Neutral Citation Number: [2015] EWHC 2990 (Admin)

Case No: CO/1302/2015

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 29/10/2015

Before :

LORD JUSTICE GROSS AND MR JUSTICE CHARLES

- -

Between :

The Queen (on the application of LF)	**Claimant**
- and -	
HM Senior Coroner for Inner South London	**Defendant**
and	
King's College Hospital NHS Foundation Trust	**Interested Party**

- -
- -

Victoria Butler-Cole (instructed by Bindmans LLP) for the **Claimant**
Jonathan Hough QC (instructed by Legal Services Southwark Council) for the **Defendant**

Hearing dates: 24 June 2015

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Judgment

Gross LJ :

INTRODUCTION

1. This is a tragic case. Maria Ferreira ("Maria") suffered from Down's syndrome. She also had a severe learning disability, limited mobility and required 24 hour care provided (or provided principally with local authority support) by the Claimant, her sister ("the Claimant"). Maria died while in intensive care at King's College Hospital in London on 7th December, 2013. She was aged 45 at the time of her death. An inquest into Maria's death was opened on 16th December, 2013.

2. Plainly an inquest will be held; that is not in dispute. However, by a written decision dated 23rd January, 2015 ("the Decision"), the Defendant Senior Coroner ("the Coroner") rejected the argument that Maria was "in state detention" at the time of her death, within the meaning of ss. 7(2)(a) and 48(1) and (2) of the *Coroners and Justice Act 2009* ("the CJA 2009") and therefore the inquest must be held with a jury. By way of judicial review, the Claimant challenges that conclusion and contends that in the circumstances the Coroner was bound to call a jury. The sole issue for the Court is whether the Claimant's challenge is well-founded.

3. We were told that the Coroner has participated in these proceedings in order to explain his reasoning and to assist the Court on any matters of specialist law and practice which arise.

4. King's College NHS Foundation Trust (the Interested Party) ("the hospital") did not file an Acknowledgment of Service and has not participated in the proceedings before us.

THE CORONIAL LEGISLATION

5. The present coronial law is contained in "the CJA 2009". Before turning to its provisions, it is instructive to start with the predecessor statute, namely, the *Coroners Act 1988* ("the 1988 Act"), which provided as follows:

> " **8. Duty to hold inquest.**
>
> (1) Where a coroner is informed that the body of a person ('the deceased') is lying within his district and there is reasonable cause to suspect that the deceased –
>
> (a) has died a violent or an unnatural death;
>
> (b) has died a sudden death of which the cause is unknown; or
>
> (c) has died in prison or in such a place or in such circumstances as to require an inquest under any other Act,
>
> then…..the coroner shall as soon as practicable hold an inquest into the death of the deceased either with or, subject to subsection (3) below, without a jury.

(3) If it appears to a coroner, either before he proceeds to hold an inquest or in the course of an inquest begun without a jury, that there is reason to suspect –

(a) that the death occurred in prison or in such a place or in such circumstances as to require an inquest under any other Act;

(b) that the death occurred while the deceased was in police custody, or resulted from an injury caused by a police officer in the purported execution of his duty;

…..

he shall proceed to summon a jury…..”

6. In *R v Inner North London Coroner, Ex p Linnane* [1989] 1 WLR 395, the deceased had begun to serve a term of imprisonment at a police station. He was found unconscious in his cell and was, ultimately, taken to hospital where he died the next day. This Court granted an order of *mandamus* compelling the coroner to empanel a jury. Taylor LJ (as he then was) held (at p.398) that the phrase “there is reason to suspect” did not “require positive proof or even formulated evidence”. Any information giving “reason to suspect” would suffice. As to whether the deceased had been “in police custody” (within s.8(3)(b)) at the time of his death, Taylor LJ said this (at p.400):

> “ Looking at this matter, I hope, with common sense, I take the view that he was in police custody. He was not in the physical custody in the sense of being physically held by, or arranged to be physically held by, any specific officer, but he was in the legal custody of the police or at any rate (and this is sufficient) there must have been to anyone properly directing themselves on the circumstances then existing, reason to suspect that he was in police custody.”

This common sense approach has regard to all the relevant circumstances relating to the concrete situation on the ground.

7. The CJA 2009 provides, insofar as material, as follows:

> “ **1 Duty to investigate certain deaths**
>
> (1) A senior coroner who is made aware that the body of a deceased person is within that coroner’s area must as soon as practicable conduct an investigation into the person’s death if subsection (2) applies.
>
> (2) This subsection applies if the coroner has reason to suspect that –
>
> (a) the deceased died a violent or unknown death,
>
> (b) the cause of death is unknown, or
>
> (c) the deceased died while in custody or otherwise in state detention.

4 Discontinuance where cause of death revealed by post-mortem examination

(1) A senior coroner who is responsible for conducting an investigation under this Part into a person's death must discontinue the investigation if –

(a) an examination under section 14 reveals the cause of death before the coroner has begun holding an inquest into the death, and

(b) the coroner thinks that it is not necessary to continue the investigation.

(2) Subsection (1) does not apply if the coroner has reason to suspect that the deceased -

(a) died a violent or unnatural death, or

(b) died while in custody or otherwise in state detention.

6 Duty to hold inquest

A senior coroner who conducts an investigation under this Part into a person's death must (as part of the investigation) hold an inquest into the death…..

7 Whether jury required

(1) An inquest into a death must be held without a jury unless subsection (2) or (3) applies.

(2) An inquest into a death must be held with a jury if the senior coroner has reason to suspect –

(a) that the deceased died while in custody or otherwise in state detention, and that either –

(i) the death was a violent or unnatural one, or

(ii) the cause of death is unknown

……

(3) An inquest into a death may be held with a jury if the senior coroner thinks that there is sufficient reason for doing so.

48 Interpretation: general

(1) In this Part, unless the context otherwise requires –

….

'state detention' has the meaning given by subsection (2);

(2) A person is in state detention if he or she is compulsorily detained by a public authority within the meaning of section 6 of the Human Rights Act 1998."

8. Given the matters to which I shall come, it is next convenient to set out the terms of Art. 5 of the European Convention on Human Rights ("ECHR"):

> " **Right to liberty and security**
>
> 1. Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:
>
> ….
>
> (e) the lawful detention ….of persons of unsound mind….
>
> 4. Everyone who is deprived of his liberty by….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."

Those with learning disabilities may be "persons of unsound mind" within Art. 5.1(e). Here, there is no or no real dispute that Maria was a person of unsound mind for these purposes.

9. A number of preliminary observations may be made at this stage. First, the Explanatory Notes to the clause of the Bill which became, s.1 of the CJA 2009 and to which it was common ground we were entitled to refer – the Notes having remained unchanged – were in these terms:

> " ….A coroner must also investigate a death, whatever the apparent cause, if it occurred in 'custody or state detention'….such as while the deceased was detained in prison, in police custody or in an immigration detention centre, or held under mental health legislation, irrespective of whether the detention was lawful or unlawful. "

While the Notes clearly contemplate a broadening of the ambit of state detention (as contrasted with the 1988 Act), they make no mention of a patient, whether suffering from a prior mental incapacity or not, receiving treatment in the intensive care unit ("ICU") of, or elsewhere in, a hospital for a physical condition. However, the Notes make it clear that the lawfulness of the detention is not relevant; what matters is whether or not at the time of death the deceased was in state detention.

10. Secondly, the Coroner's decision not to empanel a jury pursuant to s.7(2)(a)(i) of the CJA 2009 flowed from his conclusion that he did not have reason to suspect that Maria had died an unnatural death while in "state detention", i.e., while "compulsorily detained" by a public authority (S.48(2), CJA 2009). As was not or not seriously in dispute, the test to be applied to the sole issue before this Court was whether the Coroner's decision was *Wednesbury* unreasonable or otherwise involved a misdirection in law.

11. Thirdly, looming over these proceedings is the decision of the Supreme Court in *Surrey County Council v P* [2014] UKSC 19; [2014] AC 896 (*"Cheshire West"*) and the question as to whether the application of the principles to which the majority subscribed requires or otherwise supports a decision in favour of the Claimant. This authority will be considered in more detail below; for the moment it suffices to recite the relevant passage in the head note:

> " [Unanimously] …that since the term 'deprivation of liberty' in the context of the living arrangements of a mentally incapacitated person was to be given the same meaning in domestic law as in article 5 of the Convention, it was to be construed by reference to the relevant jurisprudence of the European Court of Human Rights; that under that jurisprudence the difference between a restriction and a deprivation of liberty was one of fact and degree depending on the actual situation of the person concerned , but in cases concerning the placement of mentally disturbed people in hospitals or care homes the test to be applied was whether the person was under continuous supervision and control, and was not free to leave; that [by a majority]….that same test applied even where the person was being confined for a benevolent or beneficial purpose, under court order, in a non-institutional setting which aimed at providing an environment of relative normality and to which the person did not object; that, moreover, as a matter of policy, persons of extreme vulnerability needed to be subject to periodic checks on whether the legal justification for the constraints on them continued to be made out; and that, accordingly, the appellants' living arrangements were to be considered on the basis that mentally incapacitated persons had the same rights to liberty as everyone else, so that living arrangements which amounted to a deprivation of liberty in the case of a non-disabled person would be a deprivation of liberty of the disabled person. "

12. Fourthly, the structure of Art. 5.1 is that it identifies the right to liberty and security of all persons and then provides that, save in identified circumstances, no one shall be deprived of his liberty. The question therefore arises as to whether or how Art. 5 applies to a person who but for a physical reason, or treatment for a physical disorder, would be in a position to exercise his Art. 5 rights and so his autonomy, to refuse medical treatment and leave the hospital. A ready example is a person with no prior mental incapacity who is the victim of a motor car accident or suffers a serious physical medical condition, which renders them unconscious or otherwise unable to consent to treatment on admission and subsequently in an ICU. Another is when the physical health of a person with capacity and already in hospital suffers a serious downturn that needs treatment, the effects of which mean that he cannot communicate or weigh competing factors relating to that new treatment. In both examples, the physical condition and the treatment for it can result in the patient being under the constant control and supervision of the treating team and not free to leave the ward. At least at first blush, whilst such a situation continued for a person with no prior mental incapacity, it would be remarkable if his/her right to liberty and security was being infringed.

13. Fifthly, as submitted by Mr Hough QC for the Coroner, a conclusion that a person died while in "state detention" has two practical effects for coroners:

    i) An inquest must be held, even if the cause of death has been established and found to be natural.

    ii) The inquest must be held with a jury if there is reason to suspect that the death was violent or unnatural, or of unknown cause.

14. Sixthly, Art. 5 and *Cheshire West* are directed to the assessment of a situation and the necessary process of law and safeguards relating to it whilst the relevant person is

alive. By contrast, the CJA 2009 is directed to the necessary process of law and safeguards after death.

THE FACTS

15. For present purposes, the facts may be briefly summarised and are, at least in large measure, not in dispute.

16. On the 19th November, 2013, the Claimant telephoned her GP surgery, concerned that Maria had finished a course of antibiotics and was short of breath and distressed. On the advice of the GP, the Claimant called an ambulance and Maria was taken to and admitted to "the hospital". The Claimant's evidence is that Maria had a strong dislike of hospitals and found the procedures frightening. On admission to the hospital, the initial impression formed by clinicians was that she had pneumonia – but early tests gave evidence of cardiac failure and pulmonary oedema.

17. Maria's condition fluctuated but, by the 23rd/24th November, it appeared to improve. On the 26th November, the Claimant indicated to Dr. Barker (the respiratory consultant) that Maria would like to go home. By this stage, Dr. Barker had seen Maria again and had formed a working diagnosis of pericarditis, pneumonia and possible pulmonary oedema. Dr. Barker's statement (dated 13th March, 2014) continues:

> " I could understand that she [Maria] was struggling in the hospital environment, but I was also anxious that we had not really completed all the investigations we would have done if we had a patient who found investigations easier to tolerate. …… We planned an overnight oximetry study to see what the patient's oxygen levels were at night, and a repeat X-ray. "

18. Maria remained in hospital but over the days which followed there were discussions as to discharging her with a view to care in the community, first on the 29th November then on the 2nd December.

19. Unfortunately, on the 2nd December, Maria's condition gave rise to concerns. A CT scan was requested to investigate further. Maria was seen again by Mr. Hammond, the Hospital's Learning Disabilities Coordinator. His Report (dated 4th June, 2014) says this:

> " …[the Claimant] was clear on the plan for the CT scan and echocardiogram. She was pleased with her involvement in care from [the] medical team but was very tired and said Maria was also. She was keen for her to go home ASAP once safe to do so. She requested that Maria's anxiety with continued in-patient treatment was considered as part of discharge planning. I planned a review on my next working day …[the 4th December]…"

20. Interposing here and without expressing any view as to its relevance to the inquest, if there is any substance in much of the Claimant's statement (dated 22nd August, 2014), then the manner in which members of the hospital nursing staff dealt with Maria and the Claimant over the period 19th November – 2nd December, left a very great deal to be desired.

21. Continuing with the chronology, on the night of the 2nd/3rd December, Maria's condition worsened markedly, with declining oxygen levels, high carbon dioxide

levels and an elevated heart rate. Some time after 02.00, she was transferred to the ICU and was heavily sedated and intubated. Her antibiotic treatment was increased.

22. Over the following days, Maria remained sedated and on a ventilator. According to the statement of Dr. Stephen Lewis (dated 24th October, 2014), Consultant in Critical Care and Anaesthesia, the sedation Maria received was intended to facilitate mechanical ventilation as a life-saving treatment intervention. The Claimant was told that Maria had acute pneumonia and might not survive. While in the ICU, nursing staff placed mittens on Maria's hands to prevent her reflexively grabbing at and disconnecting the endotracheal tube. Dr Lewis said this (*ibid*):

> " Reaching for an endotracheal tube while under sedation is a normal reaction, regardless of any pre-existing disability or phobia. In this respect Miss Ferreira was no different from any other intubated patient on the Intensive Care Unit. The management of this phenomenon is a daily feature of Intensive Care medical and nursing practice."

23. The final events of the 7th December can conveniently be taken from the summary contained in Mr. Hough's skeleton argument:

> " On the morning of 7 December, Dr Lewis….decided to try to take Maria off ventilation. He asked nurses to perform a sedation hold to see how she would breathe independently. He observed her condition and decided to re-commence sedation because he was concerned that Maria would not maintain her airway. A cuff leak test suggested that her airway might be swollen.
>
> At around 1.30pm on 7 December, Maria's endotracheal tube was removed. It appears that her right hand dislodged it. At that time she was wearing only one mitten because mittens were in very short supply on the ward. A nurse quickly noticed the problem and summoned help. Despite apparently prompt and careful efforts at resuscitation, Maria went into cardiac arrest and died. "

24. On the 12th December, 2013, a post-mortem examination was conducted by Dr. George, a Consultant Pathologist. He recorded the cause of death as follows:

> "1a. Respiratory failure
>
> 1b. Loss of airway (self extubation)
>
> 1c. Organising pneumonia and interstitial lung disease
>
> 2. Down Syndrome"

THE CORONER'S DECISION

25. The Coroner began by stating that a person is in state detention if he or she is compulsorily detained by a public authority: s.48(2) of the CJA 2009. He observed that there were circumstances where a hospital patient or care home resident was so detained. He recorded that he had previously expressed the view that a person subject to a "deprivation of liberty" authorised under the *Mental Capacity Act 2005* ("the MCA 2005" – see further below) should be regarded as compulsorily detained. The phrase "compulsorily detained" conveyed the concept of a person "being confined in

a place…without being free to leave". In the context of hospital patients that was "at least very similar" to the test for deprivation of liberty under Art. 5, ECHR, as considered in *Cheshire West (supra)*.

26. The Coroner went on to say this:

> " ….if the system established by the MCA is being properly operated, any deprivation of liberty in a hospital context should be authorised. Furthermore, it will often be very difficult in practice to say that a public authority has exercised the coercive power to detain a patient before it has obtained authorisation to deprive him or her of liberty. For those reasons, it will be rare to find that a patient has been compulsorily detained without there being some legal authorisation for deprivation of liberty."

Nonetheless, the Coroner accepted that, in principle, there may be situations where a patient or care home resident was, in practice, detained without a proper authorisation having been obtained; he gave the example of "…being locked in a ward against her will".

27. The Coroner next turned to the "status" of Maria at the time of her death. He highlighted five features:

> " i) An authorisation for deprivation of liberty under the MCA was not obtained, nor was she admitted under the Mental Health Act 1983. There is no evidence that any public authority took any formal step to put her under detention or take away her liberty.
>
> ii) Ms Ferreira was voluntarily admitted to hospital and consented to treatment. It seems likely that she later lacked capacity to consent to at least some of the treatment, but this itself does not mean that she was compulsorily detained at the time of her death.
>
> iii) There was an indication from medical staff that, in her own interest, she should stay in hospital for clinical investigations in reply to her sister's request that she should go home. However, as far as I can see, clinical advice was accepted and there was no firm refusal to allow her to leave.
>
> iv) From the night of 2nd/3rd December she required constant life saving treatment and constant observation for medical reasons, being sedated and intubated. There was no question of her leaving the hospital, but that was because of her condition rather than any use of coercive powers by the hospital.
>
> v) The use of restraint mittens was to prevent her from extubating herself and not to prevent her from leaving hospital. I understand that it was approved by her sister. "

28. The Coroner concluded that, in all the circumstances, he did not find reason to suspect that Maria was in state detention.

> " She had not been expressly prevented or prohibited from leaving a specified place. She had not been formally deprived

> of her liberty by authorisation, nor detained under Mental Health section."

29. Finally, the Coroner turned to his discretionary power to summon a jury, pursuant to s.7(3), CJA 2009. In all the circumstances, he decided not to exercise that discretion. It is unnecessary to say more of this exercise of the Coroner's discretion, in that it is not challenged before us. As will be recollected, the sole issue before this Court goes to whether the Coroner was bound to summon a jury pursuant to s.7(2)(a) of the CJA 2009.

THE RIVAL CASES

30. For the *Claimant*, Ms Butler-Cole submits that the Coroner erred in his Decision: the Court should grant the relief sought and declare that Maria was deprived of her liberty in terms of Art 5 ECHR and "therefore" in state detention for the purposes of s.7 CJA 2009 at the time of her death. It was difficult to distinguish "deprivation of liberty" under Art. 5 from "state detention" under the CJA 2009. It was common ground that the hospital was a public authority. Taking her stance on the basis of the Supreme Court decision in *Cheshire West*, Ms Butler-Cole underlined that the purpose or reason for a measure was irrelevant when considering whether it constituted objective deprivation of liberty. In particular, the Coroner had fallen into error in that neither a formal order nor an authorisation was needed for a deprivation of liberty or state detention to occur. The question to pose here was the likely reaction of the hospital had a request been made by the Claimant to take Maria home – both before the events of the 2nd/3rd December and thereafter. To this question, Ms Butler-Cole said the answer was obvious: the request would have been refused, given that Maria was receiving life-sustaining treatment. Applying the checklist contained in the Law Society's (2015) *Identifying a deprivation of liberty: a practical guide* ("*The Law Society Practical Guide*", at para. 4.34) in respect of ICUs to Maria, Ms Butler-Cole's skeleton argument put it this way:

> " …it is clear that she was subject to continuous monitoring; was sedated and in ICU for around 4 days; had decisions taken in her best interests; was not going to recover capacity at any point; and was in receipt of care that would always involve a high level of supervision and control in light of her severe learning disabilities. These factors demonstrate that Maria was deprived of her liberty. "

The principles laid down in *Cheshire West* could not properly be distinguished; their application required or pointed to a conclusion in the Claimant's favour. Ms Butler-Cole did not shrink from the practical consequences and acknowledged the need for more forms (and the like) if her submissions were well-founded. That said, she asked rhetorically, whether it was such a problem if doctors took more time thinking of such matters as deprivation of liberty.

31. For the *Coroner*, Mr. Hough emphasised that the issue before the Court was not about the scope or thoroughness of the inquest; the Coroner's intention was to conduct a rigorous and comprehensive inquest. The question was instead whether the Coroner was bound to conduct that inquest with a jury. There were serious practical consequences if the Claimant was right. The legislative purpose of the CJA 2009 was aimed at breaking down artificial distinctions between different forms of state custody; neither the wording of the statute nor *Cheshire West* required a decision in the Claimant's favour. The applicable test under s.7 of the CJA 2009 involved the interpretation of "ordinary English words", to be approached with common sense. There was no requirement to import into the CJA 2009 the entire Art. 5 ECHR

jurisprudence with all its nuances. However, for there to be "state detention" and thus for a person to be "compulsorily detained" under the CJA 2009, there had to be, at the least, a decision to detain, to confine the person concerned to a place or places from which he/she was not free to leave. This requirement was not satisfied here. On all the evidence, there was no such decision prior to the 2nd December. After the deterioration of Maria's condition on the night of 2nd/3rd December and her admission into the ICU, it was unreal to suggest that she was "detained" still less "compulsorily detained". Maria remained in the ICU, not because she had been detained or deprived of her liberty but because she was unable to be elsewhere. While in the ICU, there was no difference between Maria's position and someone hitherto of full mental capacity. There was a parallel with a person who attended voluntarily at a police station at a point in time when there had been no decision whether or not he/she should be arrested. The Coroner had not erred in his Decision; on a proper reading, he had not held that a person could only be detained if there was a formal order or authorisation; he had, rightly, pointed to the absence of any such order or authorisation as a factual element telling against the conclusion of "state detention" here. The Decision could not be impugned unless it was *Wednesbury* unreasonable or the Coroner had misdirected himself in law. That challenge was not made good. It was to be recollected that a person who lacks capacity to consent to a particular treatment could be treated on a "best interests" basis without *thereby* being deprived of liberty or compulsorily detained.

PATIENTS WITH A MENTAL DISORDER AND PATIENTS WHO LACK CAPACITY TO CONSENT TO THEIR CARE OR TREATMENT

32. It is next convenient to outline the statutory regime for the treatment and detention of such persons, so far as relevant for present purposes.

33. The *Mental Health Act 1983* ("the MHA") makes provision for the admission and detention of patients who require assessment and treatment for a mental disorder (as defined – any disorder or disability of the mind) and so, generally, in psychiatric wards. The MHA does not cover treatment or assessment for other disorders.

34. It is thus clear that Art. 5.1(e) applies to persons admitted to and detained in hospitals pursuant to the MHA, both because they are "persons of unsound mind" and the reason for their detention under the MHA is the assessment or treatment of their mental disorder. Further, as a matter of ordinary language, persons thus admitted and detained fit easily within the concept of "compulsory detention" (s.48(2), CJA 2009). In Maria's case, no question arose of her being detained under the MHA for the assessment or treatment of a mental disorder.

35. S.131 of the MHA provides for patients to be admitted informally. Historically, s.131 had been used to permit the admission, treatment and detention of patients with and for mental disorders on the basis of necessity. However, in *HL v United Kingdom* (2005) 40 EHRR 32, the European Court of Human Rights ("the Strasbourg Court") held that such a detention of a patient who was compliant with but who, by reason of his mental disorder, lacked capacity to consent to his admission, treatment and detention, contravened Art. 5 ECHR because of inadequate safeguards in the relevant procedure.

36. In response, the UK government amended the MCA 2005, introducing new provisions for the authorisation of a deprivation of liberty of persons who "are not ineligible to be deprived of liberty" under the MCA. The definition of this status is contained in Schedule 1A to the MCA, is complicated and need not be explored further here.

37. Broadly, the MCA 2005 furnishes three routes by which a deprivation of liberty can be authorised and so rendered lawful:

i) First, s.4A(3) provides that a person (D) may deprive another (P) of his/her liberty if by doing so D is giving effect to a relevant decision of the Court of Protection.

ii) Secondly, s.4A(5) provides that D may deprive P of his liberty if such deprivation is authorised by Schedule A1 to the MCA 2005 (which applies only to persons detained in a hospital or care home for the purposes of care or treatment – in circumstances which amount to a deprivation of liberty). Schedule A1 lays down a Deprivation of Liberty Safeguards ("DOLS") scheme. It is unnecessary to explore the detail but the DOLS scheme provides for both a "*standard authorisation*" and an "*urgent authorisation".* A *standard authorisation* may be granted by a supervisory body after an application by the managing authority of a hospital or care home and the undertaking of an assessment process that addresses six qualifying requirements (the age, mental health, mental capacity, best interests, eligibility and no refusals requirements – see Part 3 of Schedule A1). An *urgent authorisation* may be given by the managing authority of a hospital or care home itself for a period of up to seven days if there is an urgent need to detain a person before or during the process of applying for a standard authorisation. The supervisory body may extend an urgent authorisation by up to seven days on request.

iii) Thirdly, s.4B provides that a person may be deprived of his/her liberty pending an application to the court, if the deprivation of liberty is necessary to give life-sustaining treatment or prevent serious deterioration in that person's condition.

38. In authorising or reacting to a deprivation of liberty, both the court and the DOLS routes require that the "best interests" test set by the MCA is satisfied – *viz.*, doing for the patient what he could do for himself if of full capacity.

39. It should be noted that s.4A(1) of the MCA 2005 provides that the Act does not authorise any person to deprive any other person of his liberty, save in accordance with the routes outlined above. Accordingly, s. 5 of that Act - which protects a person from liability when acting in connection with the care or treatment of another person lacking capacity in relation to such care or treatment, in accordance with the "best interests" test - does not extend to care or treatment involving a deprivation of liberty. While the language of the MCA 2005 provisions is hardly straightforward, it follows: (1) that the need to draw a distinction between that which does and that which does not constitute a deprivation of liberty is inescapable in deciding whether particular care or treatment is protected by s.5; (2) that, as protected by s.5, some care and treatment of a person lacking capacity may be undertaken on a "best interests" basis without that care or treatment comprising a deprivation of liberty.

ART. 5 ECHR

40. The deprivation of liberty of those lacking mental capacity ought to be – and is - a matter of real concern. This concern is reflected in the Art. 5 jurisprudence. Five authorities suffice.

41. In *Guzzardi v Italy* (1980) 3 EHRR at [92] and [93], the Strasbourg Court made it clear that the starting point in assessing whether there had been a deprivation of liberty is "the concrete situation" of the person and that consideration of "a whole

range of criteria such as the type, duration, effects and manner of implementation of the [restrictive] measure in question" is relevant. This is referred to as the *Guzzardi* principle.

42. In *Nielsen v Denmark* (1988) 11 EHRR 175, the applicant, a minor child, complained of his committal to a Child Psychiatric Ward at the request of his mother, who was his sole legal custodian at the time. By a majority, the Strasbourg Court held that there had not been a deprivation of liberty within the meaning of Art. 5. The mother had not acted in bad faith; there had instead been a responsible exercise by the mother of her custodial rights in the interests of the child. Hospitalisation had been decided in accordance with expert medical advice; neither the curative treatment given at the hospital for the applicant's nervous condition nor the conditions under which it was administered was inappropriate in the circumstances. As expressed in the judgment:

> " 70. ……The restrictions on the applicant's freedom of movement and contacts with the outside world were not much different from restrictions which might be imposed on a child in an ordinary hospital…..
>
> 72. …..the rights of the holder of parental authority cannot be unlimited and ….it is incumbent on the State to provide safeguards against abuse. However it does not follow that the present case falls within the ambit of Article 5.
>
> The restrictions imposed on the applicant were not of a nature or degree similar to the cases of deprivation of liberty specified in paragraph (1) of Article 5. In particular, he was not detained as a person of unsound mind so as to bring the case within paragraph 1(e). ….. Indeed, the restrictions to which the applicant was subject were no more than the normal requirements for the care of a child of 12 years of age receiving treatment in hospital. The conditions in which the applicant stayed thus did not, in principle, differ from those obtaining in many hospital wards where children with physical disorders are treated. "

43. *HL v United Kingdom (supra)* concerned an applicant who was autistic and unable to consent or object to medical treatment. In 1994, he was discharged from hospital on a trial basis to paid carers. In July 1997, after becoming very agitated at a day-care centre, he was taken to hospital where a consultant psychiatrist diagnosed him as requiring in-patient treatment. As the applicant was compliant, did not resist admission and did not try to run away, the medical officer decided that it was unnecessary to detain him compulsorily under the MHA 1983 for assessment or treatment of his mental disorder. He was transferred to the hospital's Intensive Behavioural Unit as an "informal patient". Subsequently, the applicant complained that he had been detained in a psychiatric institution as "an informal patient" in violation of Art. 5.1. He further complained that the procedures available to him for a review of the legality of his detention did not satisfy the requirements of Art. 5.4. The Strasbourg Court (differing from the House of Lords) upheld both these complaints, *inter alia*, concluding that there had been a violation of Art. 5.1 as regards the lack of protection against arbitrary detention.

44. As to the distinction between a *deprivation* of liberty (contrary to Art. 5) and a *restriction* upon liberty (not amounting to a violation of Art. 5), the Strasbourg Court, applying the *Guzzardi principle*, held (at [89]) that it was "…merely one of degree or intensity and not one of nature or substance"; the question was thus fact specific. As

to the applicant's compliance, the Court held (at [90]) that "…the right to liberty is too important in a democratic society for a person to lose the benefit of Convention protection for the single reason that he may have given himself up to be taken into detention, especially when it is not disputed that the person is legally incapable of consenting to, or disagreeing with, the proposed action". On the facts (at [91]), "….the concrete situation was that the applicant was under continuous supervision and control and was not free to leave".

45. In *Storck v Germany* (2005) 43 EHRR 96, the applicant had spent a considerable period of time (some 20 months) in a psychiatric institution, at the behest of her father; she had been forcibly medicated and, on one occasion, had attempted to escape but was forcefully returned to the clinic in question by the police. The Strasbourg Court unanimously upheld her complaint of a violation of Art. 5.1. The notion of "deprivation of liberty", within the meaning of Art. 5.1 (at [74]):

> " ….does not only comprise the objective element of a person's confinement to a certain limited place for a not negligible length of time. Individuals can only be considered as being deprived of their liberty if, as an additional subjective element, they have not validly consented to the confinement in question…. "

On the facts, the Court concluded that the applicant had not validly consented. Having regard to *HL v United Kingdom (supra)*, the case of *Storck* was, *a fortiori*, one of deprivation of liberty.

46. *Stanev v Bulgaria* (2012) 55 EHRR 22 concerned proceedings issued in 2000 by relatives of the applicant, resulting in the appointment of a social worker as his guardian. The guardian arranged for him to live in a social care home for adults with mental disorders. He was not informed of this arrangement. He required the permission of the director of the care home in order to leave. His pension was transferred to the care home in order to meet his living costs. He made a number of unsuccessful applications to court to vary the terms of his guardianship. Matters did not end there; in 2004, the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, reported that conditions in the care home were so poor as to amount to inhuman and degrading treatment. Subsequently, the Bulgarian authorities acknowledged that the care home was not in conformity with European standards and would be closed as a priority. The applicant succeeded in his claims, *inter alia*, that there had been a violation of Art. 5.1. The Strasbourg Court, with respect, helpfully summarised the previous authorities in this area (at [115] – [119]), covering the matters already highlighted. Additionally, the Court said this (at [120]):

> " ….the Court has had occasion to observe that the first sentence of art. 5(1) must be construed as laying down a positive obligation on the state to protect the liberty of those within its jurisdiction. Otherwise, there would be a sizeable gap in the protection from arbitrary detention, which would be inconsistent with the importance of liberty in a democratic society. The state is therefore obliged to take measures providing effective protection of vulnerable persons, including reasonable steps to prevent a deprivation of liberty of which the authorities have or ought to have knowledge…… "

47. Pausing here, in the light of the statutory regime and the Art. 5 authorities, I venture a number of further interim observations:

i) So far as it goes, Ms Butler-Cole is plainly right in submitting that no formal order or authorisation is necessary for there to be a deprivation of liberty under Art. 5. Such authorisations relate to but do not create an objective deprivation of liberty. Further, as shown by the Notes to the CJA 2009 (cited above), the lawfulness of the detention is not relevant.

ii) The cases in the Strasbourg Court have not addressed treatment for physical disorders, unconnected to the patient's mental disorder. In cases of physical disorders (as distinguished from those involving care and treatment for mental disorders), the mental capacity of the patient will not have any effect on the nature of the treatment and care.

iii) The facts of the Art. 5 authorities reviewed above are, as will have been seen, far removed from typical ICU situations. On facts such as those of *Storck* or *Stanev*, there were overwhelming reasons for the conclusion that there had been a deprivation of liberty. Furthermore, in the Art. 5 authorities, the mental capacity of the individuals concerned is, or is likely to be, of central relevance to the issue before the court. In a typical ICU situation and without more, the treatment of the patient, may well not differ, at all or materially, regardless of the mental capacity of the patient prior to admission to the Unit.

iv) It is settled law that the difference between a deprivation of liberty contravening Art. 5 and a restriction upon liberty not doing so, is one of fact and degree. It follows that decisions in this area are necessarily fact sensitive and that the approach to be taken is equivalent to that adopted by Taylor LJ in *Linnane (supra)*.

THE SUPREME COURT DECISION IN *CHESHIRE WEST*

48. As with any authority, the context is of the first importance. At the very outset of her judgment (at [1]), Baroness Hale of Richmond DPSC (with whom Lord Sumption JSC agreed) explained what *Cheshire West* was about:

> " This case is about the criteria for judging whether the living arrangements made for a mentally incapacitated person amount to a deprivation of liberty. If they do, then the deprivation has to be authorised, either by a court or by the procedures known as the deprivation of liberty safeguards, set out in the Mental Capacity Act 2005….. If they do not, no independent check is made on whether those arrangements are in the best interests of the mentally incapacitated person, although of course the health or social care bodies who make the arrangements do so in the hope and belief that they are the best which can practicably be devised. It is no criticism of them if the safeguards are required. It is merely a recognition that human rights are for everyone, including the most disabled members of our community, and that those rights include the same right to liberty as has everyone else. "

49. As to the living arrangements themselves, these could broadly be described a placement in house with live-in carers or foster parents; the aim of the placement was to be as much like ordinary living arrangements as possible. As Baroness Hale herself observed (at [10]):

> " The facts of the two cases before us are a good illustration of the sort of benevolent living arrangements which many might find difficult to characterise as a deprivation of liberty….."

Baroness Hale further acknowledged (at [20] and [32]) that no Strasbourg authority had previously dealt with the type of placements before the Supreme Court. That said (at [32]):

> " The issue, of course, is whether that authorisation [i.e., the initial authorisation of the placement by a court as being in the best interests of the person concerned] can continue indefinitely or whether there must be some periodic independent check on whether the placements made are in the best interests of the people concerned."

50. It was common ground (at [37]) that three components of a deprivation of liberty could be distilled from *Storck* and *Stanev* (both *supra*). These were:

> " ….(a) the objective component of confinement in a particular restricted place for a not negligible length of time; (b) the subjective component of lack of valid consent; and (c) the attribution of responsibility to the state….."

51. In Baroness Hale's view (at [45]), it was "axiomatic that people with disabilities, both mental and physical have the same human rights as the rest of the human race…." Those rights included the right to physical liberty, guaranteed by Art. 5. In that regard, the fact that living arrangements were comfortable and made life as enjoyable as it could be, should make no difference (at [46]): "A gilded cage is still a cage."

52. As to an "acid test" (at [48]) for the deprivation of liberty in such cases, the particular features on which to focus were (as expressed in *HL v United Kingdom, supra*): "…that the person concerned 'was under continuous supervision and control and was not free to leave'…" (at [49]). Baroness Hale went on (at [50]) to agree with an approach which involved the court not laying down "a prescriptive list of criteria"; instead, the court should indicate the test and those factors which were *not* relevant. As to these latter factors:

> " …the person's compliance or lack of objection is not relevant; the relative normality of the placement ….is not relevant; and the reason or purpose behind a particular placement is also not relevant. "

53. As a matter of policy, Baroness Hale said this (at [57]):

> " Because of the extreme vulnerability of people like P, MIG and MEG, I believe that we should err on the side of caution in deciding what constitutes a deprivation of liberty in their case. They need a periodic independent check on whether the arrangements made for them are in their best interests……"

54. Delivering a concurring judgment and drawing from the Strasbourg decisions, Lord Neuberger of Abbotsbury PSC likewise highlighted (at [63]) "the twin features of continuous supervision and control and lack of freedom to leave" as the "essential ingredients of deprivation of liberty". Lord Neuberger was not deterred from his view by the fact that the Strasbourg court had never had to consider a case where a person was confined to "…an ordinary home" (at [71]) or that (*ibid*) "….many people might

react with surprise at simply being told that a person living in a domestic setting could complain of deprivation of liberty….".

55. In his concurring judgment, Lord Kerr of Tonaghmore JSC said this:

> " 76. While there is a subjective element in the exercise of ascertaining whether one's liberty has been restricted, this is to be determined primarily on an objective basis. Restriction or deprivation of liberty is not solely dependent on the reaction or acquiescence of the person whose liberty has been curtailed. ……. Liberty means the state or condition of being free from external constraint. It is predominantly an objective state. It does not depend on one's disposition to exploit one's freedom. Nor is it diminished by one's lack of capacity.
>
> 77. The question whether one is restricted (as a matter of actuality) is determined by comparing the extent of your actual freedom with someone of your age and station whose freedom is not limited. Thus a teenager of the same age and family background as MIG and MEG is the relevant comparator for them. If one compares their state with a person of similar age and full capacity it is clear that their liberty is *in fact* circumscribed. They may not be conscious, much less resentful, of the constraint but, objectively, limitations on their freedom are in place. ….. "

56. Dissenting, Lord Carnwath and Lord Hodge JJSC alluded in their joint judgment to there being much common ground (at [88] – [89]). On the other hand, there were (*ibid*) "legitimate concerns" as to the potential bureaucracy of the statutory procedures and as to including within the test the "benevolent living arrangements" with which the Supreme Court was concerned. Lords Carnwath and Hodge were concerned (at [99]) that "…nobody using ordinary language would describe people living happily in a domestic setting as being deprived of their liberty". Lord Clarke of Stone-Cum-Ebony JSC, also dissenting, approached the matter as essentially fact-sensitive. Agreeing with Lords Carnwath and Hodge, he was of the view (at [108]) that a "more measured conclusion" would be that MIG's and MEG's liberty had been interfered with and not that they had been deprived of their liberty.

57. I respectfully venture the following observations on *Cheshire West*:

i) The context concerned the living arrangements for mentally incapacitated persons. The issue was whether these arrangements engaged the Art. 5 rights of those persons and so should be subject to periodic independent review as to their remaining in the best interests of those concerned.

ii) The "acid test" for a deprivation of liberty was continuous supervision and control coupled with the lack of freedom to leave. Compliance or acquiescence by a person to the curtailment of liberty, especially when that person lacked capacity, was neither here nor there.

iii) Given the (majority) conclusion that the purpose, reason or benevolence underlying a placement was irrelevant, the "acid test" suggests that the principle of *Cheshire West* is capable of application or extension to patients in some hospital or ICU settings – albeit that the facts and the issue in *Cheshire West*, together with the mischief it was addressing, were far removed from the typical hospital or ICU context.

iv) A *mechanistic* application of *Cheshire West* to patients in a number of hospital settings including an ICU would have significant practical consequences, in that the "acid test" (on a literal application) is capable of encompassing all such patients, regardless of any prior mental incapacity, provided only they were not in a position to give consent to the treatment or stage of treatment in question. Ready examples have been suggested above.

v) As it seems to me, the resulting consequences would be a matter of real concern but would be unavoidable if *Cheshire West* must indeed be read this widely. In some cases those consequences would involve the making of applications to court and in others the application of DOLS. Both routes to authorisation would result in the diversion of treating teams from their care of patients on busy wards.

vi) It is already well recognised (see further below) that the inclusion by *Cheshire West* of situations not previously regarded as involving a deprivation of liberty has resulted in increases of workload, paperwork and expense.

vii) Ultimately and whatever the true scope in principle of *Cheshire West*, the question whether there has been a deprivation of liberty in any particular case is fact-sensitive and specific.

58. *Cheshire West* has been considered in a number of first instance decisions, to which some brief reference should be made. In *NHS Trust I v G (Ct of Protection)* [2014] EWCOP 30; [2015] 1 WLR 1984, Keehan J gave guidance as to the application of *Cheshire West* in the field of obstetrics, while making it clear (at [82]) that it should not be read as applying to "every pregnant woman with a diagnosed mental health illness". The purpose of the guidance was (at [83]) to prevent the need for urgent applications to the out-of-hours judge and to ensure that NHS Trusts did not rely inappropriately on the provisions of s.5 MCA. Keehan J observed (at [93]) that though the distinction between actions which amounted to restraint only and those which became a deprivation of liberty "might be difficult", that distinction could be of critical significance "…because section 4A(1) ….prevents clinicians performing acts which amount to a deprivation of liberty as part of the care and treatment under section 5". As is clear from his judgment, Keehan J recognised that *Cheshire West* was capable of applying in the context of a maternity unit within a hospital and so to care and treatment for physical reasons. He was also looking at the issues through the prism of an application to the court (rather than the DOLS).

59. In *W City Council v L (Ct of Protection)* [2015] EWCOP 20; [2015] PTSR Digest D26, Bodey J held, on the facts, that the arrangements for a 93 year old woman with severe dementia, involving a placement in her own home with carers, had not deprived her of her liberty. In his judgment (at [13] and elsewhere), Bodey J emphasised the fact-sensitive nature of the question. In *Rochdale Metropolitan Borough Council v KW* [2014] EWCOP 45, Mostyn J expressed forceful concerns as to the suggested scope of *Cheshire West*. However, for whatever reason, as we understand it, the appeal to the Court of Appeal in that case was allowed by consent; in the circumstances, it would not be productive to consider it further.

60. As is to be expected, the Supreme Court decision in *Cheshire West* has had a considerable bearing on the Guidance now available. In very broad terms, the updated Guidance reflects both an understandable attempt to adjust procedures so as to comply with *Cheshire West*, together with some expression of concern as to the practical consequences of that decision, depending on its true ambit. As all the materials make clear, any views expressed in the Guidance are subject to further clarification by way of case-law.

61. Thus in the *Chief Coroner's Guidance No. 16 on Deprivation of Liberty Safeguards* (5 December 2014), the view is expressed that any person subject to "an authorised deprivation of liberty" comes within the CJA 2009's definition of "state detention" and that, therefore, the death of any such person should be the subject of a coronial investigation. As, however, the Chief Coroner was anxious to underline, this was not a judgment or ruling but simply the expression of an opinion and subject to a decision of the High Court. The Law Commission's *Consultation Paper on Mental Capacity and Deprivation of Liberty* (paper No. 222), at para. 15.47, recognises that there has been debate about this view but expresses agreement with it.

62. As already suggested, the existence or non-existence of a DOLS authorisation is not determinative – save that if one has been granted it shows that those who sought and gave the authorisation: (1) have taken the view that in their best interests the relevant person has been or should be deprived of his liberty by a public authority and so in that sense (2) have made a decision to detain the patient in his best interests.

63. The *Intensive Care Society (*"ICS"*)* has itself provided revised Guidance, *Deprivation of liberty in intensive care* (2014). This revised Guidance, seeking to ensure compliance with *Cheshire West*, includes the following passage:

> " The acid test framed by the Supreme Court was not decided in the intensive care setting. However, the concept of a deprivation of liberty is not context-specific, so is capable in principle of applying in this setting. Due to their circumstances, most patients in intensive care units would seemingly fit the 'acid test' criteria, and it could therefore be construed that we are depriving them of their liberty. This is supported by a recent case ….[*NHS Trust v G (supra)*]…in which a judge applied the Cheshire West acid test to a maternity unit in a general hospital."

64. The *Department of Health* ("DOH") highlighted a number of concerns in an "*Update*" (dated 14th January, 2015) on the MCA 2005, linked in terms to *Cheshire West*. The DOH drew attention to the very significant increase in DOLS applications following *Cheshire West* – over 55,000 applications in the six months following the judgment pointed to a more than 8 fold increase on 2013-14 figures. The DOH went on to say this:

> " The Supreme Court judgment continues to have a number of knock-on implications in addition to the increase in applications. In all these cases, our priority is to establish a proportionate approach that prioritises the well-being of the individual who may lack capacity; considers closely the wishes and feelings of family, friends and carers; which ensures the system as a whole focuses on delivering care, support and scrutiny that benefits the individual. In short, we do not wish a system that puts paperwork before people. *"*

It may be noted that the DOH did not consider a state of unconsciousness <u>in itself</u> as constituting a mental disorder; accordingly, the DOH "would not consider that an individual who is unconscious and who does not have a mental disorder would be eligible for a standard authorisation".

65. Finally, we were referred to the *Law Society Practical Guide* (already mentioned in the context of Ms Butler-Cole's submissions). This guide posed the question as to whether *Cheshire West* furnished a test of universal application. Professionals needed

to proceed with caution, on the basis that the acid test did apply, unless a legal basis could be identified for concluding that it did not. With regard to a hospital setting, the Guide said this:

> " 4.7 When considering whether a patient is 'free to leave' for the purpose of the acid test the focus should not be on whether a patient is actually physically capable of leaving, but rather upon what actions hospital staff would take if for example family members, properly interested in their care, sought to remove them from the hospital. "

The Guide went on to observe (at para. 4.28) that the majority of patients in ICUs lack capacity to make decisions about their care and treatment during some or all of their stay. However, the application of the "acid test" to patients in these circumstances was likely to require "further judicial consideration….in due course".

DISCUSSION

66. I remind myself as to the nature of our task. It is not to attempt exhaustive guidance as to the circumstances in which *Cheshire West* is applicable. It is instead to decide, on the facts of this case, whether the Claimant can make good her complaint that the Coroner's Decision was *Wednesbury* unreasonable and/or entailed a misdirection in law in concluding that he was not bound to empanel a jury for the inquest. Put another way, must the Coroner have had reason to suspect that Maria died "in state detention", thus while "compulsorily detained" by the hospital?

67. I take as my starting point the wording of the statute. As it seems to me and unless driven to take a different approach, the language of the CJA 2009, "in state detention" and "compulsorily detained", should be given a readily understood, natural and ordinary meaning. So far as dictionaries assist, the connotation is supplied by the OED's first definitions of "detention", namely, "Keeping in custody or confinement; arrest…." and of "compulsorily", namely, "Produced by or acting under compulsion…". For completeness, "compel" is defined as "To urge irresistibly, to constrain, oblige, force…". All this suggests the need for an act or decision by a third party, overriding the freedom of choice of the individual thus detained.

68. Turning to the legislative purpose of the CJA 2009, I agree with Mr. Hough's submission: the CJA 2009 was aimed at breaking down artificial distinctions between different forms of state custody. While in no way determinative, this conclusion is reinforced by the wording of the Explanatory Notes to the Bill (referred to above), *viz.*,"….such as while the deceased was detained in prison, in police custody or in an immigration detention centre, or held under mental health legislation, irrespective of whether the detention was lawful or unlawful".

69. Accordingly, as a matter of language and context but without reference to the jurisprudence relating to Art. 5 ECHR, I would construe the wording "in state detention" and "compulsorily detained" as meaning a confinement imposed by a public authority, overriding the relevant person's freedom of choice; in short, detention properly so called, by the state, in whatever form.

70. The context of and the issues involved in the relevant Art. 5 Strasbourg jurisprudence and *Cheshire West* have already been explored. The mischief addressed by these decisions is plain: it is the concern as to the arrangements made, sometimes for years on end, for those suffering from mental incapacity. Taking *Cheshire West* as an example, the issue went to the need for periodic independent scrutiny of the living arrangements made for those with such mental incapacity. It is that need which

warrants invoking the routes provided by the MCA 2005 pursuant to which persons lacking capacity to make the relevant decisions themselves may be lawfully deprived of their liberty for treatment and care. The justification in such cases for the cost and bureaucracy inevitably involved in the various applications, authorisations or administrative decisions, is, as explained in *Cheshire West* (at [1]), "…a recognition that human rights are for everyone, including the most disabled members of our community…".

71. Mr Hough alluded to the difference in wording between the CJA 2009 and Art. 5. If that difference in wording is of real significance, then this, of itself, constitutes a short answer to the suggested application of *Cheshire West* when construing the CJA 2009. There is some force in the argument that the difference in language reflects a difference in meaning, The policy considerations underlying Art. 5 and *Cheshire West* have already been outlined. They are not the same as the considerations of policy which require an inquest to be held with a jury under the CJA 2009. The first concern the scrutiny required of living conditions; the second concern the particular form of scrutiny required when death occurs in specified circumstances. Accordingly, there is a case to be made that the natural, ordinary meaning of the wording in the statute, "state detention" and "compulsorily detained" may diverge from the interpretation of deprivation of liberty furnished by *Cheshire West*; put another way, they need not be the same. Approached in this way, particular importance may be attached to the wording "*compulsorily* detained" in the CJA 2009 as limiting those situations where an inquest with a jury is mandatory.

72. There are, however, considerable difficulties with the argument that significance is to be attached to the difference in wording between the CJA 2009 and Art. 5. First, in the present context, there are powerful arguments for treating "in state detention" and "compulsorily detained" under the former as having an essentially similar meaning to "lawful detention" and "deprived of ….liberty" under the latter. As a matter of common sense, those deprived of their liberty by the state have been detained or compulsorily detained by the state. The single word "compulsorily" will not bear too much weight. Secondly, the development of diverging lines of authority based on the absence of the word "compulsorily" in Art. 5, cannot be a welcome prospect. Thirdly, examples do not readily spring to mind of deprivation of liberty by the state under Art.5 which would not constitute "state detention" as defined in the CJA 2009.

73. Weighing these arguments, I have come to the view that "state detention" as defined in the CJA 2009 and deprivation of liberty under Art. 5 have essentially similar, if not necessarily identical, meanings. That conclusion does not preclude the possibility that there may be some situations constituting deprivation of liberty, as interpreted by *Cheshire West*, which do not *necessarily* amount to "state detention" under the CJA 2009. However, that is not this case and, in the present context, I am unable to accept that the answer is to be found by distinguishing "state detention" as defined in the CJA 2009 from deprivation of liberty under Art. 5.

74. Instead, in my view, the key to the proper scope of ss. 7(2)(a) and 48(2) of the CJA 2009 and to ensuring coherence with the Art. 5 jurisdiction lies in an intense focus on context and on the "concrete situation" (*HL v United Kingdom, supra*) before the court.

75. As already foreshadowed, the "acid test" suggests that the principle of *Cheshire West* is capable of application or extension to patients in some hospital or ICU settings.

76. But, in my respectful view, the notion that *Cheshire West* requires treating all patients in an ICU (and other hospital settings) for more than a very brief period as subject to a deprivation of liberty provided only that they lacked capacity to consent to the

particular stage of treatment, would involve a wholesale extension rather than an application of that authority. Again with respect, any such extension would be mechanistic, unwarranted and divorced from the mischief *Cheshire West* was seeking to address.

77. First, it would not draw any distinction between patients with and those without any previous mental incapacity. On this footing, prior mental incapacity has no impact on the creation or continuation of the concrete situation – so rendering a comparison between those with and without such capacity irrelevant and unnecessary. This itself furnishes a stark contrast between the generality of such cases and the issue addressed in *Cheshire West*.

78. Secondly, it would break still further new ground. As already noted, the cases in the Strasbourg Court have not addressed treatment for physical disorders, unconnected to the patient's mental disorder. In this regard it is perhaps not without significance that one of the reasons for the Strasbourg Court's decision in *Nielsen v Denmark (supra)* was that the conditions pertaining to the applicant there did not in principle differ from those applying to children with physical disorders in an "ordinary" hospital. For this purpose it is neither here nor there that considerable controversy attaches to *Nielsen v Denmark.*

79. Thirdly, and as earlier underlined, the practical consequences would be significant. So far as concerned Coroners, as Mr. Hough submitted, they would come under a duty to hold unnecessary inquests and the number of inquests requiring a jury would itself increase substantially. As to hospitals, every ICU would need to spend time and money on establishing a system for invoking one or other of the routes provided by the MCA 2005 (or the court's inherent jurisdiction) for lawfully depriving patients of their liberty for treatment and care. While the time and cost of any individual application or authorisation may well be trivial, the costs to the system would not be, in terms of the diversion of treating teams from their treatment of patients, administrative time and money - all the more so because hospitals would be bound to err on the side of caution. None of this additional burden would be justified by the policy considerations underpinning the majority decision in *Cheshire West*, arising from its context and the issue with which it was concerned.

80. Fourthly, any such wholesale extension would also seem to overlook that a person who lacks capacity to consent to a particular treatment can be treated on a best interests basis (s.5 of the MCA 2005) without, *ipso facto*, being deprived of his liberty or compulsorily detained. Plainly, a fact sensitive inquiry is required.

81. Thus, by contrast to the "ordinary" case of a patient with or without prior mental incapacity in an ICU, there are, no doubt, other situations where the principle of *Cheshire West* may well be applicable (always depending on the "concrete situation"). Examples which come to mind include instances where there is a serious debate as to the proper treatment (*cf. NHS Trust I v G, supra*) or active resistance from family members to a particular course of treatment. No doubt there are others but it is unnecessary to explore them further here, save to underline that difficult factual questions may arise as to whether individual cases fall on one or the other side of the relevant line.

82. I return to the facts of the present case, which, though crucial, can be addressed relatively briefly. I state my conclusion at once: I am unable to accept that the Coroner's Decision was either *Wednesbury* unreasonable or that he misdirected himself in law. For that matter, though it is unnecessary to go so far, I agree with the Decision. My reasons follow.

83. First, it is right to repeat the test. The Coroner's Decision was that he did not find reason to suspect that Maria was "in state detention" (i.e., "compulsorily detained") when she died. For the Claimant to succeed she must make good not simply that another coroner could properly have reached a different conclusion but that the Coroner's Decision was *Wednesbury* unreasonable and/or disclosed a misdirection of law. Nothing less will do.

84. Secondly, I am not persuaded that the language of the Decision discloses an error of law on the part of the Coroner in supposing that there could not be detention or a deprivation of liberty without a formal order or authorisation – a conclusion which would run counter to his observation, in terms, that, in principle, a patient or care home resident could in practice be detained without proper authorisation. While, with respect, the matter could certainly have been expressed differently, I am satisfied that the Coroner was doing no more than point to the absence of a formal order or authorisation as supporting, evidentially, his view that Maria had not been in state detention or compulsorily detained at the time of her death. Understood in this way, there is no error of law – whatever the weight to be attached to the absence of a formal order or authorisation, in any event, a matter for the Coroner.

85. Thirdly, with regard to the period prior to the night of 2nd/3rd December, the totality of the materials available do not require a conclusion that the hospital staff refused to allow Maria to leave or would have done so had the Claimant pressed the issue. I have not overlooked the Claimant's evidence as to her understanding that had she attempted to remove Maria she would have been stopped. To my mind that, purely subjective, understanding is outweighed by the consistent evidence from the medical staff as to continuing consideration of Maria's discharge and the intention to discharge her "once safe to do so". The reality was that the Claimant was well aware of this and for sound, caring and compelling reasons based on her assessment of the medical advice and Maria's best interests accepted that she should remain in hospital. On any view, the Coroner was entitled to conclude that there had been no refusal at this time to discharge Maria. Further still, whatever view was taken of the situation prevailing prior to the night of 2nd/3rd December it would, in my judgment, have become academic after the events of that night and Maria's admission into the ICU.

86. Fourthly and in my judgment, the Coroner was entitled to conclude that Maria had not been "detained" or "compulsorily detained" subsequent to the night of 2nd/3rd December. As a matter of ordinary language, it would be wholly artificial to say that thereafter Maria had been kept in custody or confined by the state. It would neither accord with the facts of the case nor the common sense approach adopted by Taylor LJ in *Linnane (supra)*. As Mr Hough submitted, the reality was that Maria remained in the ICU, not because she had been detained or deprived of her liberty but because for pressing medical reasons and treatment she was unable to be elsewhere. There is no evidence whatever of a decision by the hospital other than to admit Maria to the ICU and to attempt life-saving treatment.

87. As it seems to me, it is fanciful in this case to suppose that the Claimant would have sought to remove Maria from the hospital while she was undergoing treatment in the ICU and therefore idle to consider what the hospital's response would have been. I cannot accept that, as submitted by Ms Butler-Cole and suggested by the *Law Society Practical Guide*, the hospital's potential response to an unasked question – and one which could not sensibly have been asked – by itself constitutes or evidences a deprivation of liberty. In passing, the imposition of a requirement for court proceedings or a DOLS process in such a situation – the more especially where a devoted family member is already actively involved – would be both unnecessary and potentially very damaging to the therapeutic relationships involved.

88. Fifthly, the facts of this case do not disclose any deprivation of Maria's liberty, whether before or after the night of the 2nd/3rd December. Nor did the facts begin to amount to detention or compulsory detention of Maria by the hospital.

89. Accordingly, I would dismiss the Claimant's claim for judicial review of the Coroner's Decision.

Charles J:

INTRODUCTION

90. It is axiomatic that the sole issue for us in this case is whether the Claimant's challenge is well founded but unless the reasoning of the decision can be confined to the application of the CJA 2009 it will be relevant to the approach to be taken by hospitals and others to the determination of whether someone is deprived of their liberty. It would therefore be relevant to a number of issues that are actively under consideration and discussion (see, for example, the Law Commission's Consultation Paper) on Mental Capacity and Deprivation of Liberty (paper No 222 – the Law Commission Paper).

91. Unlike Gross LJ, I have concluded that this application can be dismissed on reasoning based on the application of the CJA 2009. After some introduction under headings used by Gross LJ, I will address the meaning and application of the CJA 2009 before turning to the direct application of Article 5.

92. If my conclusion on the CJA 2009 is wrong, my reasoning on the application of Article 5 and so *Cheshire West* differs from that of Gross LJ but I do not think that the differences give rise to a conflict. Certainly they lead to the same result.

THE CORONIAL LEGISLATION AND ARTICLE 5

93. The relevant provisions have been set out and commented on by Gross LJ at [5] to [14]. I agree with his preliminary comments.

94. As to the fourth comment [12], I add that the examples given are cases where the patient cannot weigh competing factors relating to the treatment, or reach and convey his informed view on them. In short, the patient cannot exercise his freedom of choice (his autonomy) for reasons that are not connected to his capacity before the onset of his physical disorders, their consequences and/or their treatment and its consequences.

95. The preliminary comment at [12] that it would be remarkable if the right to liberty and security of any such patient was being infringed gives rise to the following questions:

    i) Why is that so?

    ii) Why should the fact that a person was of "unsound mind" before the accident or deterioration make any difference?

96. Having regard to the purpose and the language of the CJA 2009, I consider that it would be surprising if Parliament had intended when passing the CJA 2009 that:

    i) An inquest must be held into the death of an elderly person in a care home whose cause of death has been established and found to be natural:

a) if objectively assessed their care package amounted to a deprivation of liberty applying *Cheshire West* and if they lacked relevant capacity to consent to that package (e.g. because of dementia), but not

b) if they had the capacity to consent to the package but no real choice about where they lived (e.g. because care and support at home or with family was not available), and

ii) an inquest must be held with a jury in respect of all people who died in hospital in the circumstances described in [12] of Gross LJ's judgment.

THE FACTS

97. These are set out by Gross LJ at [15] to [24]. That account of the history shows that the issue whether Maria was deprived of her liberty can be assessed by reference to the position before and then after the night of 2nd /3rd December 2013. We are directly concerned with the position at the time of her death and so the position after that night.

PATIENTS WITH A MENTAL DISORDER AND PATIENTS WHO LACK CAPACITY TO CONSENT TO THEIR CARE OR TREATMENT

98. Gross LJ discusses this at [32] to [39].

99. In the context of s.4(A)(3) of the MCA the relevant order is a welfare order under s. 16(2)(a) by which the Court of Protection makes the relevant decision on P's behalf. I add that when the MCA does not apply because the person does not lack capacity (as defined) but is vulnerable the High Court can authorise a deprivation of liberty in exercise of its inherent jurisdiction.

100. For the DOLS to apply, in addition to the "eligibility requirement" both the "mental health" and the "mental capacity" requirements must be satisfied. To satisfy the mental health requirement P must be suffering from "*a mental disorder (within the meaning of the MHA, but disregarding any exclusion for persons with learning disability)*" (see paragraph 14 of Schedule A1 to the MCA).

101. This mental health requirement effectively introduces a jurisdictional limit for the DOLS that is narrower than the trigger to the general capacity-based jurisdictional limit of the MCA which covers "*persons who lack capacity by reason of an impairment of, or a disturbance in the functioning of, the mind or brain that is permanent or temporary to make the relevant decision*" (see s.2(1) of the MCA). The full extent of the differences between those jurisdictional limits may be clarified in future cases but, it is at least arguable that the DOLS mental health requirement means that a DOLS authorisation cannot be given for people in a permanent vegetative state or a minimally conscious state caused by a concussion or brain injury, or who are incapacitated by head injury or by alcohol or drugs or the effects of a physical disorder and/or its treatment (see for example [2.61] of the Court of Protection Practice 2015 and [7.3] and [7.4] of the Law Commission Paper).

102. In contrast, the definition of capacity in the MCA gives the Court of Protection jurisdiction to make welfare orders that authorise a deprivation of liberty of persons whose lack of capacity is caused by a brain disorder and so who do not satisfy the DOLS mental health requirement. This is because Schedule 1A (where ineligibility is defined) does not provide that a person is ineligible if they do not satisfy the DOLS mental health requirement. Rather, in broad terms ineligibility is defined by reference to classes of people ascertained by reference to the MHA with the result that if a person is not in any of those classes they are not ineligible and so, provided they lack

the relevant capacity as defined by s. 2(1) of the MCA, they can be the subject of a welfare order made by the Court of Protection that authorises a deprivation of their liberty. (So I do not agree with [7.5] of the Law Commission Paper).

103. The "mental capacity requirement" for the application of the DOLS applies the general MCA jurisdictional limit on capacity to the question whether or not the person should be accommodated in the relevant care home or hospital for the purpose of being given the relevant care or treatment. Some people who have a mental disorder, and so who satisfy the mental health requirement, may have the capacity to make the relevant decision and so not satisfy the mental capacity requirement. In *NHS Trust I v G* it seems that the patient satisfied the DOLS mental health requirement although the application was looked at through the prism of an application to the court.

104. The overlap between s.4(B) and s.4(A)(5) has not been explored by the courts. It may be that s. 4(B) is intended to cover a short period in serious medical treatment cases that should be referred to the Court of Protection. But, in any event, s.4(B) or s. 16 (or the inherent jurisdiction if [7.5] of the Law Commission Paper is right) would have to be used if the patient did not satisfy the "mental health requirement". Victims of accidents, and patients whose condition deteriorated significantly at home, who are admitted to ICU may well not satisfy that requirement with the result that the DOLS would not apply to them and only a court can authorise their deprivation of liberty.

105. All of the DOLS, the Court of Protection and the High Court routes react to and authorise rather than create an objectively assessed deprivation of liberty and all require that the best interests test set by the MCA is satisfied.

106. The underlying approach to the application of the best interests test whenever it arises is reflected in paragraph 18 of the judgment of Lady Hale in *Aintree University Hospitals NHS Trust v James* [2013] UKSC 67, [2014] AC 591 where she says that the MCA:

> ----- is concerned with doing for the patient what he could do for himself if of full capacity but it goes no further,

107. In doing that, like a person with capacity, the Court of Protection, the High Court and decision makers under the DOLS applying the "best interests" test can only choose between available options (see *ACCG and Another v MN and Another* [2013] EWHC 3895 (CoP) and in the Court of Appeal [2015] EWCA Civ 411 in particular at paragraph 46 of the judgment of Munby LJ). In the context of the DOLS, this element of choice and the underlying approach of the MCA is reflected by paragraph 3 of Schedule A1. This provides that any person (D) does not incur liability for any act which he does for the purpose of detaining (P) pursuant to paragraph 2 thereof if he would not have incurred liability for that act if P had the capacity to consent to it and had consented to it.

108. While the language of the MCA 2005 is hardly straightforward, it follows:

i) that as Gross LJ says at [39] the need to draw a distinction between that which does and that which does not constitute a deprivation of liberty is inescapable in deciding whether particular care or treatment is protected by s.5; and that as protected by s.5, some care and treatment of a person lacking capacity as defined by s.2(1) of the MCA may be undertaken on a "bests interests" basis without that care or treatment comprising a deprivation of liberty. So, treating teams and hospital administrators need to have guidance on what constitutes a deprivation of liberty;

ii) that, by s. 4B the MCA contemplates the existence of, and provides safeguards in respect of, life saving or vital care and treatment that creates a deprivation of liberty;

iii) that, in the case of a hospital a deprivation of liberty of a person who lacks capacity can be authorised under the DOLS through the giving of an urgent authorisation (for a limited time) or a standard authorisation provided that the DOLS requirements including the "mental health requirement" are satisfied and so the patient is suffering from a mental disorder (within the meaning of the MHA, but disregarding any exclusion for persons with learning disability);

iv) that, in many urgent situations a hospital will not know whether the patient satisfies that mental health requirement. In some situations it will know whether or not prior to the treatment for physical disorders the patient did or did not satisfy that requirement and in other situations there may be room for argument about this;

v) that, the exchanges during the hearing on there being a possible need for a pile of DOLS urgent authorisation forms in ICU units do not reflect the full extent of the problems that would have to be faced by treating teams and hospitals if a significant number of their patients are deprived of their liberty because many of them will not satisfy the DOLS "mental health requirement",

vi) that, authorisation under the DOLS or by the Court of Protection is only available if the relevant person lacks capacity as defined by s. 2(1) of the MCA, and

vii) that, the autonomy of persons with capacity and the available alternatives they could choose from is the benchmark for the choices open to the MCA decision maker and the court in applying the "best interests" test.

ART. 5 ECHR

109. I agree with Gross LJ that five authorities suffice. I gratefully adopt his summary and agree with his interim observations at [40] to [47].

110. I add the following further interim observations:

(1) I accept that as stated at [8.14] of the Law Commission Paper that the ratio of *Cheshire West* in respect of the concrete situations it was addressing is to the effect that (a) reason or purpose behind the treatment, (b) compliance with the treatment, (c) lack of objection, (d) family/carer's agreement, (e) appropriateness or "relative normality" of the treatment, and (f) lack of an alternative safe place for treatment are all not relevant when considering whether on an objective assessment a deprivation of liberty is occurring.

(2) The existence of a DOLS authorisation or an application for one is only relevant either (a) as an indication that there is a deprivation of liberty because the relevant decision makers under the MCA have reached that conclusion, and/or (b) if, and to the extent that, the subjective conclusion of the relevant people at the hospital (including the treating team) is relevant to the determination of whether either (i) the patient is deprived of his liberty for the purposes of Article 5, or (ii) the patient has been compulsorily detained for the purposes of the CJA 2009.

(3) Factors relating to a case involving care and treatment for physical disorders and the combined effects of those disorders and their treatment that distinguish it from both:

(i) one involving care and treatment for mental disorder, and

(ii) one involving the care and placement of a person who lacks capacity prior to the onset of the relevant physical disorders

are that in the former (a) the mental capacity of the patient will not have any effect on the nature and effects of the treatment and care, and (b) the reality or concrete situation on the ground may well be that the physical condition and the package of treatment for it means that a patient with capacity who has not given prior consent to it could not exercise his autonomy by refusing it and leaving the hospital.

(4) With the proviso that P is not ineligible to be deprived of his liberty under the MCA, the approach taken in relevant guidance and in the cases (e.g *J v Foundation Trust* [2010] Fam 70 and *NHS Trust I v G (Ct of Protection)* [2014] EWCOP 30; [2015] 1 WLR 1984) to the amendments that introduced the MCA routes to the authorisation of a deprivation of liberty, is that they can apply to a package of care or treatment for physical disorders suffered by a person who lacks capacity as defined by s. 2(1) of the MCA. This approach is reflected in Chapter 8 the Law Commission Paper (see in particular [8.10] to [8.19]). But I am not aware of a case in which the overlap between (a) "persons of unsound mind", (b) the DOLS "mental health requirement" (and so the definition of "mental disorder" in s. 1 of the MHA) and (c) the DOLS "mental capacity requirement" (and so the definition of capacity in s. 2(1) of the MCA) has been addressed or decided.

(5) At first sight it is not obvious which of the cases/exceptions listed in Article 5.1 applies to a person with capacity before the onset of the combined effects of physical disorders and their treatment that result (a) in him not being able to weigh competing factors and give consent to his treatment, and (b) in him being deprived of his liberty on a *Cheshire West* objective assessment. The only candidate would be Article 5.1(e) on the basis that the combined effects of his physical disorders and their treatment on his mind or brain have the result that he was of "unsound mind".

(6) In *Winterwerp v The Netherlands* (1979-80) 2 EHRR 387 at [37] the Strasbourg Court points out that the Convention does not state what is to be understood by "persons of unsound mind", that the term cannot be given a definite interpretation and its meaning will evolve as research in psychiatry progresses and treatments for and attitudes towards mental illness change. Notwithstanding this focus on mental illness the premise of the arguments before us was that a person who lacks capacity as defined by s. 2(1) of the MCA is a person of unsound mind within Article 5.1(e).

(7) Without deciding the point I proceed on the basis that that premise is correct and so on the basis that Article 5.1(e) covers a wider class of people than those who satisfy the DOLS "mental health requirement".

(8) A person with capacity can forego his Article 5 right not to be deprived of his liberty and so the benefit of that Convention protection by giving consent (see *Storck* at [74] and [77]).

DISCUSSION

111. The alternative lines of argument advanced to us on the meaning and application of the CJA 2009 have a direct or indirect impact on whether Maria was (and others in her position and in different positions would be) deprived of their liberty.

112. This is because, in my view correctly, the parties proceeded on the basis that whether a person is being detained by a public authority falls to be determined by an application of the Strasbourg and domestic authorities on Article 5 (which uses the word detention in the sub-paragraphs of Article 5.1).

113. One line of argument was primarily directed to the question whether on an objective assessment Maria was or was not being deprived of her liberty. This line of argument effectively assumed that she could not give a valid consent because she lacked the capacity to do so. The cause of that lack of capacity was not a focus of the argument. A conclusion on this line of argument would be directly relevant to whether or not others in her situation would be being deprived of their liberty. The reasoning for such a conclusion would also be relevant to the issue whether persons in a wide range of different situations were or were not:

    i) being deprived of their liberty, and

    ii) in state detention for the purposes of the CJA 2009 when they died.

114. The other main line of argument was primarily directed to the impact of the language of the CJA 2009 and so, given the accepted application of Article 5 to the determination of whether a person is detained, to the word "compulsorily" in the definition of state detention. The argument is that if we were to decide or assume, applying the Article 5 jurisprudence, that objectively Maria was detained by a public authority when she died, she was nonetheless not "compulsorily" so detained. If this argument is accepted it would have a much wider impact on the application of the CJA 2009.

The meaning and application of the CJA 2009

115. "State detention" is defined by ordinary English words and so the language of that definition "compulsorily detained" should be given its natural and ordinary meaning in the context and having regard to the purposes of the CJA 2009. The relevant dictionary meanings are given by Gross LJ at [67].

116. As a matter of ordinary English "compulsory" adds to or describes a "detention" and introduces the need for some act or decision by a third party that overrides the informed freedom of choice of the individual by forcing the detention upon them.

117. Turning to the legislative purpose of the CJA 2009, like Gross LJ at [68] I agree with Mr. Hough's submission that the CJA 2009 was aimed at breaking down artificial distinctions between different forms of state custody.

118. Accordingly, as a matter of language and context but without reference to the jurisprudence relating to Article 5, I would (like Gross LJ at [69]) construe the wording of the relevant definition "compulsorily detained" in the sense of a confinement that is imposed by someone else in a way that overrides the relevant person's informed freedom of choice. But I do not agree that that meaning should be shortened to "detention properly so called by the state, in whatever form" because although in many cases it would not matter if the two words in the definition are so elided this short hand does elide the two words and so fails to properly recognise that (a) Parliament used the word "compulsorily", and (b) the use of that word can add to the meaning of "detained".

119. Mr Hough argued that there had to be at least, a decision to detain, .to confine a person to a place or places from which he was not free to leave. As a matter of ordinary language there is considerable force in that submission. However, in my view its general application to the determination of whether there has been a

deprivation of liberty in breach of Article 5 is excluded by *Cheshire West.* This is because it is incompatible with an objective approach that treats the reasons for putting the care package into place, and thus the views and decisions of the hospital and the supervisory body, as irrelevant considerations.

120. I also acknowledge that those features of the approach in *Cheshire West* mean that in the determination of whether judged objectively there is a deprivation of liberty for the purposes of Article 5, and so of whether the relevant person is free to leave, a distinction between a process of law that impels or authorises the creation of the circumstances on the ground is not relevant. This is in line with the approach in *Winterwerp* where the national law authorised rather than enjoined the confinement.

121. Accordingly, the line of argument based on the CJA 2009 has to be founded on the impact of the word "compulsory" and on there being a distinction between a compulsory Article 5 detention and an Article 5 detention.

122. At first sight that seems unattractive because both result in the relevant person not being "free to leave" because of decisions taken by others and so in something that effectively enforces or compels that result.

123. Further, in the context of the subjective element of Article 5, and so the consideration of whether the consent of the relevant person means that his Article 5 right to liberty has not been infringed:

i) the right to liberty is so important that the fact that the person has given himself up into detention does not of itself mean that he has consented to it (see *HL* at [90] and *Storck* at [75]),

ii) consent cannot be inferred in the case of a person who lacks the capacity to give it (see *HL* at [90], and

iii) the consent must be sufficiently free and unfettered (see, for example, *De Wilde and Others v Belgium* (1979-80) 1 EHRR 373 at [65], *I.I. v Bulgaria* (Application No: 44082/98 at [87] and *Secretary of State for Justice v RB* [2010] UKUT 454 (AAC) at [62]).

I have addressed the *RB* case on an obiter basis in *Secretary of State for Justice v KC* [2015] UKUT 0376 (AAC) at [124] to [132] and in my view, for the reasons given there, it is relevant to consider whether there was a real choice.

124. So in determining whether there is an Article 5 detention (and so the combination of its objective and subjective elements) the authorities show that factors relating to the circumstances in which a consent that is relied on to found the result that the person has foregone the Article 5 right to liberty, and so it is not engaged or infringed, are relevant and can lead to the conclusion that:

i) there is not an Article 5 detention, or

ii) there is an Article 5 detention because in all the circumstances the concrete situation on the ground is mandatory as opposed to contractual or consensual (the language used in the *De Wilde* case).

125. But this approach to the subjective and objective elements does not mean that all Article 5 detentions are compulsory in the sense that an analysis of all the relevant circumstances shows that they are based (or are effectively based) on a unilateral and imposed decision of the person effecting the detention. Rather, it confirms that:

i) the existence or non-existence of an effective consent and, more generally how the concrete situation on the ground was created, are or can be relevant, and

ii) as with other factors that are relevant to whether there is a deprivation of liberty for the purposes of Article 5, and the fulfilment of the requirements of Articles 5.1 and 5.4, the impact of these factors and so the circumstances relating to compliance and/or an inability to give a consent is fact and circumstance sensitive (see *Storck* at [71]).

126. This approach in the authorities to determining whether there is breach of a person's Article 5 rights reflects the list of the exceptions in Article 5.1 because they cover a range of situations some of which, as a matter of the ordinary use of language, will always lack any consensual element and so inevitably fall within the primary meaning of the word "compulsory" (e.g. the exception in 5.1(a)). Whereas, others could be based on a decision made by or on behalf of or to promote the best interests of the relevant person (e.g. the exception in 5.1(e)).

127. So, in my view, the use by Parliament of the word "compulsorily" in the definition of state detention in the CJA 2009 is not redundant or merely reflective of an objectively assessed Article 5 detention in which a consent given by or on behalf of the relevant person is irrelevant This is because the use of that word recognises and reflects the points that:

i) the subjective element is relevant to the question whether the State's obligation under Article 5.1 arises and so to the determination of whether a person is deprived of his liberty within the meaning of Article 5.1,

ii) on an objective assessment:

a) some detentions within Article 5 (and more generally) are "compulsory" in its primary sense that they are imposed in a way that overrides the relevant person's informed freedom of choice, and

b) some detentions are not because they are based on a consent or substituted consent of the relevant person (and so decisions made by or on behalf of, or to promote the interests of, that person) , and

iii) when the subjective element is taken into account some of the objective non-compulsory detentions referred to in sub-paragraph (ii)(b) will give rise to an Article 5 detention and others will not.

128. As a matter of the ordinary use of language on the assumption that all of the following are on the correct application of *Cheshire West* objective detentions within Article 5 none of them fit with the primary meaning of the words "compulsory Article 5 detention":

i) a deprivation of liberty (detention) that is founded on a need for physical treatment that the patient cannot give consent to, because it is based on the perceived need for the concrete situation on the ground rather than its imposition by another,

ii) a lawful deprivation of liberty (detention) that is founded on a substituted decision made on behalf of and in the best interests of a person who lacks capacity because it has a consensual rather than an imposed base, even if there

is no real choice after the possible choices have been properly considered and decisions have been made on their availability, and

iii) a consent to the least restrictive available option and the deprivation of liberty it causes by a person with capacity in his own best interests, because he has consented to the objectively assessed deprivation of liberty.

129. Further, in my view, those examples indicate that giving effect to the word "compulsorily" in the statutory definition in the sense that it limits detentions to those that are imposed in a way that overrides the relevant person's informed freedom of choice would:

i) promote the underlying intention and purposes of the CJA 2009 which is directed to safeguards after death, and

ii) avoid the consequences referred to in [96] above.

130. As I explain later, in my view it would be wholly artificial to say that at the time of her death Maria was **compulsorily** detained. Her freedom of choice had not been overridden in any sense and nothing had been unilaterally imposed on her, rather:

i) there was no dispute about her need for treatment for her physical disorders,

ii) the decisions about it were based on what was thought to be the best ways to promote her best interests in the treatment of her physical disorders, and thus that need, and

iii) the effects of her physical disorders and their treatment meant that she, like anyone else suffering the same physical disorders and having the same treatment was unable to be elsewhere or to give an informed consent to that treatment and its consequences on her freedom to leave the hospital .

131. This conclusion is focused on the facts of this case at the time of Maria's death and the common sense approach adopted by Taylor LJ in *Ex p Linnane*. It means that the Coroner did not err in law and this application should be dismissed.

132. However, my reasoning would found a wider rationale for giving this meaning and effect to the word "compulsorily" in the application of the CJA 2009 which would address the much wider consequences of the arguments based on an application of *Cheshire West* and thus on the foundation that the factors listed at [110(1)] are irrelevant:

i) advanced by the Claimant, namely that anyone who lacks capacity to consent to their care package and who dies in circumstances that amount to a *Cheshire West* objective deprivation of liberty dies in "state detention", and

ii) advanced by the Coroner, in line with his general advice, that a person who dies when subject to a DOLS authorisation, dies in "state detention".

Those wider consequences are that many elderly people who live and die in care homes or on the approach in *Ex p Linnane* after a brief move to a hospital or a hospice will die in state detention.

133. As I have said earlier at [96], I do not consider that this is a result that Parliament would have intended when it enacted the CJA 2009.

134. The possible rationale to avoid that result in the application of the CJA 2009 is that a process of law based on best interests and substituted decision making on behalf of a person who lacks capacity is not one that creates a "compulsory" detention because it does not override the relevant person's informed freedom of choice but exercises it for them.

135. This possible rationale was not argued before us in this context and so I do not base this part of my decision on it.

Article 5 detention

136. This is the line of argument relied on by Gross LJ who does not agree with my conclusion on the CJA 2009.

137. The mischief addressed in *Cheshire West,* and the cases referred to in it, is identified by Gross LJ at [70]. As he points out, the justification in such cases for the diversion of resources, cost and bureaucracy inevitably involved in the various applications, authorisations or administrative decisions, is, as explained in *Cheshire West* (at [1]), "…a recognition that human rights are for everyone, including the most disabled members of our community…".

138. That recognition reflects the point that the rights given by Article 5 (and Article 8) are directed to freedom (including freedom of choice and so autonomous self determination) and that such autonomy is an aspect of the essence of both the Article 5 right to liberty and security of person and the procedural safeguards required to promote it under consideration in *Cheshire West.*

139. The point that the essence of Article 5 includes the promotion and safeguarding of a person's autonomy is reflected by, and finds its natural home in, the subjective element of the determination of whether there has been an Article 5 deprivation of liberty and the frequent references in the cases that a person must not be deprived of his liberty in an arbitrary manner.

140. In my view, the recognition I have mentioned in *Cheshire West* of the autonomy aspect of the essence of Article 5 is an accepted part of the background to much of the approach and reasoning therein to the objective assessment of whether there is a deprivation of liberty of persons who lacked capacity to consent to the care package that governed their living arrangements and lifestyle and so, in the case of the majority, its conclusions that:

    i) the relevant comparison for an objective assessment of the effect of circumstances on a person who lacks capacity to consent to them is with someone who (a) has that capacity, and (b) does not have disabilities that mean that, in their best interests, they need the help, assistance or supervision, provided by the relevant care package and accordingly that the reasons for the relevant care package do not matter,

    ii) the compliance of a person without the relevant capacity is not relevant, and

    iii) the policy considerations (see [57] of *Cheshire West*) founded the view that the Supreme Court should err on the side of caution and conclude that the circumstances under consideration amounted to a deprivation of liberty because then they would be subject to periodical checks.

141. Alternatively, if the autonomy aspect of the essence of Article 5 is not an accepted part of the background to that conclusion, in my view, as it was not a relevant factor in *Cheshire West* because of the reasons why the relevant persons lacked capacity the

ratio of that decision does not exclude the autonomy aspect of the essence of Article 5 being taken into account in applying the intense and fact sensitive approach that is required when it is relevant.

142. In my view, it is relevant in a number of hospital situations. These include the ready examples Gross LJ has given at [12] because they are situations in which the inability of a patient, through a lack of capacity that existed (or may have existed) before the onset of his physical disorders, their consequences and/or their treatment and its consequences has no effective impact. In all situations when this is so:

i) the effective and so relevant inability to make an informed decision about and so give an effective consent to the concrete situation is the same for patients who did and did not have any pre-existing lack of capacity, and

ii) the cause of the concrete situation on the ground to which the patient has not been able to consent is the same for patients who did and did not have any pre-existing lack of capacity.

143. In such cases the need to take the autonomy aspect of the essence of Article 5 into account in the overall assessment of whether the concrete situation on the ground gives rise to an Article 5 detention (deprivation of liberty) provides the answers to the questions I posed in [95] because it highlights that any pre-existing lack of capacity of the relevant patient has no effective impact on the creation or continuation of that concrete situation and so that:

i) the patients with a pre-existing lack of capacity are not in a more vulnerable position than those who had no pre-existing lack of capacity,

ii) a comparison between (a) those with and (b) those without capacity before the onset of their physical disorder and/or its treatment is inappropriate and unnecessary,

iii) reliance on the Article 5.1(e) exception for all or some of such patients as person of "unsound mind" is also inappropriate and unnecessary,

iv) the impact of the concrete situation on the human rights of all such patients is for relevant purposes the same, and

v) it is unrealistic to conclude that the freedom of choice (autonomy) of any of the patients is engaged in a way that founds the conclusion that they are deprived of their liberty for the purposes of Article 5 (or otherwise).

144. As to the point referred to in [143 (iii)], I am proceeding on the basis that the class of persons of "unsound mind" covered by the exception in Article 5.1(e) includes both those who had capacity before the onset of their physical disorders and their treatment and those who did not (see paragraph [110]). If that is wrong, it would provide a further argument in favour of the conclusion that none of them are deprived of their liberty because no exception would apply to those who previously had capacity to decide on their care and treatment.

145. Put another way, as Gross LJ says at [77] such an extension of *Cheshire West* would not draw any distinction between patients with and those without any previous mental incapacity, which furnishes a stark contrast with the issue addressed in *Cheshire West.* The existence of that contrast shows that the issues at the heart of this case were not under consideration in *Cheshire West* and so provides a good reason for not applying it as if it sets out a set of statutory principles across very different concrete situations. Another reason for not doing this is the wide range of circumstances covered by the

exceptions in the sub-paragraphs of Article 5.1. In this context, I agree with the comment of Gross LJ at [78] on *Nielsen v Denmark.*

146. If it is not appropriate to compare the respective positions of persons with and without capacity before the onset of the relevant physical disorders and/or their treatment:

i) the other aspect of the comparison used in *Cheshire West* (namely between those who have and those who do not have the disabilities, disorder and problems that found the need for the care package) falls away,

ii) the comparison made by Lord Kerr at [76] and [77] of his concurring judgment in *Cheshire West* (cited by Gross LJ at [55]) goes nowhere because any pre-existing lack of capacity of the patient makes no effective difference to the existence on an objective assessment of the concrete situation on the ground, and

iii) what is left is a concrete situation on the ground that applies to all the relevant patients irrespective of whether they had a pre-existing lack of capacity and the question becomes whether that situation is a breach of the Article 5 right to liberty and security of person of all of them.

147. Turning to the mischief and policy considerations *Cheshire West* was seeking to address I agree with what Gross LJ says at [79]. This shows that they do not support a conclusion that the principles identified in *Cheshire West* should be applied without modification to the different situation of a patient who is in hospital for care and treatment for physical disorders.

148. I acknowledge that s.4B and s.5 of the MCA recognise that some concrete situations involving life saving, vital or other treatment will give rise to a deprivation of the liberty of a person who lacks capacity (as defined by s. 2(1) of the MCA) to consent to the care and treatment and the consequences of it being given.

149. However, in my view this recognition does not found the view that <u>all</u> or indeed any particular life saving or vital treatment which has the results that:

i) the patient is under constant supervision and control and cannot leave the hospital, and

ii) the patient does not have the capacity to consent it to because of an impairment of, or disturbance in the functioning of, the mind or brain caused by the effects of a physical disorder and/or its treatment

involve a deprivation of liberty. At the most it recognises that some may. Also, it recognises the history of applications under the inherent jurisdiction to authorise treatment and the restraining of a patient to give it (*cf. NHS Trust I v G, supra*). Such cases and those now brought in respect of serious medical treatment are often brought before the relevant treatment of a patient who lacks capacity starts (and thus before the onset of a lack of capacity caused by the physical disorder and/or its treatment). Also, a number are triggered by active resistance from family members to a particular course of treatment or active objections by the patient who lacks capacity or significant doubts over diagnosis and treatment or a history in which a patient with capacity has expressed objections to or doubts about certain types of treatment. Also, the determinative question is likely to be, on an application of the best interests test, what the care and treatment should be.

150. I acknowledge that when the autonomy element of the essence of Article 5 is taken into account difficult questions will arise on a fact sensitive basis in cases:

i) where the lack of capacity arises only from a physical disorder and/or its treatment, and

ii) where the lack of capacity so arises but also the patient does not or would not have capacity for other unconnected reasons.

These will include issues relating to the length of time that the relevant care and treatment has lasted, changes in it and the impact of any pre-existing lack of capacity. On the fact sensitive exercise that is required by the authorities I do not have to go and should not go further than the facts of the present case. But I do have to address the Claimant's argument, in line with the approach suggested in the guidance given by the Law Society (see [65] of Gross LJ's judgment), that the appropriate test is to ask the question what would be done if someone properly interested sought to remove the patient from the hospital or that became a live issue for any reason.

151. Like Gross LJ, I do not agree that this hypothetical question needs to be put in each case. This is because it does not reflect the concrete situation on the ground. Rather its introduction has the potential for promoting and introducing controversy (a) between the treating team and caring and responsible family members, such as the Claimant in this case, or (b) which would not exist if the patient had the benefit of such help and support. Further, a DOLS or a court process in a situation where there is no disagreement on the ground could be very damaging to the therapeutic relationships involved.

152. The hypothesis will in many cases lead to the result that hypothetically a treating team would seek to impose its view on a patient who lacked capacity. To my mind a conclusion that if it was challenged a treating team would seek to impose its view does not show whether or not the patient is free to leave or his autonomy is being overridden. Rather, any interference with those freedoms should be assessed against the actual situation.

153. So, for example, and in line with the Coroner's guidance, if controversy has arisen and a DOLS authorisation has been sought this would be a factor in favour of a conclusion that the patient's autonomy was being overridden and the absence of any such application would be a factor favouring the view that the care or treatment can be given in reliance of s. 5 of the MCA.

154. I acknowledge that this approach might at first sight be said to depart from the approach taken to compliance in *Cheshire West* (which is based on earlier Strasbourg cases) but, in my view, this is shown not to be the case if the need to seek authorisation is tested by reference to the additional safeguards it would provide and thus by reference to the need for the independent checks referred to by Baroness Hale to be in place to promote the autonomy element of the essence of Article 5.

155. This case and any other where the patient has a devoted family member who is actively involved and motivated by the best interests of the patient provide examples of concrete situations in which the patient has an appropriately independent person considering and assessing the options from the patient's perspective. If that leads to accord with the treating team and any other interested family members as to what is in the best interests of the patient the need for additional checks does not exist on the ground. And, if the authorisation process was initiated, it would effectively replicate the existing safeguards to no good purpose and could have the damaging consequences referred to earlier.

MY CONCLUSION ON THE FACTS OF THIS CASE

156. Firstly, all of the relevant care and treatment was directed to Maria's physical disorders. I shall assume that before her treatment for her physical disorders meant that she could not give an informed consent to that treatment Maria lacked capacity to make decisions on all aspects of her treatment and care and so by reason of that lack of capacity was a person of "unsound mind" for the purposes of Article 5.1(e).

157. With regard to the period prior to the night of 2nd/3rd December, if Maria had had the relevant capacity she could and no doubt would have taken a full part in the discussions concerning and the decisions made on her treatment for her physical disorders. The evidence shows that her sister, the Claimant, took such a part and did so from the perspective of what would best promote Maria's best interests. I agree with what Gross LJ says at [85].

158. That position and support remained the same after the night of 2nd/3rd December.

159. In addition from that night the package of care and treatment for Maria's physical disorders meant that if before that night she had had relevant capacity to make decisions about her treatment thereafter (like anyone else with her physical disorder and undergoing that care and treatment) she was never or never realistically in a position to assess and make decisions about her care and treatment. Maria remained in the ICU because for pressing medical reasons and treatment she was unable to be elsewhere. There is no evidence whatever of a decision by the hospital other than to admit Maria to the ICU to attempt life-saving treatment and I agree with what Gross LJ says at [87] that it is fanciful in this case to suppose that the Claimant would have sought to remove Maria from the hospital while she was undergoing treatment in the ICU and therefore idle to consider what the hospital's response would have been.

160. Applying my conclusions on the approach to be taken, at the time of her death:

    i) Maria was not compulsorily detained, and so was not in state detention for the purposes of the CJA 2009, and further or alternatively

    ii) Maria was not deprived of her liberty in breach of her Article 5 rights and so was not in state detention for the purposes of the CJA 2009.

CONCLUSION

161. The Coroner's reasoning does not clash with mine in a way that shows he erred in law or for any other reason failed to take all and only relevant factors into account. In any event, I am of the view that on what I have concluded is the correct approach in law to the factors to be taken into account a Coroner could only reach the conclusion that Maria was not in "state detention" at the time of her death.