Neutral Citation Number: [2023] EWCOP 12

Case No: 14053021

IN THE COURT OF PROTECTION

Manchester Civil and Family Justice Centre,
1 Bridge Street West,
MANCHESTER
M60 9DJ

Date: 18 April 2023

Before :

HIS HONOUR JUDGE BURROWS
(Sitting as a nominated Judge of the Court of Protection
and as a Judge of the High Court pursuant to s. 9(1) Senior Courts Act 1981)

- -

Between :

MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	**Applicant**
- and -	
JS	**Respondents**
(by her litigation friend, MS)	
-and-	
MANCHESTER CITY COUNCIL	

- -
- -

Helen Mulholland, K.C., and Aisling Campbell (instructed by **Hill Dickinson**) for the **Applicant**
Robert Darbyshire (instructed by **Weightmans**) for the **Local Authority**

Hearing dates: 21 and 24 February 2023 (with written submissions thereafter)

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APPROVED JUDGMENT

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

HIS HONOUR JUDGE BURROWS :

OUTLINE

1. This case is about a young woman of 17 who I will call Jane (or JS). I shall protect her identity by using this name and initials. I will only refer to JS's mother as "her mother" or MS. None of the public authorities need to have their identities hidden. I will, however, refer to any clinical staff to by their initials only.

2. Due to urgency of the case, MS acted for her daughter as litigation friend. However, I invited the Official Solicitor to become JS's litigation friend, something that had not occurred by the time this judgment was handed down.

3. This case is an unusual variation on a common theme. It concerns a young person with complex mental health needs that leave her in danger by her own hand as well as at the hands of others. Her presentation can be dramatic and disturbing. The various organs of the state whose duty it is to provide care and safety to JS are seemingly unable to do so. This is due to a combination of the challenges presented by her condition and behaviour, a lack of readily available resources and, as I will explain, a fundamental difficulty in understanding and applying the law.

4. I am grateful to Ms Helen Mulholland, K.C. (she 'took silk' after the relevant hearing, but before judgment was handed down) and Ms Aisling Campbell who provided me with both oral and written arguments which were succinct, sensitive and high quality. I am also particularly grateful for their comments and corrections of my original draft judgment.

5. Unfortunately, this judgment is longer than I had wanted. However, it is necessary for me to outline the facts in some detail. I also have to deal with an area of the law that is extremely complicated, in fact unduly so in view of the vulnerable circumstances of the

people to whom it applies and the need for it to be used by busy clinicians in their daily work. This is the issue of ineligibility under the Mental Capacity Act 2005 (MCA) and, in particular, Schedule 1A and Case E. Also, and consequently, I have to deal with issues concerning medical treatment under the Mental Health Act 1983 (MHA) and the issue of detention under that Act as well as the MCA.

JANE'S RECENT CIRCUMSTANCES

6. On 16 December 2022, Jane was admitted to a specialist child and adolescent psychiatric unit on the site of Prestwich Hospital in North Manchester, called Junction 17. The admission was for the assessment and treatment of her mental health condition. She has a diagnosis of autistic spectrum disorder (ASD), attention deficit hyperactivity disorder (ADHD), learning disability and an attachment disorder.

7. Jane was assessed as having capacity to consent to admission. Despite these diagnoses and their manifestations, which I will outline below, she became an "informal" patient under s. 131 MHA at the facility.

8. There were concerns that Jane would become institutionalised by her admission to Junction 17. Therefore, on 4 January 2023, she was discharged into the care of her mother. I make it clear at the outset, Jane's mother is a loving and caring parent. Her inability to keep her daughter safe is despite her love for her daughter, and she is not at fault.

9. The very next day Jane ran away from home and into traffic. She was detained by the police who were so concerned about her mental health they used their powers under s.136 MHA to detain her and take her to a place of safety.

10. That place of safety was the Accident and Emergency Department of the North Manchester General Hospital at Crumpsall. There, a Mental Health Act assessment was carried out by the Greater Manchester Assessment and Inreach Centre (GMAIC) which is responsible for conducting gatekeeping assessments for Tier 4 in-patient units. That is the Child and Adolescent Mental Health Services (CAMHS) highest tier. This can be in any mental health unit, but it is usual and preferable for people under 18 to be treated in a specialist CAMHS provision, such as Junction 17.

11. Despite Jane's presentation and her recent running away into a hazardous environment just a day after her discharge from Junction 17, GMAIC assessed her as not requiring admission. She was therefore discharged back into her mother's care, with a community-based care and treatment plan.

12. Two days later, on 7 January 2023, Jane was once again detained by the police using s.136 MHA. She had left home, and it seems took 96 paracetamol tablets as an act of self-harm or attempted suicide.

13. Jane was assessed by the out of hours psychiatry liaison team from Greater Manchester Mental Health NHS Foundation Trust (GMMH). She was detained under s. 2 of the MHA. She was admitted to North Manchester General Hospital and into an acute adult medical ward (J6). This caters for adults of both sexes and all ages, including geriatric patients, with a wide variety of medical conditions. It is not a psychiatric ward. It is not a ward designed to cater for people of Jane's age.

14. Once she had received successful treatment for the physical consequences of her overdose, Jane was considered **medically** (i.e., physically) fit for discharge on 10 January 2023. In the absence of any suitable provision elsewhere, Jane remained on the acute

adult general ward for a number of weeks. Her s. 2 detention expired on 5 February 2023. She remained there as an inpatient whilst efforts were made to find an appropriate place and package of care for her discharge. In the absence of a proper placement, it was hoped she could return home to her mother. It was agreed by all the professionals that ward J6 was inappropriate and was detrimental to Jane's health.

JANE'S CARE AND TREATMENT IN HOSPITAL

15. A flavour of Jane's care and treatment at J6 is given in the statements and notes I read. According to one statement, there were many incidents during the currency of her s. 2 detention where she absconded or attempted to abscond. She tried to self-harm on a number of occasions, including by the use of sharp objects, attempting to swallow batteries, and claiming to have swallowed screws. She tried to lock herself in a toilet in order to carry out these acts of self-harm.

16. In order to try to manage Jane, the Hospital put in place a "Care Plan of Restrictions" for her. I summarise those restrictions:

    (1) Jane is not to leave the ward.

    (2) She is to be subject to "1:1 supervision (with a minimum of 2:1 assessed as necessary and appropriate by the ward staff during periods of escalation)".

    (3) She is to be supervised when in the bathroom at all times by her care support worker and the bathroom door must not be locked.

    (4) Physical restraint and oral sedative medication **may** be used (as set out in the plan) if de-escalation techniques have been attempted but are unsuccessful.

(5) Jane's room is "reviewed" by the Nurse in charge at least twice daily on shift handover "to remove any risky objects that Jane could use to cause herself or others harm"

(6) Jane's cubicle may be subject to additional searches if necessary and proportionate if there is a risk that she may have retained items she could later use to harm herself.

17. The plan was reasonably detailed, but there is little purpose in me quoting it here extensively. How Jane presented and how that plan works/worked in practice is best demonstrated by some entries in the incident logs. On 26 January 2023:

> Incident details - Patient became aggressive when she was prevented from leaving the ward. The patient is on a section 2. While security was preventing the patient from leaving she punched one of the officers in the face and abdomen. When back on her bed she also kicked the officer in the upper thigh and groin area. The patient also was self-harming herself before being taken back to her bed by banging her head against the wall.

18. Later, on 26 January 2023, "patient escaped from room and tried to escape [from the hospital], security stopped the escape, but patient got pin off the fire extinguisher and proceeded to squirt foam over staff and ward".

19. On 30 January 2023 there was a similar incident to that on 26 January 2023.

20. There was a further incident on 3 February 2023 when Jane drew all over the walls of the ward with a red pen. Then:

> Held hand with pen in place and attempted to talk down behaviour - Unsuccessful as security grabbed limb and escalated restraint to quick and hard. As a result security restrained upper limbs - pen and lid was removed from persons however patient began to kick out at security - lower limbs left unrestrained and shouting over patient between security team witnessed. Managed to poorly restrain and dragged patient to the floor - RN had to support head to floor before potential harm caused. Poor uncontrolled restrain witnessed. Once on the floor, guards attempted to drag up to standing- stopped and allowed patient to get self-up off the floor aided. Once up taken to her room and a debrief conducted by SR over poor restraint witnessed.

21. On 5 February 2023, the Hospital's authority to detain Jane under s.2 of the MHA lapsed. She remained in Hospital, and subject to the same level of restrictions. She was not free to leave. The Management Care Plan in the Hospital reads (emphasis added):

> Section 2 finished 05/02/2023 awaiting DOLS to be applied via Courts, [Jane] is **currently being held by common law**.

22. It is important immediately to comment that it was anticipated on the expiry of MHA detention that the MCA would be used for exactly the same care plan, with exactly the same purpose namely to treat Jane's challenging and self-injurious behaviour, largely by physical containment and the use of restraint both by physical intervention and medication.

23. That medication was: Fluoxetine (which is an antidepressant) 20 mg; quetiapine (which is an anti-psychotic) 25 mg in the day, 50 mg at night; and melatonin (to aid sleep) 8 mg. It seems entirely obvious to me those treating Jane considered her behaviour to be a manifestation of her mental disorder. This pharmacological treatment was intended to combat it.

24. The final example I shall give was on 6 February 2023:

> …security guard and [member of staff] reported patient sitting on edge of bed and fell to floor. Patient had seizure, pressed the emergency bell. Observations updated. Seizure care given. Informed doctor (security guard and HCA not sure about if this is a fall). Patient seen by doctor, as per doctor's report, no reports of any symptoms of suggestive seizure. Around 3 o clock, the patient complained of pain and pain medication given. Patient tried to swallow disposable glass, took most of it out from mouth, when taking out patient bit my hand. Suspecting patient swallowed small part of disposable glass. Informed doctor and then after some time patient removed screw from wall and swallowed, that also informed doctor and registrar

THE APPLICATION TO THE COURT OF PROTECTION

25. From the date the s. 2 expired Jane was not subject to any lawful regime of detention. It is unarguably the case that during that period she was subject to a regime of detention in that she was under continuous supervision and control and was not free to leave the ward (see P v Cheshire West & Chester Council [2014] UKSC 19). It is further accepted that during that time she lacked the capacity to make decisions about her care and treatment because of her mental health conditions. She was therefore not able to consent to her residence, care, or treatment or to being deprived of her liberty. The hospital notes quoted suggest she could be detained under the "common law". It was quite properly conceded by Ms Mulholland and Ms Campbell that this was not a lawful justification.

26. I conclude that during the period after her MHA section expired and this Court authorising her care plan, Jane was unlawfully deprived of her liberty. The issue of just satisfaction must await the active involvement of the Official Solicitor.

27. On 10 February 2023, the Trust (i.e., the Hospital) made an application to the Court of Protection seeking the following declarations:

> ……[Jane] lacks the capacity to make decisions about her hospital admissions and care plan for restrictions and that it is in her best interests to remain at North Manchester General Hospital and to be subject to restrictions contained in the Care Plan dated 9 February 2023 and that any deprivation of liberty arising from those arrangements is lawful and in JS's best interests

28. Fortunately, Manchester City Council, who are responsible for Jane were involved in the hearing of that application before me. They worked very hard to try to ensure that Jane

could be discharged into a safe package of care at home. It is important to note that no Tier 4 provision was available to Jane. The Hospital was ill equipped environmentally and in terms of its lack of specialist CAMHS psychiatric expertise to care for Jane.

29. I was extremely concerned about my legal powers to authorise or approve the arrangements at J6. I was concerned that Jane ought to be detained under the MHA. For that reason, I required further submissions as to whether she was ineligible to be detained under the MCA. As a "belt and braces" approach I considered whether Jane ought to be subject to the High Court's inherent jurisdiction. I was therefore authorised to sit as a High Court Judge at the hearing that was ostensibly before the Court of Protection.

30. In view of the imminence of Jane's discharge into the community and the need to consider the legal arguments in detail, I authorised her continued detention at J6 under the MCA. I directed the submission of detailed argument on ineligibility from the Trust. The City Council had no argument it wished to put. Jane's mother who was effectively acting for her had nothing to add.

31. It was important that I dealt with these arguments not just out of academic curiosity but because sadly Jane is likely to be subject to similar circumstances again and it is important that some road map is available for clinicians, lawyers and the court.

32. I will add that by the time this judgment was handed down events had moved on. The circumstances are depressingly familiar. Jane was discharged on 27 February 2023 to her home with a package of care and support. On 2 March 2023 she attempted to harm herself. She was detained by the police under s. 136 MHA. The police must be frustrated and concerned about being seen as a form of psychiatric triage in the community. She

was admitted to the Emergency Department of the Manchester Royal Infirmary. She was placed on a general medical ward. She was detained yet again under s. 2 MHA. Section 2 of the MHA is intended to provide detention for a period not exceeding 28 days to enable professionals to assess and perhaps treat a mentally disordered patient. Section 3 is the longer treatment order.

33. Jane was once again examined by GMAIC and they assessed her as not being detainable under s. 3 MHA. The reason for this is because a Tier 4 admission would (they say) further increase Jane's "risk level" in the context of neurodevelopmental disorder rather than a treatable mental illness because of the increasing incidents of self-harm and verbal aggression.

34. Once again, and equally depressingly, it was intended she would be discharged (physically as well as legally) at the expiry of her s. 2.

35. Her mother emailed me desperate about the safety of her daughter. Apart from passing on her concerns to the increasingly large cast of public authorities involved in Jane's care, I was unable to provide her with any reassurance.

CAPACITY

36. I read the consultant responsible for Jane's mental health treatment in J6, Dr K's capacity assessment, his statement and considered his oral evidence.

37. There appeared to be little dispute that Jane lacks capacity to make the relevant decisions.

38. The following passage from Dr K's statement seemed to capture the essence of her incapacity (quoted verbatim):

> The current clinical view is that her main mental health conditions are ASD, ADHD and LD – moderate. These neurodevelopmental disorders affect her ability to manage emotional, psychological distress, manage daily stress and relationships, changes to the environment, limit her ability to adapt to changes. He rigid thinking prevents her from considering other options. She is not able to see other peoples perspectives. She isn't able to understand others emotional responses. She isn't able to understand complex information appraise it and adapt her response. These therefore manifest in agitation and self harm. She isn't able to identify triggers and cannot remember incidents of severe agitation. She is impulsive. All this makes her behaviour unpredictable. When she is in an agitated state she isn't able to think and consider the risks that her actions pose. She is not able to appraise her arousal and control herself and this therefore has required that restrictions are placed to maintain her safety in hospital. There have been minority of occasions when verbal de-escalation has been effective. When highly aroused she has needed physical restraint and medications to reduce agitation and maintain her safety. In the current hospital setting the restrictions have been needed to keep her safe as some of the triggers such as noise cannot be controlled.

39. In the context of all the other evidence, that seemed to me to explain why Jane lacks capacity to make decisions concerning her residence care and treatment. Applying the statutory test in ss 1, 2 and 3 of the MCA I was satisfied that the presumption of capacity was rebutted. She is unable to understand her mental health problems and she is unable to realise how challenging those conditions are, as well as how dangerous they are for herself. I am satisfied that is caused by her mental health condition, which includes ASD and the ADHD. It means that she is unable to make decisions concerning how she is to be cared for and treated, and in what setting.

BEST INTERESTS

40. I had to approach the issue of best interests in a practical way. There has, in recent years, been an epidemic of cases in which young people have been placed in environments intended to keep them safe, but which have been either woefully inadequate at doing so or, as here, have actively aggravated and worsened their circumstances.

41. I need to expand a little on that observation. In prefacing what I have to say I need to make one thing clear. Dr K and his team were called upon to deal with an extremely

difficult case when Jane was admitted to their hospital. She had been a patient in a specialist unit dealing with children and young people with serious psychiatric problems. She had been discharged the day before she took an overdose and was taken to NMGH by the police. Having been called upon to act as Jane's place of safety, the clinical and nursing staff had to make do with the skill, resources and environment they had. She was placed on a general, mixed-sex adult ward. She was placed under section. That was because of her challenging behaviour and presentation caused by her mental disorder.

42. Having heard the oral evidence of Dr K he was clear that he was not treating what is usually called the "core condition" because such treatment was simply not available, but he was treating the manifestations of that condition, namely the behaviour outlined above in the incidents I have summarised.

43. It was agreed between the parties that the only option to secure Jane's best interests was for her to be discharged from Hospital to her mother's care, once support services had been put in place. These included regular visits by professionals, appointments at Junction 17 and a return to college (with tutorial visits to her home pending her return). Mr Darbyshire, for the City Council who throughout the hearing was clearly engaged in communications with those instructing him (in a good way) was able to assure the court that the support would be in place "soon" and that there is likely to be in place at least the outline of a care plan by the following Friday.

44. It seems to me that the options available were clear. Jane could go home in a few days to the best care plan that was going to be made available to her. There was agreement that a transition plan as such was not needed. In fact, she needed to go home as soon as possible. However, it was agreed by all parties that the package had to be in place first. With that I agreed. In the meantime, it seemed to me that the existing care provision in hospital, sub-optimal though it undoubtedly was, was the only option at that time.

45. I therefore had no hesitation in deciding that it was in Jane's best interests to remain where she was subject to the present regime until that package was available. Restraint, be it physical or chemical must be the last resort not the first. In this case the regime of restraint had been used as a rough and ready patch over the suboptimality of the care provided. I declared it to be in Jane's best interests to remain only with very considerable hesitation.

46. That being said, her interests may well have been better served, and she would have been better protected, if she had been detained under the MHA. The whole mechanics of the MHA through s. 117 is to require the various services concerned with the patient, both inside and outside the Hospital to work together for a speedy and appropriate discharge. It also ensures funding for care afterwards. The Court of Protection has no powers to make MHA orders.

47. In short, the consensus was that Jane had to go home as soon as she could.

48. I decided to give judgment on the issue of ineligibility. I did not think it was an academic issue due to Jane's imminent discharge from hospital. I thought the issue was likely to arise again in her case in the not too distant future. Unfortunately, I was right. The issue has arisen before I was able to deliver this judgment having firstly considered further written submissions.

INELIGIBILITY

49. The issue of ineligibility is notoriously complex and difficult. Unjustifiably so, in my view. It reaches its synthesis in Schedule 1A of the MCA. The structure of the provision is far too complex bearing in mind it affects the life and liberty of vulnerable people like Jane. When reading the legislation in advance of the first hearing I looked at the provisions that are intended to replace Schedule 1A in the new schedule AA1 Part 7

paras 45 to 57 of the new regime (the "Liberty Protections Safeguards"). It was the cause of some disappointment that the language of the new provision almost entirely repeats that of the old.

50. I indicated to Ms Mulholland in argument that I was finding it difficult to see how the present care plan for Jane, which I was being invited to authorise under the MCA, was anything other than treatment for her mental disorder. Ms Mulholland quite properly responded that before I gave a judgment on this issue, she would like to make further submissions particularly on the question of the nature of the treatment given to Jane.

51. Since I had decided that it was overwhelmingly in Jane's best interests for her to remain where she was only for so long as she needed to before moving home, that period being a short one, I decided I would accept jurisdiction under the MCA in the interim. I would make a declaration that Jane lacked the relevant capacity. I would furthermore decide the issue of ineligibility at a later date.

52. However, I made it clear that the issue had to be determined because it is so important for clinicians and those providing care in any setting to understand the legal framework within which they operate. In particular, it is vital that NHS consultants, particularly psychiatrists, understand that the MCA and the MHA have to be used where but only where it is appropriate to do so. Furthermore, the inherent jurisdiction of the High Court is a "great safety net" that is used to bridge genuine gaps in the legislative framework, not something that should regularly be used as a matter of necessity (let alone convenience) where resources are inadequate to provide protection, or where professionals with a duty to choose the right framework, for whatever reason choose not to.

53. I will keep the statutory explanation to a minimum here. The background is that the MHA and the MCA are statutory codes to deal with the care and treatment of vulnerable people. The MHA is for those with mental disorders that necessitate its use, and those provisions apply mainly in Hospital, but also in the community. There are sections of the MHA that enable Hospitals to detain patients for medical treatment (ss 2, 3 and 37 being the principal ones). Others enable patients to be under some control in the community (ss 7 and 8 (guardianship), s17 (leave of absence), s17A-E (community treatment orders) and for restricted patients there are conditional discharges with the power of recall.

54. The MHA is mainly concerned with patients detained in Hospital, however. It is a comprehensive code that deals with the powers of admission and discharge, whether that be via the Responsible Clinician, the Hospital Managers or the specialist First-Tier Tribunal that gives judicial oversight, which is compliant with Article 5 of the European Convention.

55. The MCA is a statutory code with a much wider ambit. It applies, quite literally, to anyone over 16 lacking the capacity to make any decision. It concerns health and welfare, but also property and affairs. It is relevant to those receiving care or treatment outside Hospital, but also to those receiving care and treatment in a hospital for conditions that are not mental health conditions.

56. The Acts overlap. Where a person lacking mental capacity is subject to the MHA in the community, the MHA cannot authorise his deprivation of liberty or enforce treatment. That is where the powers of the MCA can come in. Equally, where a person is subject to an MHA section in a Hospital there are considerable restrictions on the extent to which the MCA can be used. That is for a very good reason. The MHA is purpose built for such a specialised cohort of people and deals with the particularly difficult decisions

that have to be made for them. These are all dealt with by s. 28, and schedule 1A paragraph (2) Cases A to D.

57. Jane is in none of those categories. However, she may fall into Case E of that Schedule. Since the main part of this provision is a table, I will include it in this judgment:

> Part 1
>
> INELIGIBLE PERSONS
>
> *Determining ineligibility*
>
> 2. A person ("P") is ineligible to be deprived of liberty by this Act ("ineligible") if—
>
> (b) P falls within one of the cases set out in the second column of the following table, and
>
> (b) the corresponding entry in the third column of the table—or the provision, or one of the provisions, referred to in that entry—provides that he is ineligible.

	Status of P	Determination of ineligibility
Case A	P is— (a) subject to the hospital treatment regime, and (b) detained in a hospital under that regime.	P is ineligible.
Case B	P is— (a) subject to the hospital treatment regime, but (b) not detained in a hospital under that regime.	See paragraphs 3 and 4.
Case C	P is subject to the community treatment regime.	See paragraphs 3 and 4.
Case D	P is subject to the guardianship regime.	See paragraphs 3 and 5.
Case E	P is— (a) within the scope of the Mental Health Act, but (b) not subject to any of the mental health regimes.	See paragraph 5.

58. For someone to be "*ineligible*" under Case E the relevant person:

> (a) has to be within the scope of the MHA 1983, and
>
> (b) paragraph 5 has to be satisfied. [i.e., the patient must object to some or all of the mental health treatment].

59. "Within the scope of the Mental Health Act" is defined by paragraph 12 of Schedule 1A as (my emphasis):

> "(1) P is within the scope of the Mental Health Act if-
>
> (b) an application in respect of P **could** be made under s.2 or s.3 of the Mental Health Act, and
>
> (b) P **could** be detained in a hospital in pursuance of such an application, were one made.

60. I shall consider only s. 3 of the MHA here. Jane had already been detained under s. 2, and it would seem unlikely if she were to be detained under the MHA so soon after discharge from that section that she would be placed under the same section again.

61. The process of admission for a patient under s. 3 of the MHA involves a number of actors under the statutory scheme.

62. Foremost among those are the Approved Mental Health Professionals (AMHPs). These are competent, trained and professionally independent persons appointed under the Mental Health (Approved Mental Health Professionals) (Approval) (England) Regulations 2008 (SI 2008/1206). Section 13 of the MHA describes the circumstances in which the Local Authority must make arrangements for an AMHP to make an assessment of a patient where they have reason to think that an application for admission to hospital needs to be made.

63. There are provisions under s. 12 of the MHA for medical recommendations for detention under s. 3. I will not go into these for reasons that will be clear shortly.

64. The crucial document in the "sectioning" process is the Application for Admission, this is defined and regulated by s. 6 of the MHA. That application is the culmination of the sectioning process. It comes after the recommendations under s. 12, and the consultation with the patient's nearest relative under s. 11(4), on the assumption the nearest relative does not object. The application for admission is properly made to the hospital managers and provides them with legal authority to detain the patient.

65. The AMHP has a very important role. It is his/her judgment, based upon the overall circumstances of the case, including the medical recommendations, the results of consultations with the patient and her nearest relative, but also an evaluation of risk and the availability of alternative care and treatment that determines whether the application is made. They are a critical MHA decision maker. It seems to me the wording of the MCA places the Court in a similar position to the AMHP when determining whether P "could" be detained.

66. The issue of whether an application "could" be made under s. 3 and whether the patient "could" be detained in a hospital for medical treatment are central to the determination of ineligibility. Also, for the purposes of this case is the meaning of medical treatment for the purposes of detention under s. 3.

67. To make the decision easier for the Court of Protection, or anyone else who has to decide, it is assumed for the purposes of Schedule 1A Para 1(12)(4) that the medical recommendations for admission under s. 3(2) of the MHA have been made. That means that:

> "An application for admission for treatment may be made in respect of a patient on the grounds that-
>
> (a) He is suffering from mental disorder of a nature or degree which makes it appropriate for him to medical treatment in a hospital, and
>
> (b)……..
>
> (c) it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section; and
>
> (d) appropriate medical treatment is available for him.
>
> (e) The term "medical treatment" is defined at s. 145 MHA as including "nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care".

68. This is subject to sub-s (4) which provides (emphasis added):

> Any reference in this Act to medical treatment, in relation to mental disorder, shall be construed as a reference to medical treatment the purpose of which is to alleviate, or prevent a worsening of, the disorder or **one or more of its symptoms of manifestations**.

69. It seems to me immediately clear that the care plan for Jane on the ward was for medical treatment in this broad sense. It consisted in care, namely providing her with a safe place with nursing care. The purpose of that care plan, including the use of restraint both physical and chemical was to ensure that Jane did not harm herself, or that she absconded away from the care setting in order to do so.

70. I appreciate that the treatment was not optimal and was not aimed at the "core disorder" from which she suffers. That is likely to be addressed only by psychological and other therapies over a long period of time.

71. However, in my judgment, in no meaningful sense could Jane's behaviours outlined above be described as anything other than manifestations of her mental disorder. Or

put another way, Jane's mental disorder causes her to abscond from safe environments, such as her home or hospital. It causes her to place herself at great risk of danger. It causes her to injure herself using sharp objects or taking overdoses. She has done this with alarming regularity. Nothing that those responsible for her care have been able to do has prevented her from doing so. However, that is what they were trying to do, and their treatment was aimed at that.

72. Before dealing with the issue of whether she "could" have been detained under s. 3 of the MHA, I will deal with the issue of whether she was objecting. Paragraph 5 provides:

> **P objects to being a mental health patient etc**
>
> (1)This paragraph applies in cases D and E in the table in paragraph 2.
>
> (2)P is ineligible if the following conditions are met.
>
> (3)The first condition is that the relevant instrument authorises P to be a mental health patient.
>
> (4)The second condition is that P objects—
>
> (a)to being a mental health patient, or
>
> (b)to being given some or all of the mental health treatment.
>
> (5)The third condition is that a donee or deputy has not made a valid decision to consent to each matter to which P objects.
>
> (6)In determining whether or not P objects to something, regard must be had to all the circumstances (so far as they are reasonably ascertainable), including the following—
>
> (a)P's behaviour;
>
> (b)P's wishes and feelings;
>
> (c)P's views, beliefs and values.
>
> (7)But regard is to be had to circumstances from the past only so far as it is still appropriate to have regard to them.

73. Was Jane objecting to her medical treatment? The answer is obvious, and the Trust concedes this. She was objecting. She was physically resisting her care plan. She was assaulting staff on the Ward when they tried to prevent her from leaving or harming

herself. She was trying to abscond from Hospital. Attempting to cause herself injury is also evidence that she objected to treatment.

74. I have been referred to BHCC v KD [2016] EWCOP B2, a detailed and careful judgment of HHJ Farquhar. An interesting point of construction arises out of that case. As we can see above, in order for a detained person (P) who is objecting to their treatment as a mental health patient, and therefore ineligible under Schedule 1A, "the relevant instrument" must authorise "P to be a mental health patient".

75. The meaning of "relevant instrument" is contained in paragraphs 13 and 14 of Schedule 1A. This provides that where the authorised course of action means the accommodation of the relevant person in the relevant hospital or care home for the purpose of being given the relevant care or treatment, the relevant instrument is either the standard authorisation (under Schedule A1) or the order made by the court under s. 16(2)(a).

76. In the BHCC case, HHJ Farquhar concluded that it was necessary for all the conditions in Paragraph 5 to be met. I agree. In this case the order I was asked to make under s.16(2)(a) would be the relevant instrument.

77. I must now deal with whether Jane could have been detained under the MHA. She had been detained under s. 2 of the MHA on two previous occasions. Those sections had lasted until they expired. No one had discharged her because the statutory criteria for the section no longer applied, whether that was the Responsible Clinician, the Hospital Managers or a First Tier Tribunal.

78. Could she have been detained under s. 3? It may be thought that if professionals such as those who had assessed her for Tier 4 admission, and the psychiatrist, Dr K thought she could not be detained under section that should be the end of the matter. Certainly,

it may be argued that the Court, a Judge without psychiatric, psychological or AMHP training could not answer that question differently.

79. In fact, the question is one **I** have to answer. It is clear from the statute and the approach taken by Mr Justice Hayden in Northamptonshire Healthcare NHS Foundation trust & Others v ML [2014] EWCOP 2.

80. This was the central issue in the case of GJ v The Foundation Trust, a PCT & Secretary of State for Health [2009] EWHC 2972 (Fam.) (Mr Justice Charles). The judgment is complex, as one would expect for such a complicated piece of legislation. However, having considered Charles, J's judgment once again, his message is clear and straightforward.

81. In paragraph [58] His Lordship emphasises the primacy of the MHA over MCA. This is clear from the wording of Schedule 1A of the MCA in making the assumption that no alternative to authorise treatment is available under the MCA. Of course, there may be an alternative available outside hospital, and that would be relevant to the MHA decision-maker when deciding whether the patient should be detained under the MHA in Hospital. Mr Justice Charles later recognised this in AM v South London & Maudsley NHS Foundation Trust & Secretary of State for Health [2013] UKUT 0365 (AAC).

82. However, the critical point in this case is there was no alternative to Hospital treatment at the point the Hospital sought an order from the Court of Protection. It was hoped Jane would be discharged under a community supported care plan. But that had to be in place in order for discharge to occur. Otherwise, Jane would be left in great danger.

83. So, the question I have to ask is whether at the point the Court of Protection was being asked to approve a care plan that would involve treatment for her mental disorder to

some of which she objects, and that would deprive Jane of her liberty could she have been detained under the MHA?

84. The judgment in GJ is also clear on this. Counsel in GJ gave the Court three competing definitions of "could" when considering whether P could be detained under the MHA and treated under that Act. First, "the possibility test", namely whether it was possible for an application for detention to be made. Secondly, that no reasonably competent psychiatrist could come to the view that P did not meet the criteria for detention. Finally, the "what the decision maker thinks test"- i.e. the decision-maker (the Court in this case).

85. At [79] Charles, J. says this:

> it is more likely that parliament intended that the decision-makers under the 2005 Act were to apply their own expertise to assess and decide whether those criteria or grounds are met in a given case……

86. He goes on at [80]:

> So, in my judgment the construction urged by the Secretary of State is the correct one, namely that the decision-maker should approach paragraph 12(1)(b) by asking himself whether in his view the criteria set by, or the grounds in, section 2 or section 3 of the 1983 Act are met (and if an application was made under them a hospital would detain P).

87. It is important to re-emphasise that the decision-making process must be predicated on there being no available alternative under the MCA. Of course, in GJ and some other cases, there were two "competing" conditions from which P suffered one of which was physical (diabetes and the consequences of failing to manage that condition) and a mental health condition (in GJ's case Korsakoff's syndrome). In that case, there was a significant issue as to whether GJ would be detained for his mental health condition were it not for his diabetes. Diabetes is not a manifestation of a mental disorder, and therefore treatment for it is not treatment for a mental disorder.

88. In this case, however, Jane suffers from mental disorders. There has been an occasion where she suffered a physical disorder as a result of the overdose. However, once the consequences of the overdose were successfully treated, the only reason for her to be in hospital was for the treatment of the mental disorder and its manifestations.

89. I reject any suggestions or submissions that Jane is not within the scope of the MHA. The submissions made on behalf of the Hospital on these issues, whilst firmly and eloquently expressed, I cannot accept.

90. Firstly, that she was accommodated at the Hospital as a place of safety because there was nowhere else for her to go and, once the physical damage caused by her overdose was successfully treated, she needed no in patient medical treatment. The answer to that is: of course, she did. She was a danger to herself. She needed to be nursed safely and medicated to address the effects of her mental disorder (viz. to injure herself and abscond away for safety).

91. It was submitted that although Jane suffers from a mental disorder it was not of a nature or degree to make it appropriate for her to receive medical treatment for that disorder in a hospital. This is clearly wrong. The medical treatment she did receive as a detained patient in hospital was necessary to keep her safe and to prevent her from absconding or harming herself. There was no readily available alternative when she was receiving it.

92. It is submitted that the outcome of the MHA Assessments was that inpatient care for Jane's condition was neither available nor desirable because she could be treated in the community under the MCA. This too is plainly wrong. She could only be treated in the community once a suitable package of care was available for her. Until then she could not safely leave hospital. That was the situation with which I was confronted at the first hearing. At that point hospital was the only option.

93. This is quite a familiar situation for those who practise mental health law. Patients who have been detained under the MHA (like Jane) can theoretically be discharged into the community with a suitable package of care, but only when that package is actually available. Many weeks or months can be spent putting such packages together (funding, placement, support etc) and in place. During which time patients remain detained. The whole s. 117 process is designed to speed that up so as to ensure detained patients get out and stay out of hospital. Of course, because Jane was never detained under s. 3 of the MHA, s. 117 aftercare was not available to her.

94. The hospital thought that utilising the MHA to detain Jane would be harmful to her mental health, as would her remaining in Hospital. This is an invalid argument which contains two fallacies. First, she was detained by her care plan which I have summarised above. What jurisdictional label is placed on the care plan is immaterial to its restrictive nature, whether that be MHA, MCA, "common law", the High Court's inherent jurisdiction is irrelevant to whether she was detained for treatment. That was the care plan's doing.

95. Secondly, keeping her in Hospital for a day longer than was necessary was also nothing to do with the regime she was subject to. Good clinical practice and the operation of Article 5 of the European Convention requires a patient to be detained only for so long as is necessary. The MHA does not prolong detention. In fact, as I have already said, proper use of s. 117 should reduce the overall time a patient spends in Hospital because professionals inside and out of Hospital concerned with health and social care should all work together to put together an effective discharge plan speedily.

96. There seems to be a belief, not just in this case but in others which I have heard recently, that the decision to use the MHA should be viewed in isolation from what is available elsewhere at the time the decision to detain or not detain is taken. Ideally, a 17-year-old

vulnerable young person would not be detained in a psychiatric facility, let alone a mixed adult general ward. However, where there is literally no option in which that young person will be safe, or as safe as possible in the circumstances, I cannot see how the MHA decision maker can avoid the decision I have had to make in this judgment. If the patient has to be detained for treatment for their mental disorder, and there is no alternative outside the hospital setting, and no other treatment plan available, then it seems clear to me the patient should not be detained under the MCA but rather under the MHA.

97. In my judgment, Jane was receiving medical treatment for her mental disorder. The order I was asked to make in the Court of Protection was intended to authorise that care plan which inevitably led to Jane being deprived of her liberty for that purpose.

98. In their written submissions, Ms Mulholland and Ms Campbell draw analogies between Jane's position and those cases that are presently the subject matter of the Family Division of High Court's National DoLs Court, cases such as Re T (a child) [2021] UKSC 35 and An NHS Trust v ST (Refusal of Deprivation of Liberty Order) [2022] EWHC 719 (Fam.). As they put it:

> These cases invariably involve children with complex backgrounds and presentations who find themselves 'stuck' in hospital settings because the relevant local authorities are so under-resourced that they cannot find alternative placements for them.

99. They go on:

> The Trust recognises that each case is fact-sensitive but highlights that, upon the expiry of the detention under the MHA 1983, the Court had no hesitation in endorsing the inherent jurisdiction as the correct legal mechanism for authorising any deprivation of liberty arising out of the hospital placements, the MCA2005 not being available for children under 16.

100. I agree with the suggestion that there is an analogy between this case and those. I agree that there are cases in which the High Court must use its powers to protect those who are at risk if there is no other legal power in place enabling those responsible for the child's care to keep them safe. Certainly, that happens where Local Authorities are unable to find suitable and regulated provision for the care of young people and have to resort to unregulated placements.

101. However, it seems to me that in Jane's case the MCA and the MHA taken together provide a legal structure that enables those with responsibility for her care to do so within the law, as well as clear guidance as to which of those legal powers are to be used. I am not satisfied the inherent jurisdiction of the High Court should be used to ensure that those powers are used, although the High Court would have other powers available through the prerogative writs and judicial review to do so. Indeed, I am interested to know what would have happened if, during the period of Jane's unlawful detention in Hospital, someone had applied for a writ of habeas corpus from the High Court, and what powers that Court may have used.

CONCLUSION

102. My conclusion is that Jane was ineligible to be deprived of her liberty in the Hospital under MCA. She was within the scope of the MHA under Case E. I have concluded for the reasons I have given that she could have been detained and treated under the MHA. I would go further and say that she should have been so detained and treated.

103. Had I reached that conclusion at the hearing, I would have been invited to invoke the inherent jurisdiction to authorise Jane's detention. I did not have to do that because of the steps I took. However, I would be reluctant to do so for the following reasons. First, because the inherent jurisdiction should be used only where a vulnerable adult or (in this

case) a child is left at risk because of a gap in the statutory framework designed to keep them safe. That is not the case here. The MHA should have been used. It was available. There is no gap for the inherent jurisdiction to patch. Secondly, the MHA is a long-established bespoke code dealing with the difficult regulation of the treatment of detained patients in Hospitals. The use of the inherent jurisdiction or the MCA for that matter would have the perverse result of a Judge having to make decisions over the management of medical treatment when that code exists and is available for use. For the Court to assume that role would (a) place Judges in an impossibly difficult position and (b) act as an incentive for those entrusted with using the MHA, clinicians and Hospitals, not to use it.

104. That completes this judgment.