



Neutral Citation Number: [2019] EWCOP 28

Case No: COP1344751T

IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 17/07/2019

Before:

MRS JUSTICE LIEVEN DBE

Between:

BIRMINGHAM CITY COUNCIL

Applicant

- and -

SR

Respondent

Case No: COP12931267

Between:

LANCASHIRE COUNTY COUNCIL

Applicant

- and -

JTA

Respondent

Simon Burrows (instructed by Lancashire County Council and Birmingham City Council) for
both **Applicants**

Respondents not represented and did not attend.

Hearing dates: Thursday 4th July 2019

Approved Judgment

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

.....

MRS JUSTICE LIEVEN DBE

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

1. There are two applications before me under the Mental Capacity Act 2005 (MCA) for authorisations relating to the Respondents' care plans involving, inter alia, deprivation of liberty. They both raise issues about the interrelationship between the MCA and the Mental Health Act 1983 (MHA). Both applications were made on the COP DOL11 forms for authorisations under the streamlined procedure introduced pursuant to the two *Re X cases 2014 EWCOP 25 and 2014 EWCOP 37*. However, in the light of the Supreme Court decision in *M v Secretary of State for Justice* (2018) 3 WLR 1784, it was decided in both cases that they should be heard together before a High Court judge at an oral hearing.
2. I did consider in both cases whether I should adjourn the applications in order for SR and JTA to be represented. However, it was quite clear on the evidence that both individuals, although assessed not to have capacity, were strongly supportive of being allowed to live at the named placements and of being "deprived of their liberty" in those placements. For the reasons set out below I also reached the clear view that it was in their best interests that this should happen. In the case of SR if I had adjourned the matter then it is likely that this would have led to a yet longer period in which he was unnecessarily (though not unlawfully) detained in a psychiatric hospital when he could have been in a more suitable community placement. In those circumstances I decided that the most appropriate course was to proceed to hear the applications and not adjourn for SR or JTA to be represented. I am confident that they have not been prejudiced by this course, and there is no interference in their article 6 or article 8 ECHR rights.

SR

3. This is an application by Birmingham City Council, BCC, for authorisation under the Mental Capacity Act for a care package in respect of SR at a placement known as BL, the authorisation including that he can be deprived of his liberty at BL.
4. SR is currently detained in a psychiatric hospital under a restriction order pursuant to s.37/41 of the Mental Health Act 1983. He is detained as a consequence of being convicted of attempted sexual assault of his elderly mother in early 2013. He had also been convicted in 1977 of sexual assault, again on his mother. Both incidents were

carried out under the influence of alcohol. His mother died due to natural causes in November 2012.

5. SR has a diagnosis of mild learning difficulties and autism spectrum disorder. Whilst in hospital he has engaged in a number of programmes and therapeutic interventions. He is now assessed by his Multidisciplinary Team as being fit for discharge. It is the view of this Team that he would need 1:1 supervision in the community, both to prevent him consuming alcohol and to prevent the risk of re-offending.
6. The report of SR's consultant psychiatrist, Dr T, is that he is very anxious regarding his ability to cope around unknown females. SR has described having intrusive thoughts about attacking women and he remains certain that he will attack women unless closely supervised. Dr T records that SR has been able to manage with females he knows, and that there is no objective evidence that his concerns about the risk of assaulting women would occur.
7. A capacity assessment was undertaken by CE, an independent best interests' assessor. The assessment recorded that SR is highly socially embarrassed around women. SR considers that he requires 24-hour supervision around women in order to keep them safe from him. He focuses on his sexual thoughts and desires which obsess his thoughts. The opinion of the assessor was that SR has a distorted and egocentric perception of the world that makes him unable to weigh up the information needed to have capacity to consent to the care, treatment and support he needs to live in the community. He was therefore assessed as not having capacity in this regard. This is therefore a somewhat unusual case where the patient thinks he needs more supervision and more restrictions on his liberty, because he over estimates his needs and the risks he poses.
8. Dr T's evidence to the First Tier Tribunal (Health, Education and Social Care Chamber) (FTT) was that SR did not require ongoing hospital management and that he could be adequately managed in a robustly supported community placement.
9. SR appeared before the FTT on 10 January 2019. The Tribunal had the capacity assessment, prepared by CE, which concluded that SR didn't have capacity in respect

of his future care requirements. The Tribunal adjourned for Dr T to produce a fully up to date report and

“3. In a second unexpected development, a capacity assessment had been commissioned which, the Panel was informed, concluded that the Patient lacked capacity in respect of his future care requirements. This report was clearly relevant to potential issues of conditional discharge/ post-discharge care, particularly having regard to the possible need for continuing deprivations of liberty, and in the light of the recent Supreme Court decision in MM. It was also necessary for a review of risk assessment in the light of capacity evidence.”

10. The next hearing was on 21 March 2019 before a differently constituted FTT. That hearing was again adjourned for further information. The Tribunal said;

“1. This is an application made by the solicitors representing the patient.

2. I do not propose to recite at length the contents of their detailed application, it is sufficient to note that the primary reason advanced by them concerns the apparent misunderstanding by the RA of the process necessary to ensure that any proposed discharge of the patient into conditions which amount to a deprivation of liberty is authorised appropriately by the Court of Protection

3. It is however the case, without wishing to add to any previous confusion that may have occurred, that the Supreme Court in MM (Lady Hale paragraph 27) made clear that they were not expressly required to determine whether as a matter of law the obiter in the Court of Appeal decision in MM at paragraph 35 was, in fact a correct statement of the law. Arguably she implied that she did not regard it as such...”

11. The third Tribunal hearing was on 3 May 2019, and was yet again adjourned. The Tribunal said;

“3. I am told that there has been some significant confusion within the Local Authority Social Work and legal team as to the relevant information that is required by the Tribunal and the law relating to such circumstances, which I agree is now less certain following the Supreme Court’s decision in MM [2018], and the implications that has for the continuing validity of the Upper Tribunal’s decision in KC [2015], the authority relied upon to suggest that a deprivation of liberty can be authorised in situations such as SR’s. The decision in MM has clarified that the Tribunal does not have the power to make the type of ‘protective conditions’ envisaged by Charles J in KC.

4. I am told that in SR's case, the Local Authority has only within the last few days accepted responsibility to initiate an application to the Court of Protection for the order proposed for Deprivation of Liberty. The patient's solicitor takes the view that it is not possible for the Tribunal to consider SR's case for conditional discharge (or deferred conditional discharge) until such time as there is clear information in relation to the progress regarding this application.

5. I agree with the view I am told was expressed by a previous (unnamed) Tribunal Judge sitting on this case that it was his view that before the Tribunal would be prepared to consider the grant of a conditional discharge there would need to know that such an authorisation was in place, or very close to being in place by the Court of Protection. I therefore grant the adjournment requested in the terms requested, although personally speaking I am not anywhere as confident as the patient's solicitor that this matter will be resolved as quickly as they anticipate. It may therefore be necessary for a subsequent application to be made to vary these directions." [emphasis added]

12. The intention is that SR would live at BL, which is a supported living unit for two residents. SR has made clear that he wishes to live at BL and be fully supported there. He is recorded as saying that he is happy with the arrangements that are made for him there.

JTA

13. JTA is 62 years old. He has lifelong learning disabilities, communication difficulties and bi-polar disorder. He has had periods of admission in psychiatric units since 1967. JTA's index offence was in 1994 when he was convicted of sexual assault on a female and he then spent 10 years in hospital.
14. He appeared before the FTT in 2016. On 20 September 2016 the FTT made a conditional discharge. The conditions included that (1) he reside at a named staffed accommodation; and (5) "*shall not be permitted to leave his accommodation unless accompanied and supervised at all times*". Condition (5) undoubtedly amounts to a deprivation of liberty, and it would seem that in the light of M it is an unlawful condition. In September 2016 DJ Rogers in the Court of Protection authorised the residence and care plan. Therefore, although the condition may well have been unlawful, the deprivation of liberty was appropriately made under the MCA. I have before me an application for a continuation of that authorisation. In October 2016 JTA moved to the named accommodation as per the conditional discharge.

The law

15. The problem which arises in this case relates to the interrelationship between the MHA, and in particular the power to conditionally discharge a patient; and the powers under the MCA.
16. Under the MHA, if a patient is detained under a s.37/41 then the FTT shall make a conditional discharge under s.73(2) if the statutory requirements are met. Section 73(1) and (2) state;
- (1) Where an application to [the appropriate tribunal] is made by a restricted patient who is subject to a restriction order, or where the case of such a patient is referred to [the appropriate tribunal], the tribunal shall direct the absolute discharge of the patient if—*
- (a) the tribunal is not satisfied as to the matters mentioned in [paragraph (b)(i), (ii) or (iia) of section 72(1) above; and*
- (b) the tribunal is] satisfied that it is not appropriate for the patient to remain liable to be recalled to hospital for further treatment.*
- (2) Where in the case of any such patient as is mentioned in subsection (1) above—*
- (a) paragraph (a) of that subsection applies; but*
- (b) paragraph (b) of that subsection does not apply,*
the tribunal shall direct the conditional discharge of the patient.
17. Section 72(1)(b) provides;
- b) the tribunal shall direct the discharge of a patient liable to be detained otherwise than under section 2 above if [it is]4 not satisfied—*
- (i) that he is then suffering from [mental disorder or from mental disorder]5 of a nature or degree which makes it appropriate for him to be liable to be detained in a hospital for medical treatment; or*
- (ii) that it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment; or*
- (iia) that appropriate medical treatment is available for him; or*
- (iii) in the case of an application by virtue of paragraph (g) of section 66(1) above, that the patient, if released, would be likely to act in a manner dangerous to other persons or to himself.*
18. The effect of a conditional discharge is that the Secretary of State can recall the patient under s.42. There is a requirement on the patient to comply with the conditions, but no statutory sanction for non-compliance, albeit non-compliance may, but by no means always does, result in recall.
19. The other relevant power under the MHA is s.17, which allows a patient, including a restricted patient to be given leave of absence from the hospital. Section 17 states;

“(1) The [responsible clinician]1 may grant to any patient who is for the time being liable to be detained in a hospital under this Part of this Act leave to be absent from the hospital subject to such conditions (if any) as [that clinician] considers necessary in the interests of the patient or for the protection of other persons.

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

20. There have been a number of cases on the scope of the power to impose conditions, and in particular whether the conditions imposed under s.73 can themselves authorise the deprivation of the patient’s liberty outside the hospital in which they have previously been detained under the MHA. The issue was considered by the Supreme Court in *M v Justice Secretary* (2018) 3 WLR 1784. The applicant was detained under s.37/41 MHA. The applicant’s psychiatric evidence was that he could be discharged into the community, but should be required to live at a particular place and only go out with an escort. He was determined to have capacity to consent to this arrangement, and was prepared to consent. The FTT was asked to rule on whether it would be lawful for him to be conditionally discharged subject to these conditions.

21. The Supreme Court held that s.42(2) and 73(2) of the MHA did not permit the SoS/FTT to impose a condition which would amount to a deprivation of liberty within the meaning of Article 5, even where the patient consented. Before setting out her conclusions Baroness Hale set out her view in relation to the Court of Protection’s powers;

“26. The Court of Protection cannot authorise the deprivation of liberty of an incapacitated person who is “ineligible” within the meaning of Schedule 1A to the MCA: section 16A of the MCA, as inserted by section 50(3) of, and Schedule 8 to, the 2007 Act. A restricted patient who is actually detained in hospital is ineligible (falling within Case A in paragraph 2 of Schedule 1A). A restricted patient who is conditionally discharged from hospital falls either within Case B or Case C and is not wholly ineligible. A deprivation of liberty whose purpose consists wholly or mainly in medical treatment in hospital cannot be authorised, but a deprivation for other purposes can be authorised, provided that it is not inconsistent with the requirements of their MHA regime.

27. *Whether the Court of Protection could authorise a future deprivation, once the F-tT has granted a conditional discharge, and whether the F-tT could defer its decision for this purpose, are not issues which it would be appropriate for this court to decide at this stage in these proceedings. Assuming that both are possible, and therefore that there might be an incompatibility with article 14, read either with article 5 or with article 8, it would make no difference to the outcome of this case. The outcome of this case depends upon whether it is possible to read the words “discharge ... subject to conditions” in section 42(2) (dealing with the Secretary of State's powers) and “conditional discharge” in section 73(2) (dealing with the F-tT's powers) as including the power to impose conditions which amount to a deprivation of liberty within the meaning of article 5.”*

22. Baroness Hale then turned to her conclusions on the issue in the appeal and found that a conditional discharge under the MHA could not authorise a deprivation of liberty, see [28] onwards. She gave three reasons for this conclusion. The first was that there would be an interference with the fundamental right to liberty if the Secretary of State could impose a condition depriving someone of their liberty, with no appropriate safeguards under the Act. The second, that the MHA imposes no coercive powers over the conditionally discharged and so practically any such deprivation of liberty would not be legally enforceable. The third reason was that to find such a power would be contrary to the whole scheme of the MHA because of the provisions on discharge of patients.
23. Baroness Hale acknowledged that the result of this decision could be that some patients detained in hospital under the MHA would not now be discharged and they would therefore be subject to a more intrusive form of deprivation of liberty, than would otherwise have been the case. However, as she explained at [24] article 5 does not concern itself with the conditions of detention, *Ashingdane v UK* 1985 7 EHRR 528, merely whether the individual has been lawfully deprived of their liberty or not.
24. The consequence of M is that restricted patients who are found to be eligible for discharge under s.72 and 73, but only if they are subject to further deprivation of liberty in the community, cannot now be made subject to a conditional discharge which authorises their further detention in the community.
25. The Secretary of State's response to the decision in M has been set out in a Guidance document produced by the Mental Health Casework Section; “*Discharge conditions*

that amount to a deprivation of liberty". This is guidance not law, but it sets out the Secretary of State's proposed solution to the problem posed by the Supreme Court's decision. The Guidance distinguishes between patients with capacity, whom the Secretary of State proposes could be considered for long term leave of absence under s.17(3) and patients lacking capacity. Both the individuals in the current case have been assessed not to have capacity, and therefore I do not deal further with the position of patients with capacity.

26. In respect of patients lacking capacity the Guidance then breaks that category down into two parts. Firstly, those patients whose best interests require them to be subject to a care plan to help them perform daily living activities or self-care and where the support would amount to a deprivation of liberty. Secondly, those whose care plan required a deprivation of liberty primarily in order to protect the public.
27. For the first category the Guidance suggests at para 4.1 that if the care plan requires a DoL authorisation under the MCA, the FTT can issue a deferred conditional discharge, and the necessary arrangements made to put in a place a DoL authorisation before the patient is discharged.
28. For the second category, the Guidance suggests at para 4.2 that a conditional discharge would not be appropriate and s.17(3) leave would be open to consideration.
29. The issue as to whether a patient can be detained because s/he poses a risk to the public, and it is said to be in his/her best interests to be detained for that reason, was considered by Moor J in *Y County Council v ZZ* [2013] COPLR 463. Moor J recognised that the purposes of the restrictions on P's liberty was to address, prevent and control P's sexual urges and he said at [49];
- "I have come to the clear conclusion, for all the reasons given by the various doctors, that it is lawful as in Mr ZZ's best interests to deprive him of his liberty in accordance with the local authority care plan, pursuant to schedule A1 of the Mental Capacity Act 2005. I make that declaration. In doing so, I am following the advice of the expert professionals who know Mr ZZ so well. Indeed, the Official Solicitor accepts, on his behalf, that I should do so. I make it clear to Mr ZZ that I have no doubt that the restrictions upon him are in his best interests. They are designed to keep him out of mischief, to keep him safe and healthy, to*

keep others safe, to prevent the sort of situation where the relative of a child wanted to do him serious harm, which I have no doubt was very frightening for him, and they are there to prevent him from getting into serious trouble with the police.”

30. The same patient with substantially the same restrictions was considered again by Peter Jackson J in *Re (N) (Deprivation of Liberty)* [2016] EWCOP 47, and he adopted the same approach.
31. As is set out above, the Supreme Court did not deal with the powers of the Court of Protection under the MCA to deprive an individual who had been (or was contemplated to be) conditionally discharged under the MHA.
32. Under the MCA the CoP has the power to make decisions in a patient (P)’s best interests in respect of welfare decisions, which can include decisions as to where they live and decisions that deprive P of his/her liberty. The CoP only has this power if the individual lacks the capacity to make the said decision themselves. In the present case both the individuals have been assessed as lacking capacity, but it can immediately be seen that if they did have capacity then the legal position would be entirely different.
33. There are categories of case under Schedule 1A of the MCA of “Persons ineligible to be deprived of liberty by this Act”. Parts of this Schedule are more than a little opaque, but the position seems to be as follows. Case A covers patients who are detained in hospital under the MHA. Case B is patients subject to the hospital treatment regime under the MHA but not detained under the MHA. Case C is those subject to the community treatment regime under the MHA.
34. As Baroness Hale said at [26] in *M*,

“A deprivation of liberty whose purpose consists wholly or mainly in medical treatment in hospital cannot be authorised, but a deprivation of liberty for other purposes can be authorised, provided that it is not inconsistent with the requirements of the MHA regime”.”

35. It seems SR and JTA fall within Case B because they remain subject to the “hospital treatment regime” as defined in Para 8 of Schedule 1A, namely a hospital order under s.37, but they are not detained. Case B then refers to paragraphs 3 and 4. Paragraph 3(2) states; “*P is ineligible if the authorised course of action is not in accordance with a requirement which the relevant regime imposes.*” The relevant regime is that under the MHA.
36. Case D is those subject to the guardianship regime under the MHA. Case E covers the situation where P objects to being a mental health patient.
37. It therefore follows that in these cases both individuals fall, or potentially fall, within Case B, as being subject to the hospital treatment regime under the MHA but either not detained (in the case of JTA) or will not be detained at the date the order under the MCA comes into effect (SR). For individuals who fall within Case B they are ineligible if paragraphs 3 or 4 apply. Paragraph 3 (2) states;

“P is ineligible if the authorised course of action is not in accordance with a requirement which the relevant regime imposes”

38. It therefore covers the situation where there is a conflict or inconsistency between the authorised course of action under the MCA (i.e. the care plan including the deprivation of liberty) and any requirement under the MHA. Happily, there is no such conflict here.

Conclusions

39. In both cases the patients have been assessed not to have capacity in respect of decisions about their care packages, where they live, and their liberty or otherwise. I accept those assessments and therefore conclude that both patients do not have capacity in the relevant respects.
40. Equally, I have no doubt, and there is no dispute or any potential for a dispute, that it is in both patients’ best interests that they should be cared for and accommodated in the community settings proposed. In reaching this conclusion I take fully into account their wishes and feelings, which in both cases are that they are allowed to live in the proposed placements.

41. In the case of SR, it might be argued that the purpose of the deprivation of liberty and some of the other elements of the care package is the protection of the public, rather than the care of SR. However, for the reasons given by Moor J in ZZ I think that is a false dichotomy. It is strongly in SR's best interests not to commit a further offence, or to place himself at risk of recall under the MHA, if the Secretary of State were to conclude that the risk of other offences was too great. In those circumstances the provisions of the care plan in terms of supervision and ultimately deprivation of liberty is, as Moor J put it, "*to keep him out of mischief*" and thereby assist in keeping him out of psychiatric hospital. This is strongly in his best interests, as well as being important for reasons of public protection.
42. It is for this reason that I am not convinced that the division the Secretary of State makes in the Guidance between patients whose care plan is in the patients' best interests, and those where the deprivation of liberty is primarily for the purpose of managing risk to the public, is one that stands up to close scrutiny. However, on the facts of this case I have found that both patients would fall into the first category in any event.
43. The final point is whether there is anything in the Supreme Court decision in M or the MCA itself in the light of M, which would prevent the Court of Protection authorising a deprivation of liberty here. In my view there would not be any such difficulty. M is concerned with the powers under the MHA to deprive a conditionally discharged patient of his/her liberty. The Supreme Court made clear that they were not considering the powers under the MCA to authorise a deprivation of liberty, see [27] of the judgment.
44. The caselaw establishes that the Court of Protection may make declarations and orders concerning best interests, including deprivation of liberty, in advance of any discharge under the MHA, see DN v Northumberland, Tyne & Wear NHS Foundation Trust [2011] UKUT 327 (AAC). In a case such as SR it is appropriate that this should happen, so that the FTT and the Secretary of State can be confident that SR will be deprived of his liberty to a proportionate degree when he is discharged into the community.

45. Equally, there is nothing in Schedule 1A of the MCA, which would prevent the Court of Protection from authorising the deprivation of liberty of a conditionally discharged patient, whether or not that discharge had been deferred.
46. I am loathing to speculate about arguments that might be made. However, to a degree there is some suggestion in the FTT's reasoning in SR that he might be ineligible under Schedule 1A because a conditional discharge under the MHA cannot be made in the light of M and therefore to deprive him of his liberty under the MCA would be inconsistent with the MHA, that argument does not appear to me to be correct. The inconsistency required under Cases B and C would be between the power that has been exercised under the MHA and any a deprivation of liberty under the MCA. There is no inconsistency between the two orders, it is merely that under the MHA, as interpreted in M, there is no power to deprive the patient of his/her liberty. That does not prevent the MCA powers being used.
47. I should end by making clear, that there are of course different issues if the patient has capacity in respect of the care plan and any proposed deprivation of liberty. That is not these cases and therefore I make no comment upon that situation.