R need community assistance perhaps for different reasons. So, the issue of deprivation of liberty persists past discharge and is something that needs to be addressed. I do not accept that the Trust is trying to put a freeze on things, quite the opposite. The Secretary of State also has valid concerns about protection of the public which arises in Mr O's case in particular so again that must be considered. In that regard I do not lose sight of the fact that both Mr O and Mr R were made the subject of hospital orders for various offences and made the subject of restriction for public protection.

[86] In both cases the Tribunal has said that Mr O and Mr R should be conditionally discharged although no final order has been made as the cases were adjourned. The case of *R v Bournewood & a Mental Health NHS Trust* [1999] 1AC 458 highlighted the need for procedural safeguards in this area. In Northern Ireland the Review Tribunal performs this task. This is a specialist judicial body which is Article 5 compliant.

[87] Following from *MM* the Tribunal (and the Secretary of State) is restricted in terms of the conditions that can be applied to a conditional discharge. Whilst I have not heard argument on this I am assuming that the only conditions that can be imposed are broadly those regarding residence and support services. In any event, that is not the point as in this case a placement is sought which amounts to further deprivation of liberty for Mr O and Mr R. Both patients are said to consent but that is not valid in these circumstances. I have not heard any argument about the merits of restriction rather than deprivation of liberty. That means that these people are effectively stuck unless a solution can be found. The patients can challenge their detention as Mr O has done by way of *habeas corpus* and judicial review. Or they will simply have to wait for a change in the law. Another option is the use of temporary leave. An alternative route is the complementary use of mental capacity law/inherent jurisdiction to authorise a deprivation of liberty.

[88] It is a deeply unattractive proposition that patients stay in hospital longer than they have to and this raises obvious issues with Convention compliance. The option of temporary leave is much more palatable given that it allows a patient to live in the community. The only downside offered in argument to me in Mr O's case

is ongoing supervision and management by the Secretary of State. Whilst, counsel have raised issues with the legality of this option I am wary about any firm declaration to this effect given that this might prejudice Mr O and others enjoying this type of release.

[89] Another option is to utilise the mental capacity regime as a complement to the mental health regime. This was flagged by Lady Hale in *MM* and subsequently some judges have taken this course in cases which are uncontentious such as *SR and MC*. I am not aware that these decisions were appealed. So, it appears that a route is open to the person lacking capacity in England and Wales at present. I wanted to know whether this was also available in Northern Ireland and it was for that reason that I joined the commissioning department to proceedings. The submission made by the Department of Health states that it is open and that Regulation 46 is no bar. That is presumably on the same basis identified by Lieven J that a conditional discharge ends detention under the Mental Health Act and so there is no conflict between the two regimes. That is all fine for a person who lacks capacity. Here, in both cases, the person is said to have capacity. The Department of Health raises another issue about this namely that in cases of severe mental impairment, where a serious public protection issue arose then it was likely that such a person would lack capacity. I find that submission understandable however there cannot be any presumption as that would go against the grain of current mental capacity law which facilitates autonomous decision making by those with capacity. Whilst the vast majority of those with severe mental impairment may lack capacity each case has to be determined on its own facts upon objective medical evidence.

[90] In any event, the issue of capacity has troubled me in both cases. The Official Solicitor has raised similar concerns in her paper. Highlighting of this issue should not be taken as some attempt to manufacture an easier solution. It is simply a fact that there are question marks. That will have been obvious to the parties as I raised this at the outset of proceedings particularly as no evidence was called. Historic reports have been filed in relation to Mr O and Mr R by Dr Milliken. These state that both patients have capacity to decide on their living arrangements in the community. The most recent report of Dr Milliken of 14 October 2020 reiterates this in the case of Mr O however that report states that he does not have litigation capacity. Hence, Mr Heraghty told me that Mr O has brought the *habeas corpus* application by way of a next friend. There is no up to date report in relation to Mr R. I also note correspondence from the Department of Health directing an independent capacity assessment in both cases. Notwithstanding this evidential gap, I will deal with the other issues given the arguments that have been raised in an effort to provide some guide to the parties going forward.

[91] The use of the inherent jurisdiction has survived the mental capacity legislation and clearly it has been used to deprive capacitous persons of their liberty in other situations. This is in accordance with the protective nature of the jurisdiction balancing paternalism with autonomy. I share the reservations of other judges about applying the jurisdiction to persons with capacity and so I am very

cautious about this. However, I also have an obligation to act in a Convention compliant way.

[92] These cases do not neatly fit into the brackets set out in *SA* and *DL* because the will of the persons is not overborne by external factors. However, such persons are likely to have a mental health diagnosis, in these cases severe mental impairment. They are also stuck as any consent is not valid given the decision in *MM* applying the case of *Buzjadi*. If the Department of Health states that the mental capacity legislation can be utilised in Northern Ireland in relation to an incapacitous person seeking conditional discharge the capacitous person in the same situation is left at a disadvantage. There is an obvious consequence to this which engages Article 14 of the Convention allied with Article 8 and 5. In my view this could justify an argument that the inherent jurisdiction can be utilised to protect a class of vulnerable persons who are clearly at the margins and may otherwise be discriminated against. In such circumstances, which are bound to be rare, there is no reason in principle why the capacitous restricted patient should not come within the court's jurisdiction for consideration.

[93] I agree that this is not a perfect solution given the interaction required between two courts however this is not insurmountable in my view. I would prefer to try to assist the Review Tribunal as a superior court in what is likely to be a very small number of cases in this jurisdiction if this issue arises. Such a step would be facilitative and it accords with the courts obligation to act in a Convention compliant way. I do not think that the *AB* case developed the argument and so it is not an authority upon which I specifically rely. I venture that the main complaint in relation to that judgment relates to public protection although the Secretary of State offered no arguments in that case. The *DN* case highlights the caution required but it was also different type of case where the patient was neither vulnerable nor of unsound mind in the eyes of the court. Each case is obviously fact specific.

[94] I reflect that this case is unlike other cases I have read where the statutory scheme prohibits a certain outcome. There is no specific statutory provision for those with capacity but that is unsurprising because of the subjective element of Article 5. Perhaps there is more difficulty in cases where protection of the public is the only aim, that remains to be seen, and will depend on the facts of each case. In terms of jurisdiction, this court would not actually be discharging the patient. That power rests solely with the Tribunal. So, these cases differ from the bail cases I have been referred to. The proposed deprivation of liberty authorisations are prospective to ensure compliance with a fundamental right and avoid any liability. This is unlike the other situations referred to in the jurisprudence where intervention is specifically governed by statute.

[95] In my view the real question is whether such an outcome can satisfy the requirements of Article 5 of the Convention both in terms of detention and the procedural safeguards that can be put in place pending legislative change.

[96] In dealing with this question it quickly becomes apparent that the two cases before me are different. I am told that Mr O does not want to engage in another assessment, however I would at the very least need to hear evidence as to how he might meet the test of unsound mind and the *Winterwerp* criteria before any application could get off the ground. During the submissions Mr Heraghty raised the fact that the conditions now being imposed on Mr O as part of the care plan approved by the Tribunal were arguably as strict as in the hospital setting. This is the point at the core of the Human Rights Commission submission which needs to be grappled with. In that vein, Mr O now brings a *habeas corpus* challenge against the Trust. The case of *Kolanis v UK* 2006 42 EHRR 12 deals with the law in this area. Also, Mr O's proposed placement is not agreed and settled despite having been raised before the Tribunal as an issue. I am loath to step into factual arguments which were heard before the Tribunal. These matters may also have been raised in the judicial review which I am told is concluded. This leads me to wonder whether there should be a sequence to the various legal cases or whether all of these matters should be heard together. I will hear from counsel as to how they want me to take this case forward given the issues I have raised. I should say that notwithstanding Mr Potter's urgings, I do not think that an interim order is appropriate given the substantial issues that remain unresolved in this case.

[97] In Mr R's case there are clearer lines. In the first place he may well benefit from a comprehensive capacity assessment as his lawyers now recognise in their latest submissions. In any event, Mr R has the benefit of temporary leave and as I have said I do not want to upset his arrangements. His is a case where there are long term issues which do not appear contentious. It seems to me that this is probably a case where the principles in *Ilnseher v Germany* also apply. Drawing on the Attorney General's argument, there may be a point in Mr R's case about the efficacy of his consent given that he has been on temporary leave for some time. I will adjourn this case to allow Mr R's lawyers to consider the next step in liaison with the Trust and any other party who may assist.

[98] In concluding this judgment I raise two further issues. The first is one of practice. I have simply been provided with papers from the Tribunal. Applications of this nature are distinct and must be accompanied by proper grounding reports dealing with all of the issues but particularly how exactly the Article 5 tests are met, specifically the Article 5(1)(e) requirements and the procedural safeguards required by Article 5(4) and the aim of any deprivation of liberty. Also, this case highlights the fact that mental health law in Northern Ireland as elsewhere requires attention. There is a very clear need for legislative reform in this area which should be prioritised.

Conclusion

[99] Accordingly, as I require further evidence and consideration of the legal issues, I will adjourn both cases for the moment and I will hear from counsel as to any matters that arise. I appreciate that there is greater urgency in Mr O's case and

so I expect his lawyers to suggest a way forward as soon as possible. Mr R's case can take more time. I encourage all parties to discuss this case further and I am committed to assisting as best I can. There is liberty to apply.