



COUR EUROPÉENNE DES DROITS DE L'HOMME
EUROPEAN COURT OF HUMAN RIGHTS

FOURTH SECTION

CASE OF H.L. v. THE UNITED KINGDOM
(Application no. 45508/99)

JUDGMENT

STRASBOURG

5 October 2004

FINAL

05/01/2005

In the case of H.L. v. the United Kingdom,

The European Court of Human Rights (Fourth Section), sitting as a Chamber composed of:

Mr M. PELLONPÄÄ, *President*,

Sir Nicolas BRATZA,

Mrs E. PALM,

Mrs V. STRÁŽNICKÁ,

Mr J. CASADEVALL,

Mr S. PAVLOVSKI,

Mr L. GARLICKI, *judges*,

and Mr M. O'BOYLE, *Section Registrar*,

Having deliberated in private on 27 May 2003 and 14 September 2004,

Delivers the following judgment, which was adopted on the last-mentioned date:

PROCEDURE

1. The case originated in an application (no. 45508/99) against the United Kingdom of Great Britain and Northern Ireland lodged with the Court under Article 34 of the Convention for the Protection of Human Rights and Fundamental Freedoms ("the Convention") by a United Kingdom national, Mr H.L. ("the applicant"), on 21 December 1998. The President of the Chamber acceded to the applicant's request not to have his name disclosed (Rule 47 § 3 of the Rules of Court).

2. The applicant, who had been granted legal aid, was represented by Mr R. Robinson, a solicitor practising in London instructed by one of the applicant's carers, Mr E. The United Kingdom Government ("the Government") were represented by their Agents, Mr D. Walton and Ms H. Mulvein, of the Foreign and Commonwealth Office.

3. The applicant mainly alleged that he had been detained in a psychiatric institution as an "informal patient" in violation of Article 5 § 1 of the Convention and that the procedures available to him for a review of the legality of his detention did not satisfy the requirements of Article 5 § 4 of the Convention. He also complained of his treatment in that institution.

4. The application was allocated to the Third Section of the Court (Rule 52 § 1). Within that Section, the Chamber that would consider the case (Article 27 § 1 of the Convention) was constituted as provided in Rule 26 § 1.

5. On 1 November 2001 the Court changed the composition of its Sections (Rule 25 § 1). This case was assigned to the newly composed Fourth Section (Rule 52 § 1).

6. By a decision of 10 September 2002, the Chamber declared the applicant's complaints under Article 5 §§ 1 and 4 admissible and the remainder of his application inadmissible.

7. The applicant and the Government each filed observations on the merits (Rule 59 § 1).

8. A hearing took place in public in the Human Rights Building, Strasbourg, on 27 May 2003 (Rule 59 § 3).

There appeared before the Court:

(a) *for the Government*

Ms H. MULVEIN,	<i>Agent,</i>
Mr N. PLEMING QC,	
Mr R. SINGH QC,	<i>Counsel,</i>
Ms L. VENABLES,	<i>Adviser;</i>

(b) *for the applicant*

Mr R. GORDON QC,	
Mr P. BOWEN,	
Mr P. KING,	<i>Counsel,</i>
Mr R. ROBINSON,	<i>Solicitor.</i>

Mr E., the applicant's carer, also attended.

The Court heard addresses by Mr Gordon and Mr Fleming.

THE FACTS

I. THE CIRCUMSTANCES OF THE CASE

9. The applicant was born in 1949 and lives in Surrey. He has suffered from autism since birth. He is unable to speak and his level of understanding is limited. He is frequently agitated and has a history of self-harming behaviour. He lacks the capacity to consent or object to medical treatment. For over thirty years he was cared for in Bournemouth Hospital ("the hospital"), a National Health Service Trust hospital. He was an in-patient at the Intensive Behavioural Unit ("IBU") of the hospital from its inception in or around 1987. The applicant's responsible medical officer (who had cared for him since 1977) was Dr M. (clinical director of learning

disabilities, deputy medical director and consultant psychiatrist for psychiatry of learning disabilities).

10. In March 1994 he was entrusted on a trial basis to paid carers, Mr and Mrs E., with whom he successfully resided until 22 July 1997. He was not formally discharged, and the hospital remained responsible for his care and treatment. From 1995 onwards the applicant attended on a weekly basis a day-care centre run by the local authority.

A. Admission to the hospital – 22 July to 5 December 1997

11. On 22 July 1997 the applicant was at the day-care centre when he became particularly agitated, hitting himself on the head with his fists and banging his head against the wall. Staff could not contact Mr and Mrs E. and got in touch with a local doctor, who administered a sedative. The applicant remained agitated and, on the recommendation of the local authority care services manager (A.F.) with overall responsibility for the applicant, he was taken to the accident and emergency unit at the hospital.

12. At the hospital, the applicant remained agitated and anxious and was received and assessed by Dr P. (acting consultant psychiatrist – learning disabilities services) as being in need of in-patient treatment. He was transferred, with the physical support of two nursing assistants, to the hospital's IBU. He was recorded as making no attempt to leave. Having consulted, Dr P. and Dr M. considered that the best interests of the applicant required his admission for in-patient treatment. Dr M. did consider his committal under the Mental Health Act 1983 ("the 1983 Act") but concluded that that was not necessary as the applicant was compliant and did not resist admission. The applicant was therefore admitted as an "informal patient". Dr M. later confirmed (in her submissions in the judicial review proceedings referred to below) that, if the applicant had resisted admission, she would have detained him compulsorily under the 1983 Act as she was firmly of the view that he required in-patient treatment.

13. Dr M.'s personal attendance notes for that day record the reports she had received of extremely disturbed behaviour at the day-care centre on that day and previously; the suggestion by A.F. that the applicant may have been suffering from a cyclical mood disorder and the recommendation that the applicant be assessed to establish any action required; Dr M.'s detailed consultation throughout the day with the applicant's local doctor, Dr P., A.F., ward staff and other care professionals; the conclusion that, given the escalation of behavioural problems, the applicant required readmission for "thorough investigation and treatment" but that he would not be "sectioned" as he was "quite compliant" and had "not attempted to run away"; the numerous unsuccessful attempts to contact the applicant's carers; and the decision to discourage visits by the applicant's carers as it risked causing them and the applicant distress.

Her notes for the following day, 23 July 1997, recorded that the applicant was calm, had complied with all care needs and accepted the change without problem; that his carers were “happy with [the] suggestion not to visit for a few days”; and the clinical opinion that, given the reports of escalating behavioural problems and self-harm and the suggestion by A.F. of a cyclical mood disorder, time was needed to observe, assess and administer appropriate treatment. Various tests were proposed to rule out any “organic pathology”. The applicant was to be referred to the psychology and speech therapist for assessment and a care plan was to be drawn up as appropriate “for maintenance purposes on discharge”. His carers were to be made aware of the need not to visit until the team treating the applicant felt confident for them to do so.

14. In its letter dated 23 July 1997 to the applicant’s social worker (copied to Dr P.), the day-care centre enclosed a detailed report of the incident that had occurred the previous day and outlined serious behavioural issues to be considered by the applicant’s health care professionals before he could be allowed to return to the day-care centre. It was noted that the applicant’s outbursts had increased over the previous few months and that he had been finding it increasingly difficult to cope with his environment and group. A summary of the applicant’s behaviour and attendance at the day-care centre between January and July 1997 was also included.

15. On 18 August 1997 Dr M. prepared a detailed report on the applicant’s history, care and progress for the manager (learning disabilities) of the local health authority as a follow-up to their recent discussions regarding the applicant. Dr M. indicated that the hospital was coming to the conclusion that the applicant, as well as being autistic, suffered from a mood disorder, and noted that his discharge at that time would be against medical opinion.

16. On 22 August 1997 a consultant psychiatrist in learning disabilities (Dr G.) assessed the applicant at the request of Mr and Mrs E. His report described the applicant as suffering from a severe learning disability, autistic traits and a possible cyclical mood disorder. That psychiatrist recommended further assessment of the applicant in the IBU and better cooperation between the hospital’s professional team, the day-care centre and Mr and Mrs E.

17. On 29 October 1997 the Court of Appeal indicated (see the proceedings detailed below) that the applicant’s appeal would be decided in his favour. Accordingly, on that day the applicant was detained in the hospital under section 5(2) of the 1983 Act (following receipt of a notice from a doctor in charge of an in-patient that an application ought to be made for the latter’s detention for, *inter alia*, treatment under section 3 of the 1983 Act, the patient may be detained for up to seventy-two hours to allow for that application to be processed). On 31 October 1997 the applicant was admitted for treatment as an involuntary patient under section 3 of the 1983

Act (two medical practitioners having recently examined the applicant would have certified his detention for treatment as necessary).

18. On 2 November 1997 the applicant's carers visited him for the first time since his readmission in July 1997.

19. On 4 November 1997 the applicant's legal representatives applied for a review of his detention by a Mental Health Review Tribunal ("MHRT"). Legal aid was granted to instruct an independent psychiatrist to prepare a report. The psychiatric report, dated 27 November 1997, was prepared jointly by a consultant psychiatrist and a registrar in the psychiatry of learning disability, both attached to the Department of Psychiatry at the University of Cambridge. The psychiatrists recommended the applicant's discharge because they were of the opinion that his mental disorder was "currently neither of a nature or degree to warrant continued detention in hospital, nor [was] it necessary for his health or safety or for the protection of others".

On 4 December 1997 the applicant's representatives applied to the hospital managers for his release (section 23 of the 1983 Act), a meeting of the managers taking less time to convene than a meeting of the MHRT.

20. The multidisciplinary team responsible for the applicant's care and treatment decided that he had settled enough to be managed at home, and on 5 December 1997 he was released on leave of absence (under section 17 of the 1983 Act) into the care of Mr and Mrs E.

21. On 9 December 1997 Dr P. prepared a report for the forthcoming managers' review meeting. He noted that the applicant's discharge on 5 December 1997 under section 17 of the 1983 Act was to be complemented by weekly psychiatric outpatient follow-up appointments, continued medication and monitoring by a community nurse. Dr P. was hopeful that the community team and their consultant psychiatrist could take over the applicant's care so that he could be formally discharged from the hospital.

22. On 12 December 1997 the hospital managers decided to formally discharge the applicant to the carers (section 23 of the 1983 Act).

B. Correspondence between Dr M. and the applicant's carers

23. The first letter from Dr M. to Mr and Mrs E. after the applicant's admission to the hospital was dated 23 July 1997. Having noted the attempts made to contact them on 22 July 1997, Dr M. outlined in detail what had happened and how the applicant was progressing. Dr M. indicated that, while the aim was to discharge the applicant to them as soon as possible, she was unable to predict the length of his stay as it depended on the completion of all necessary investigations and assessments. Dr M. indicated that visits would be unwise until the hospital staff felt that it would be appropriate, in order to avoid the applicant thinking that he could go home with Mr and Mrs E. following each visit at a time when he was "not

clinically fit for discharge”. Dr M. invited Mr and Mrs E. to contact her about meeting her the following week.

24. Dr M. sent a further detailed update on the applicant’s care, assessments and progress to Mr and Mrs E. on 31 July 1997. Having noted Mr and Mrs E.’s requests to staff to visit the applicant, Dr M. indicated that the current serious observational assessment would be prejudiced by such visits and suggested that the situation be reviewed the following week. Dr M. pointed out that the applicant was not clinically fit for discharge.

25. Since Mr and Mrs E. had expressed concerns to staff at the hospital about the applicant’s care and treatment, Dr M. sent a long letter to Mr and Mrs E. on 6 August 1997 in which she explained the clinical team’s responsibility to provide the applicant with the care and clinical input he required. In particular, Dr M. noted:

“I would like to take the opportunity to stress, through this correspondence, that we, as a Clinical Team, within the [IBU], are here, primarily to provide the treatment for [the applicant] who was admitted under our care, as an emergency. It would be extremely irresponsible of us not to provide [the applicant] with the care and the clinical input that he deserves and is in need of. His disposal/discharge from within the unit is dependent ... on the Multidisciplinary Clinical Professionals’ considered views, following their assessment and the work that they intend doing with [the applicant], specifically, in relation to his challenging behaviour and/or mental health needs. As I have stressed, in my earlier correspondence, these things do take time and unfortunately we have to be a little patient to allow the professionals some room and space to carry on with their work in the provision of care ... [The applicant] has been admitted to the [IBU] on an ‘informal’ basis and this is not a time-limited admission. I am not sure if you have misunderstood his status and are under the impression that perhaps he was admitted and held under ‘the Mental Health Act’. Even then, there is no ‘one month’ time-limit, as it all depends on the patient’s fitness for discharge ... On behalf of the Clinical Team, I would like to stress that [the applicant] is being treated within the [IBU] and once he is fit for discharge, he will be discharged back to the address from where he was admitted, with a ‘Treatment Plan’ which will include all aspects of his care and a ‘maintenance plan’ prescribed.”

Given the ongoing treatment and assessments, it was not possible to specify a discharge date. Dr M. repeated her offer to meet Mr and Mrs E. to discuss the applicant’s care.

26. In a further letter of 2 September 1997, Dr M. confirmed to Mr and Mrs E. that the conclusions drawn from the assessments to date meant, and the recent clinical professionals’ meeting had decided, that the applicant was to be “fully” referred for care and treatment to the IBU and that his stay was likely to be a long one. She invited Mr and Mrs E. to attend a clinical meeting about the applicant’s care and treatment on 18 September 1997 and offered to meet Mr and Mrs E. separately to discuss, *inter alia*, the subject of visits.

27. Mr and Mrs E. replied in a letter of 5 September 1997 that they could not agree with the suggested plan for the applicant and would be in touch again prior to the relevant meeting. By a letter dated 16 September

1997, Mr and Mrs E. confirmed that they would not be able to attend the meeting on 18 September 1997 as they were seeking legal advice. Dr M. responded by letter dated 19 September 1997 expressing regret that Mr and Mrs E. felt that their attendance at the clinical meeting could jeopardise the applicant's position. In a separate letter of the same date, Dr M. outlined the results of the clinical meeting, including a recommendation that Mr and Mrs E. visit the applicant once a week, and requested them to contact her to arrange this.

28. On 20 October 1997 Dr M. reassured Mr and Mrs E. that the subject of them visiting the applicant had been discussed at the hospital at some length and encouraged Mr and Mrs E. to meet her to discuss the applicant's needs.

29. Detailed behaviour management guidelines were issued on 27 November 1997 by the psychology service of the hospital to, among others, Dr M., Mr and Mrs E., the applicant's social worker and other therapeutic services that were to be involved in the applicant's future care. Appendix 1 was a detailed clinical description of the applicant's mental state (autism and a cyclical mood disorder), needs and reactions prepared on the basis of extensive psychiatric and behavioural observations and assessments, with a view to achieving a global approach to his condition, treatment and care. Appendix 2 contained an extremely detailed "communication dictionary" which was designed to enhance communication with the applicant through voice, action and routine. Appendix 3 contained recording charts.

30. By a letter of 2 December 1997 to the applicant's legal representatives, Dr M. acknowledged receipt of the guidelines of 27 November 1997 (described above) and explained the clinical team's plans regarding the applicant's release on leave of absence in the near future with a view to a possible full discharge at a later date.

C. The applicant's domestic proceedings

31. In or around September 1997, the applicant, represented by his cousin and "next friend", applied for leave to apply for judicial review of the hospital's decision to admit him on 22 July 1997, for a writ of habeas corpus and for damages for false imprisonment and assault (a technical assault associated with his admission).

1. The High Court's judgment of 9 October 1997

32. The High Court refused the application. It found that, although the 1983 Act provided a comprehensive statutory regime for those formally admitted to psychiatric care, section 131(1) of the 1983 Act preserved the common-law jurisdiction in respect of informal patients. Since the applicant had not been "detained" but had been informally admitted and since the

requirements of the common-law principle of necessity had been satisfied, his application was rejected.

2. *The Court of Appeal's judgment of 2 December 1997 (R v. Bournewood Community and Mental Health NHS Trust, ex parte L. [1998] 2 Weekly Law Reports 764).*

33. Lord Woolf, Master of the Rolls, delivered the principal judgment. On the question of whether the applicant was “detained”, he noted that it was agreed that this was a question of objective fact which did not depend on the presence or absence of consent or knowledge. He considered that a person was detained in law if those who had control over the premises in which he was situated intended that he should not be permitted to leave and had the ability to prevent him doing so. He went on:

“We do not consider that the [High Court] judge was correct to conclude that [the applicant] was ‘free to leave’. We think it is plain that, had he attempted to leave the hospital, those in charge of him would not have permitted him to do so. ... Mr and Mrs E. had looked after [the applicant], as one of the family, for over three years. They had made it plain that they wanted to take him back into their care. It is clear that the hospital was not prepared to countenance this. If they were not prepared to release [the applicant] into the custody of his carers, they were not prepared to let him leave the hospital at all. He was and is detained there.”

34. Lord Woolf also found that the right to detain a patient for treatment for mental disorder was to be found only in the 1983 Act, the provisions of which applied to the exclusion of the common-law principle of necessity. Section 131 which preserved the right to admit a patient informally applied only to a patient who had the capacity to and did consent to his admission. Since the applicant had been admitted for treatment without his consent and the other formalities required by the 1983 Act, his detention was unlawful:

“It follows from our judgment that the whole approach of the [hospital] in this case was based on a false premise. It was based on the belief that they were entitled to treat [the applicant] as an in-patient without his consent as long as he did not dissent. That was a wrong approach. They were only allowed to admit him for treatment if they complied with the statutory requirements. ... [W]here [the 1983 Act] covers the situation, no necessity to act outside the statute can arise. The [hospital's] powers to act under the common-law doctrine of necessity can arise only in relation to situations not catered for by [the 1983 Act].”

35. The Court of Appeal awarded nominal damages and granted leave to appeal to the House of Lords.

3. *The House of Lords' judgment of 25 June 1998 (R v. Bournewood Community and Mental Health NHS Trust, ex parte L. [1999] Appeal Cases 458).*

36. The House of Lords granted leave to, among others, the Mental Health Act Commission to intervene in the proceedings. In its submissions

to the House of Lords, the Commission outlined the beneficial consequences to patients of the Court of Appeal's conclusion that persons in the applicant's position were "detained" for the purposes of the 1983 Act, which included the application to such persons of the substantive and procedural safeguards of the Act. The Commission also described the survey it had completed since the Court of Appeal's judgment by sending a questionnaire to all National Health Service Trust hospitals (and registered nursing homes). Sixty-two percent of those establishments responded, from which the Commission was able to submit that, if the Court of Appeal's judgment were applied to patients such as the applicant, there would be an additional 22,000 detained patients resident on any one day and an additional 48,000 compulsory admissions per year under the 1983 Act.

37. The House of Lords gave judgment on 25 June 1998 and unanimously allowed the appeal. Lord Goff (with whom Lords Lloyd and Hope agreed) delivered the principal judgment. Lords Nolan and Steyn also agreed that the appeal should be allowed but for different reasons.

38. Having considered the drafting history of section 131 of the 1983 Act, Lord Goff disagreed with the Court of Appeal and concluded that section 131 applied to patients who consented as well as to compliant but incapacitated patients. He underlined, however, that the statutory history of the section, which put the matter beyond all doubt, appeared not to have been drawn to the attention of the Court of Appeal and that the Court of Appeal did not have the benefit, as did the House of Lords, of assistance from counsel appearing for the Secretary of State. As to the basis upon which a hospital was entitled to treat, and to care for, patients who were admitted as informal patients under section 131(1) but lacked the capacity to consent to such treatment or care, Lord Goff stated as follows:

"It was plainly the statutory intention that such patients would indeed be cared for, and receive such treatment for their condition as might be prescribed for them in their best interests. Moreover, the doctors in charge would, of course, owe a duty of care to such a patient in their care. Such treatment and care can, in my opinion, be justified on the basis of the common-law doctrine of necessity ... (*Re F. (Mental Patient: Sterilisation)*) [1990] 2 AC 1) It is not therefore necessary to find such justification in the [1983 Act] itself, which is silent on the subject. It might, I imagine, be possible to discover an implication in the statute providing similar justification; but even assuming that to be right, it is difficult to imagine that any different result would flow from such a statutory implication. For present purposes, therefore, I think it appropriate to base justification for treatment and care of such patients on the common-law doctrine."

39. Lord Goff then considered whether the applicant had been "unlawfully detained" as alleged and as found by the Court of Appeal. He pointed out that for the tort of false imprisonment to be committed there must, in fact, be a complete deprivation of, or restraint on liberty: an actual and not a potential deprivation of liberty went towards constituting the tort.

Lord Goff then turned to the facts and quoted extensively from the affidavit (sworn on 3 October 1997) of Dr M.:

“At 11 o’clock on 22 July 1997 I was contacted by ... [the] social worker and [the applicant’s] case manager. She advised me that there had been an incident at Cranstock Day Centre, where [the applicant] had been attending since 1995, when [the applicant] had seriously self-harmed and was extremely disturbed. She said that he had to be sent to the Accident & Emergency Department and she requested assistance from the psychiatric services to assess [the applicant] with a view to admitting him if necessary. One of my team members, [Dr P.], staff grade psychiatrist, attended the Accident & Emergency Department as requested. His notes state that he took a history from ... the team manager at Cranstock Day Centre who reported that since March 1997 [the applicant’s] episodes of self-injurious behaviour had increased in severity. On 22 July 1997 whilst he was at Cranstock he had been agitated, hyperventilating, pacing up and down and hitting himself on the head with his fists. He was also banging his head on the wall. The whole area had to be evacuated to avoid disturbance and assure the safety of others. He was given 4 mgs of Diazepam to try to calm him down at the time but this had no effect. The GP was therefore called who administered 5 mgs of Zimovane. However he still remained agitated in the Accident & Emergency Department. He was assessed and treated at A & E. [Dr P.] later assessed [the applicant] as being agitated and very anxious. He noted redness of both his temples, that he was punching his head with both his fists at times and hyperventilating. [Dr P.] assessed that [the applicant] required in-patient treatment and transferred [the applicant] to the Behavioural Unit. [Dr P.] noted that [the applicant] ‘makes no attempt to leave’. I recorded that we considered whether it was necessary to detain [the applicant] under the Mental Health Act 1983 but it was decided that this was not necessary as he was, as I noted at the time, ‘quite compliant’ and had ‘not attempted to run away’. He was therefore admitted as an informal patient. If [the applicant] had resisted admission I would certainly have detained him under the [1983] Act as I was firmly of the view that he required in-patient treatment. This was clearly thought through and supported following discussion with [Dr P.], ward staff, other professionals and the Care Services Manager. An appropriate framework of care and treatment was implemented.”

40. Lord Goff then noted how Dr M. had then

“... described how Mr and Mrs E. were informed on 22 July of [the applicant’s] admission, as was [the applicant’s] next of kin. At first, with the agreement of Mr and Mrs E., it was arranged that they would not visit [the applicant] for a few days, in accordance with the usual clinical practice. On 23 July Dr M. wrote to Mr and Mrs E. and in her letter invited them to come and meet her the following week when it was her intention to discuss the possibility of phased visits, but they did not accept this invitation to meet her. On the same day an advocacy worker was appointed as [the applicant’s] advocate. [The applicant] was again assessed. A programme of tests and observations was then put into effect.”

41. Lord Goff continued to quote from Dr M.’s affidavit:

“As [the applicant] is an informal patient there has never been any attempt to detain him against his will or carry out any tests, observations or assessments to which he indicated a dislike or with which he refused to cooperate. [The applicant] has always accepted his medication which has always been administered orally. He was also fully compliant when blood was taken from him for testing. He did not however cooperate with the attempts that were made to carry out a CT scan and EEG, which were necessary in view of his old history of fits and temporal lobe abnormality, on 5 and

6 August 1997 and so these tests were abandoned. [The applicant] cooperated to a certain extent with the speech therapy assessment which was carried out on 15 September 1997 and the occupational therapy assessment. However, as soon as he showed any signs of distress the assessments were postponed and reviewed. [The applicant] is accommodated on an unlocked ward and has never attempted to leave the hospital but has accepted the change in his environment very well and is not distressed by it ... It was, in my professional opinion, in [the applicant's] best interests to be admitted on 22 July 1997 and it is also in his best interests to continue with in-patient treatment to prevent further deterioration of his mental health. His discharge at this point in time would therefore be against medical advice. At the time of and since admission [the applicant] has been fully compliant with treatment and never indicated that he wishes to leave the hospital. In view of this it has not been necessary to detain him under the Act ... If [the applicant] stopped cooperating or indicated a wish to leave then I would have to consider at that time whether his condition warranted detention under section 3 of the Act. As these circumstances have not so far arisen detention has not been necessary."

42. Lord Goff considered that, in the light of the above account by Dr M., the following conclusions might be drawn:

"The first is that, as I have already recorded, although [the applicant] had been discharged from hospital into the community on a trial basis, and on that basis had gone to live with Mr and Mrs E. as his paid carers, nevertheless he had not been finally discharged. It followed that the appellant trust remained responsible for his treatment, and that it was in discharge of that responsibility that the steps described by Dr M. were taken. The second is that when, on 22 July, [the applicant] became agitated and acted violently, an emergency in any event arose which called for intervention, as a matter of necessity, in his best interests and, at least in the initial stages, to avoid danger to others. Plainly it was most appropriate that the appellant trust, and Dr M. in particular, should intervene in these circumstances; certainly Mr and Mrs E., as [the applicant's] carers, could not assert any superior position. Third, I have no doubt that all the steps in fact taken, as described by Dr M., were in fact taken in the best interests of [the applicant] and, in so far as they might otherwise have constituted an invasion of his civil rights, were justified on the basis of the common-law doctrine of necessity.

I wish to add that the latter statement is as true of any restriction upon his freedom of movement as then occurred, as it is of any touching of his person. There were times during the episode when it might be said that [the applicant] was 'detained' in the sense that, in the absence of justification, the tort of false imprisonment would have been committed. I have particularly in mind the journey by ambulance from the Day Centre to the Accident and Emergency Unit. But that journey was plainly justified by necessity, as must frequently be so in the case of removal to hospital by ambulance of unfortunate people who have been taken ill or suffered injury and as a result are incapacitated from expressing consent. I wish further to add that I cannot see that Dr M.'s statements to the effect that she would if necessary have taken steps compulsorily to detain [the applicant] under the Act of 1983 have any impact on the above conclusions. Those concerned with the treatment and care of mentally disordered persons must always have this possibility in mind although, like Dr M., they will know that this power is only to be exercised in the last resort and they may hope, as in the present case, that it would prove to be unnecessary to exercise it. Such power, if exercised in accordance with the statute, is of course lawful. In the present case all the steps in fact taken by Dr M. were, in my opinion, lawful because justified

under the common-law doctrine of necessity, and this conclusion is unaffected by her realisation that she might have to invoke the statutory power of detention.

Finally, the readmission of [the applicant] to hospital as an informal patient under section 131(1) of the Act of 1983 could not, in my opinion, constitute the tort of false imprisonment. His readmission, as such, did not constitute a deprivation of his liberty. As Dr M. stated in paragraph 9 of her affidavit, he was not kept in a locked ward after he was admitted. And the fact that she, like any other doctor in a situation such as this, had it in her mind that she might thereafter take steps to detain him compulsorily under the Act, did not give rise to his detention in fact at any earlier date. Furthermore, his treatment while in hospital was plainly justified on the basis of the common-law doctrine of necessity. It follows that none of these actions constituted any wrong against [the applicant].”

43. For these reasons, Lord Goff allowed the appeal. He had two “subsidiary points”, the second one being as follows:

“... the function of the common-law doctrine of necessity [lies] in justifying actions which might otherwise be tortious, and so has the effect of providing a defence to actions in tort. The importance of this was, I believe, first revealed in the judgments in *Re F. (Mental Patient: Sterilisation)* [1990] 2 AC 1. I wish, however, to express my gratitude to counsel for the appellants ... for drawing to our attention three earlier cases in which the doctrine was invoked, viz. *Rex v. Coate* (1772) Lofft 73, especially at p. 75, per Lord Mansfield, *Scott v. Wakem* (1862) 3 F. and F. 328, 333, per Bramwell B., and *Symm v. Fraser* (1863) 3 F. and F. 859, 883, per Cockburn CJ, all of which provide authority for the proposition that the common law permitted the detention of those who were a danger, or potential danger, to themselves or others, in so far as this was shown to be necessary. I must confess that I was unaware of these authorities though, now that they have been drawn to my attention, I am not surprised that they should exist. The concept of necessity has its role to play in all branches of our law of obligations – in contract (see the cases on agency of necessity), in tort (see *Re F. (Mental Patient: Sterilisation)* [1990] 2 AC 1), and in restitution (see the sections on necessity in the standard books on the subject) – and in our criminal law. It is therefore a concept of great importance. It is perhaps surprising, however, that the significant role it has to play in the law of torts has come to be recognised at so late a stage in the development of our law.”

44. Lord Nolan, for his part, agreed with the Court of Appeal that the applicant had been detained: he referred to the contents of Dr M.’s long letter of 6 August 1997 and to the additional matters on which the Court of Appeal had relied in this respect (and quoted above). Nevertheless, he allowed the appeal as he was satisfied that

“the trust and its medical staff behaved throughout not only in what they judged to be the best interests of [the applicant], but in strict accordance with their common-law duty of care and the common-law principle of necessity”.

45. Lord Steyn also allowed the appeal. He recognised that to uphold the decision of the Court of Appeal would be to ensure that a number of important protections applied to the applicant and that to allow the appeal would result in an indefensible gap in mental health law. However, he considered that it was possible, on a contextual interpretation of the 1983 Act, to allow the appeal.

46. In the first place, he found that the applicant had been detained:

“It is unnecessary to attempt a comprehensive definition of detention. In my view, this case falls on the wrong side of any reasonable line that can be drawn between what is or what is not imprisonment or detention. The critical facts are as follows: (1) When on 22 July 1997 at the Day Centre [the applicant] became agitated and started injuring himself, he was sedated and then physically supported and taken to the hospital. Even before sedation he was unable to express dissent to his removal to hospital. (2) Health care professionals exercised effective power over him. If [the applicant] had physically resisted, the psychiatrist would immediately have taken steps to ensure his compulsory admission. (3) In hospital staff regularly sedated him. That ensured that he remained tractable. This contrasts with the position when he was with carers: they seldom resorted to medication and then only in minimal doses. (4) The psychiatrist vetoed visits by the carers to [the applicant]. She did so, as she explained to the carers, in order to ensure that [the applicant] did not try to leave with them. The psychiatrist told the carers that [the applicant] would be released only when she, and other health care professionals, deemed it appropriate. (5) While [the applicant] was not in a locked ward, nurses closely monitored his reactions. Nurses were instructed to keep him under continuous observation and did so.

Counsel for the Trust and the Secretary of State argued that [the applicant] was in truth always free not to go to the hospital and subsequently to leave the hospital. This argument stretches credulity to breaking point. The truth is that for entirely bona fide reasons, conceived in the best interests of [the applicant], any possible resistance by him was overcome by sedation, by taking him to hospital and by close supervision of him in hospital. And if [the applicant] had shown any sign of wanting to leave, he would have been firmly discouraged by staff and, if necessary, physically prevented from doing so. The suggestion that [the applicant] was free to go is a fairy tale. ... In my view [the applicant] was detained because the health care professionals intentionally assumed control over him to such a degree as to amount to complete deprivation of his liberty”.

47. Secondly, he found that detention to be justified under the common-law doctrine of necessity:

“It is now necessary to consider whether there was lawful authority to justify the detention and any treatment of [the applicant]. This is a matter of statutory construction. But it is important to approach the mental health legislation against the context of the principles of the common law. The starting-point of the common law is that when a person lacks capacity, for whatever reason, to take decisions about medical treatment, it is necessary for other persons, with appropriate qualifications, to take such decision for him: *Re F. (Mental Patient: Sterilisation)* [1990] 2 AC 1, at 55H, per Lord Brandon of Oakbrook. The principle of necessity may apply. For the purposes of the present case it has been assumed by all counsel that the requirements of the principle are simply that (1) there must be ‘a necessity to act when it is not practicable to communicate with the assisted person’ and (2) ‘that the action taken must be such as a reasonable person would in all circumstances take, acting in the best interests of the assisted person’: *Re F.*, supra, per Lord Goff of Chieveley, at 75H. There was not unanimity on this point in *Re F.* But I am content to approach the matter in the same way as counsel did ... Against this common-law background the Percy Report recommended a shift from the ‘legalism’ whereby hospital patients were ‘certified’ by special procedures, to a situation in which most patients would be ‘informally’ received in hospital, the term ‘informally’ signifying ‘without any legal formality’. This was to be achieved by replacing the existing system ‘by the offer of

care, without deprivation of liberty, to all who need it and are not unwilling to receive it': see Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (1954-1957) ... The desired objective was to avoid stigmatising patients and to avoid where possible the adverse effects of 'sectioning' patients. Where admission to hospital was required compulsion was to be regarded as a measure of last resort. The Mental Health Act of 1959 introduced the recommended changes. Section 5(1) was the critical provision. ... Counsel appearing on behalf of [the applicant] accepted that the effect of section 5 was to leave in place the common-law principle of necessity as a justification for informally receiving in hospital or mental nursing homes compliant incapacitated patients.

In 1982 Parliament substantially amended the Act of 1959. In 1983 Parliament enacted a consolidating statute with amendments, namely the Mental Health Act 1983. By section 131(1) of the Act of 1983 the provisions of section 5(1) of the Act of 1959 were re-enacted verbatim. ... Prima facie section 131(1) must be given the same meaning as section 5(1). On this basis, section 131(1) also preserved the common-law principle of necessity as a means of admitting compliant incapacitated individuals. But counsel for [the applicant] submitted that section 131(1), unlike its predecessor, only applies to consenting capacitated patients. He argued that contextual differences between the statutes of 1959 and 1983 required the court to interpret the language of section 131(1) of the Act of 1983 in a narrower sense than section 5(1) of the Act of 1959. ... On orthodox principles of statutory interpretation the conclusion cannot be avoided that section 131(1) permits the admission of compliant incapacitated patients where the requirements of the principle of necessity are satisfied. Having had the benefit of the fuller argument produced by the intervention of the Secretary of State, I have to accept that the view of the Court of Appeal on the meaning of section 131(1) cannot be upheld."

48. Accordingly, the common-law doctrine of necessity had been preserved by section 131(1) of the 1983 Act and the applicant's detention and treatment were justified on that basis.

49. Lord Steyn went on to note that the effect of the House of Lords' judgment was to leave compliant incapacitated patients without the safeguards enshrined in the 1983 Act:

"This is an unfortunate result. The common-law principle of necessity is a useful concept, but it contains none of the safeguards of the 1983 Act. It places effective and unqualified control in the hands of the hospital psychiatrist and other health care professionals. It is, of course, true that such professionals owe a duty of care to patients and that they will almost invariably act in what they consider to be the best interests of the patient. But neither habeas corpus nor judicial review are sufficient safeguards against misjudgments and professional lapses in the case of compliant incapacitated patients. Given that such patients are diagnostically indistinguishable from compulsory patients, there is no reason to withhold the specific and effective protections of [the 1983 Act] from a large class of vulnerable mentally incapacitated individuals. Their moral right to be treated with dignity requires nothing less. The only comfort is that counsel for the Secretary of State has assured the House that reform of the law is under active consideration."

D. The Health Service Commissioner (“the Commissioner”)

50. In March 2000 Mr and Mrs E. complained to the Commissioner about the applicant’s readmission to hospital. The complaints subjected to investigation were: (a) that the clinical decision to admit the applicant on 22 July 1997 was unreasonable; and (b) that the clinical management of his admission was inadequate. The independent assessors investigated. In their report, they considered that the applicant’s admission to the IBU on 22 July 1997 was “probably unavoidable”. He had a significantly better quality of life with his carers and more serious consideration should have been given to sending him home on the day his carers had been located or, at least, the following day. The assessors considered that it was difficult to see why, even if it was necessary to retain him overnight, he was not discharged the following day and his subsequent evaluation conducted on an outpatient basis. The process of assessment of the applicant had been too long and resources should have been available to speed up that process. In this latter respect, the assessors did not believe that any of the clinicians were acting irresponsibly or maliciously and their main recommendation for the future was that admissions to the IBU be “strictly time-limited” and that adequate resources be made available to enable a multi-disciplinary assessment to be carried out if at all possible on an outpatient basis and, if not, as speedily as possible.

51. The Commissioner, in his report of 15 November 2001, agreed with the assessors’ conclusions, adopted their recommendations and conveyed the hospital’s apologies to Mr and Mrs E. for the shortcomings identified. The hospital had also informed the Commissioner that, through the Intensive Assessment and Treatment Service, the assessors’ recommendations for outpatient assessment had been implemented.

II. RELEVANT DOMESTIC LAW AND PRACTICE

A. Relevant statutory provisions

1. The Mental Health Act 1983 (“the 1983 Act”)

52. The majority of persons who receive in-patient psychiatric care are treated without resort to the compulsory powers under Part II of the 1983 Act and these are called “informal patients”.

Such patients are either “voluntary patients”, namely, those persons with legal capacity to consent and who have consented to admission for treatment, or persons who do not have the legal capacity to consent to treatment but who are admitted for treatment on an “informal basis” as they do not object to that admission (incapacitated but compliant).

53. Section 131(1) of the 1983 Act provides as follows:

“Nothing in this Act shall be construed as preventing a patient who requires treatment for mental disorder from being admitted to any hospital or mental nursing home in pursuance of arrangements made in that behalf and without any application, order or direction rendering him liable to be detained under this Act, or from remaining in any hospital or mental nursing home in pursuance of such arrangements after he has ceased to be so liable to be detained.”

54. The 1983 Act provides for a number of substantive and procedural safeguards to those “detained” under its provisions.

(a) Patients can only be detained for assessment (section 2) or for treatment (section 3) where the strict statutory criteria set out in Part II of the Act have been met. In general (and emergency admissions apart), detention requires the acceptance by the relevant institution of an application in the prescribed form by a qualified person. That application must be founded upon written medical recommendations in the prescribed form of two medical practitioners, both of whom have recently examined the patient and have no personal interest and one of whom has special experience in the diagnosis or treatment of mental disorder.

(b) Part IV of the 1983 Act sets out rules on the need to obtain a patient’s consent or a second medical opinion for certain forms of medical treatment.

(c) Part V provides for an opportunity to apply, or to be automatically referred, to a Mental Health Review Tribunal (“MHRT”) for a review of the need for continued detention.

(d) The “nearest relative” of a detainee has the power, *inter alia*, to object to an application for involuntary committal under section 3 of the 1983 Act, to discharge a patient from such detention and to apply to the MHRT (in certain cases) for a patient’s discharge (sections 26-32).

(e) A former detainee has access to aftercare services (section 117).

(f) The Secretary of State must create a Code of Practice (section 118) in order to guide those concerned with the treatment of psychiatric detainees. Section 120 charges the Secretary of State with the supervision of the exercise of the powers and duties conferred and imposed by the 1983 Act and accords him associated powers to visit, interview and investigate. Section 121 established the Mental Health Act Commission, which exercises the functions of the Secretary of State under section 118 and 120 of the 1983 Act.

(g) Detainees have a right to receive information about their detention from hospital managers (section 132 of the 1983 Act).

2. *The Health Service Commissioners Act 1993 (“the 1993 Act”)*

55. The relevant parts of section 3 of the 1993 Act, entitled “General remit of Commissioners”, provide:

“(1) On a complaint duly made to a Commissioner by or on behalf of a person that he has sustained injustice or hardship in consequence of –

(a) a failure in a service provided by a health service body,

(b) a failure of such a body to provide a service which it was a function of the body to provide, or

(c) maladministration connected with any other action taken by or on behalf of such a body,

the Commissioner may, subject to the provisions of this Act, investigate the alleged failure or other action.

...

(4) Nothing in this Act authorises or requires a Commissioner to question the merits of a decision taken without maladministration by a health service body in the exercise of a discretion vested in that body.”

56. Section 5 of the 1993 Act is entitled “Exercise of clinical judgment” and provides as follows:

“(1) A Commissioner shall not conduct an investigation in respect of action taken in connection with –

(a) the diagnosis of illness, or

(b) the care or treatment of a patient,

which, in the opinion of the Commissioner, was taken solely in consequence of the exercise of clinical judgment ...

(2) In subsection (1), ‘illness’ includes a mental disorder within the meaning of the Mental Health Act 1983 ...”

B. Relevant jurisprudence

1. General

57. The common-law doctrine of necessity was relied on as early as *Rex v. Coate* (1772) Lofft 73, *Scott v. Wakem* (1862) 3 Foster and Finalson’s Nisi Prius Reports 328, 333, and *Symm v. Fraser* (1863) 3 Foster and Finalson’s Nisi Prius Reports 859, 883 (see Lord Goff’s judgment, paragraph 43 above). These cases provide authority for the proposition that the common law permitted the detention of those who were a danger, or potential danger, to themselves or others, in so far as this was shown to be necessary. This jurisdiction has also been exercised in relation to a range of medical treatment issues and, in particular, in relation to sterilisation

operations (*Re F. (Mental Patient: Sterilisation)* [1990] 2 Appeal Cases 1) and the continuance of artificial nutrition and hydration (*Airedale NHS Trust v. Bland* [1993] Appeal Cases 789, 869).

58. The High Court has a certain jurisdiction to make declarations as to the best interests of an adult who lacks the capacity to make decisions. The jurisdiction will be exercised when there is a serious justiciable issue requiring a decision by the court.

2. *Re F. (Adult: Court's Jurisdiction)* ([2001] *Family Division Reports* 38)

59. In June 2000 the Court of Appeal found that, where there was a risk of possible harm to a mentally incapable adult, the High Court had power, under its inherent jurisdiction and in the best interests of that person, to hear the issues involved and to grant the necessary declarations. It therefore dismissed an appeal which contested the High Court's jurisdiction to make a declaration requested by a local authority in respect of the residence and contacts of an adult who lacked capacity and who was at risk of harm.

60. Lady Justice Butler-Sloss noted that the local authority was seeking to rely on the inherent jurisdiction of the court under the doctrine of necessity in order to direct where T. should live and to restrict and supervise her contact with her natural family. The local authority, supported by the Official Solicitor, submitted that the doctrine operated on a day-to-day basis in making ordinary decisions for the care and protection of an incapable adult as recognised in the present case (*R v. Bournewood Community and Mental Health NHS Trust, ex parte L.* [1999] Appeal Cases 458). T.'s mother contended that the courts were unable to fill the gap caused by statutory amendments: while there was a limited jurisdiction to make declarations in medical cases on issues capable of resolution at the time of hearing, that did not extend to cases where the effect would be coercive over a long period without limit of time and without a clear view of future requirements for that person.

61. Lady Justice Butler-Sloss had no doubt that there was a serious justiciable issue which required a decision by the court. Mental health legislation did not cover the day-to-day affairs of mentally incapable adults and in both *Re F. (Mental Patient: Sterilisation)* and *Bournewood* (cited above) the courts had recognised that the doctrine of necessity might properly be relied on side by side with the statutory regime. The jurisdiction of the High Court to grant relief by way of declarations was therefore not excluded by the Mental Health Act 1983. As to the question of whether the problem (residence and contact) arising in the case came within the established principles so as to give the court jurisdiction to hear the issue of T.'s best interests and make declarations, she found in the affirmative:

“There is an obvious gap in the framework of care for mentally incapacitated adults. If the court cannot act and the local authority case is correct, this vulnerable young

woman would be left at serious risk with no recourse to protection, other than the future possibility of the criminal law. That is a serious injustice to T. who has rights which she is unable, herself, to protect.

...

Although the decision of this court in *Re S. (Hospital Patient: Court's Jurisdiction)* [1996] Fam 1 turned upon the *locus standi* of the claimant, the underlying issue, recognised by counsel and by this court was the best interests of S. When the matter was remitted to Hale J for decision, the question that she answered was his future residence (see *Re S. (Hospital Patient: Foreign Curator)* [1996] 1 FLR 167. Lord Goff in *Bournewood* recognised ... that the concept of necessity had a role to play in all branches of the law where obligations existed and was therefore a concept of great importance. In *Re S.* the Master of the Rolls set out the long-established power of the High Court to grant declarations in a wide variety of situations and to assume jurisdiction if there is no practicable alternative. He looked at the line of medical and similar cases and said at page 18 ... :

‘Collectively, these cases appear to constitute the development of a new advisory declaratory jurisdiction.’

In *Re C. (Mental Patient: Contact)* [1993] 1 FLR 940, one of the cases referred to by Sir Thomas Bingham MR, there was a dispute between the parents of an adult mentally incapacitated girl over contact between her and her mother. Eastham J held ... that:

‘In an appropriate case, if the evidence bears out the proposition that access is for the benefit of the patient in this case, S., I see no reason at all why the court should not grant access by way of a declaration.’

In both *Re C.* and *Re S.* the declarations sought were in support of identifying the best interests of an incapable adult where individuals around him or her were in conflict over his/her future welfare. The application for declaratory relief in the present appeal is between a local authority and a mother but ... there is no distinction to be drawn between a local authority and an individual. A declaration is, in many ways, a flexible remedy able to meet a variety of situations. In the present conflict, where serious question marks hang over the future care of T. if returned to her mother, there is no practicable alternative to the intervention of the court. The declarations sought by the local authority may require alteration according to the facts found by the judge, but he would have the jurisdiction to vary them to meet the situation after those findings were made. There is the possibility that the judgment itself might resolve the situation. If it does not and declarations are required which determine where T should live, there is nothing in principle to inhibit a declaration that it was in her best interests that she should live in a local authority home and should not live anywhere else, nor, while she was in the home to regulate the arrangements for her care and as to with whom she might have contact. Such were the implications of the second stage of *Re S.* before Hale J and of *Re C.* (above).

I am clear that it is essential that T.’s best interests should be considered by the High Court and that there is no impediment to the judge hearing the substantive issues involved in this case.

The assumption of jurisdiction by the High Court on a case-by-case basis does not, however, detract from the obvious need expressed by the Law Commission and by the Government for a well-structured and clearly defined framework of protection of vulnerable, mentally incapacitated adults, particularly since the whole essence of declarations under the inherent jurisdiction is to meet a recognised individual problem and not to provide general guidance for mentally incapacitated adults. Until Parliament puts in place that defined framework, the High Court will still be required to help out where there is no other practicable alternative.”

3. R.-B. (A Patient) v. Official Solicitor, sub nom Re A. (Male Patient: Sterilisation) ([2000] 1 Family Court Reports 193).

62. Lady Justice Butler-Sloss found as follows in a judgment delivered in December 1999:

“Another question which arises from the decision in *Re F.* is the relationship of best interests to the *Bolam* test (*Bolam v. Friern Hospital Management Committee* [1957] 1 WLR 582). Doctors charged with the decisions about the future treatment of patients and whether such treatment would, in the cases of those lacking capacity to make their own decisions, be in their best interests, have to act at all times in accordance with a responsible and competent body of relevant professional opinion. That is the professional standard set for those who make such decisions. The doctor, acting to that required standard has, in my view, a second duty, that is to say he must act in the best interests of a mentally incapacitated patient. I do not consider that the two duties have been conflated into one requirement. To that extent I disagree with the Law Commission’s Report on Mental Incapacity (paragraph 3.26 ...) and I prefer the alternative suggestion in [the] footnote ... ”

4. R. (Wilkinson) v. the Responsible Medical Officer Broadmoor Hospital ([2001] Court of Appeal, Civil Division (England Wales) 1545).

63. Mr Wilkinson, an involuntary psychiatric detainee, applied for judicial review of past and future treatment decisions. He argued that the domestic court had to examine the competing medical views before it in order properly to review the lawfulness of the enforced medical treatment in his case. The respondents argued that the level of scrutiny on judicial review, even applying the “super-Wednesbury” approach, did not allow the courts to substitute their view for that of the primary medical decision-maker and opposed the examination of the relevant health professionals. The High Court refused to call and cross-examine the health professionals on their medical opinions.

64. By the time the Court of Appeal heard the case, the Human Rights Act 1998 (incorporating the Convention into domestic law) had come into force (in October 2000). The applicant argued therefore that the provisions of, *inter alia*, Articles 2, 3, 6, 8, and 14 of the Convention reinforced his position as to the level of examination of the varying medical views to be carried out, while the respondents maintained that the 1998 Act did not

mean that the courts must adopt a primary fact-finding role in such circumstances.

65. As regards any future proposed medical treatment (post-1998 Act), the Court of Appeal found that Articles 2, 3 and 8 of the Convention required, on judicial review, a full review of the merits of the relevant medical decisions and that a review in accordance with the “super-Wednesbury” criteria would not have been sufficiently intrusive as to constitute such a proper review of the merits of those medical decisions. In this connection, the Court of Appeal referred to the European Court’s judgment in *Smith and Grady v. the United Kingdom* (nos. 33985/96 and 33986/96, §§ 135-39, ECHR 1999-VI).

C. The Law Commission’s Report on “Mental incapacity”, February 1995

66. In the early 1990s the Law Commission produced a series of consultation papers entitled “Mental incapacitated adults and decision-making” culminating in the above-mentioned report. The introduction noted:

“1.1. It is widely recognised that ... the law as it now stands is unsystematic and full of glaring gaps. It does not rest on clear or modern foundations of principle. It has failed to keep up with social and demographic changes. It has also failed to keep up with developments in our understanding of the rights and needs of those with mental instability.”

67. As to the meaning of best interests, the report noted as follows:

“3.26. Our recommendation that a ‘best interests’ criterion should apply throughout our scheme cannot be divorced from a recommendation that statute should provide some guidance to every decision-maker about what the criterion requires. No statutory guidance could offer an exhaustive account of what is in a person’s best interests, the intention being that the individual person and his or her individual circumstances should always determine the result. In our 1993 consultation papers, however, we suggested that certain principles of general application would always be relevant. At least in so far as substitute health-care decisions are concerned, the principles we suggested probably involve a significant departure from the present state of the law. This, as set out in [*Re F. (Mental Patient: Sterilisation)*] [1990] 2 AC 1, appears to provide that a doctor who acts in accordance with an accepted body of medical opinion is both (1) not negligent and (2) acting in the best interests of a patient without capacity.”

The footnote at this point in the report (and to which Lady Justice Butler-Sloss referred in *R.-B. (A Patient) v. Official Solicitor*, cited above) indicated as follows:

“It may be that all [the judges in *Re F.*] were saying was that a doctor must *both* (1) meet the standard of care required to avoid liability in negligence and (2) act in an incapacitated patient’s best interests. However, since they gave no indication of how those ‘best interests’ were to be identified, some commentators have concluded that the two requirements were in fact one. The speeches of the law lords in *Airedale NHS*

Trust v. Bland [1993] AC 789 cannot be said to have resolved this important point, and Lord Goff again referred to the professional negligence standard when discussing what was in the patient's best interests."

68. The report went on:

"This apparent conflation of the criterion for assessing complaints about professional negligence with the criterion for treating persons unable to consent has been the butt of vehement criticism. No medical professional body responding to consultation paper no. 129 argued in favour of retaining such a definition of 'best interests'. Many were extremely anxious to see some clear and principled guidance given as to what 'best interests' might involve. ...

3.27. It should be made clear beyond any shadow of a doubt that acting in a person's best interests amounts to something more than not treating that person in a negligent manner. Decisions taken on behalf of a person lacking capacity require a careful, focused consideration of that person as an individual. Judgments as to whether a professional acted negligently, on the other hand, require careful, focused consideration of how that particular professional acted as compared with the way in which other reasonably competent professionals would have acted. ..."

69. The Law Commission recommended that, in deciding what is in a person's best interests, regard should be had to:

"(1) the ascertainable past and present wishes and feelings of the person concerned and the factors that person would consider if able to do so;

(2) the need to permit and encourage the person to participate, or to improve his or her ability to participate, as fully as possible in anything done for and any decision affecting him or her;

(3) the views of other people whom it is appropriate and practicable to consult about the person's wishes or feelings and what would be in his or her best interests;

(4) whether the purpose for which any action or decision is required can be as effectively achieved in a manner less restrictive of the person's freedom of action."

D. The Mental Health Act Code of Practice 1999

70. A revised Code of Practice, prepared pursuant to section 118 of the 1983 Act, came into force on 1 April 1999. The 1983 Act did not impose a legal duty to comply with the Code but, as it was a statutory document, failure to follow it could be referred to in evidence in legal proceedings.

71. Under the title "Informal patients", the Code stated:

"2.7. Where admission to hospital is considered necessary and the patient is willing to be admitted informally this should in general be arranged. Compulsory admission powers should only be exercised in the last resort. Informal admission is usually appropriate when a mentally capable patient consents to admission, but not if detention is necessary because of the danger the patient presents to him or herself or others. Compulsory admission should be considered where a mentally capable patient's current medical state, together with reliable evidence of past experience,

indicates a strong likelihood that he or she will have a change of mind about informal admission prior to actually being admitted to hospital, with a resulting risk to their health or safety or to the safety of other people.

2.8. If at the time of admission the patient is mentally incapable of consent, but does not object to entering hospital and receiving care or treatment, admission should be informal (see *R. v. Bournewood Community and Mental Health NHS Trust, ex parte L.* [1998] 3 ALL ER 289 ...). The decision to admit a mentally incapacitated patient informally should be made by the doctor in charge of the patient's treatment in accordance with what is in the patient's best interests and is justifiable on the basis of the common-law doctrine of necessity ... If a patient lacks capacity at the time of an assessment or review, it is particularly important that both clinical and social care requirements are considered, and that account is taken of the patient's ascertainable wishes and feelings and the views of their immediate relatives and carers on what would be in their best interests."

72. The relevant parts of paragraph 15.21 read as follows:

"There are particular considerations that doctors must take into account in discharging their duty of care for those who lack capacity to consent. Treatment for their condition may be prescribed for them in their best interests under the common-law doctrine of necessity (see the decisions of the House of Lords in *Re F.* [1990] 2 AC 1 and *R. v. Bournewood Community and Mental Health NHS Trust, ex parte L.* [1998] 3 ALL ER 289). According to the decision in the case of *Re F.*, if treatment is given to a patient who is not capable of giving consent, 'in the patient's best interests' the treatment must be:

- necessary to save life or prevent a deterioration or ensure an improvement in the patient's physical or mental health; and
- in accordance with a practice accepted at the time by a reasonable body of medical opinion skilled in the particular form of treatment in question (the test that was originally laid down in [the *Bolam* case])."

E. Practice Note and Direction 2001

73. On 1 May 2001 a practice note was issued by the Official Solicitor entitled "Declaratory proceedings: medical and welfare decisions for adults who lack capacity". It combined the guidance given in earlier practice notes concerning sterilisation operations for incapacitated persons and the continuance of artificial nutrition and hydration for those in vegetative states, and was extended to cover a wider range of medical and welfare disputes concerning adults who lack capacity. The relevant parts provide:

"2. The High Court has jurisdiction to make declarations as to the best interests of an adult who lacks decision-making capacity. The jurisdiction will be exercised when there is a serious justiciable issue requiring a decision by the court. It has been exercised in relation to a range of medical treatment issues, in particular sterilisation operations and the continuance of artificial nutrition and hydration. It has also been exercised in relation to residence and contact issues. The jurisdiction is

comprehensively reviewed and analysed in *Re F. (Adult: Court's Jurisdiction)* [2000] 2 FLR 512.

THE NEED FOR COURT INVOLVEMENT

3. Case-law has established two categories of case that will in virtually all cases require the prior sanction of a High Court judge. The first is sterilisation of a person (whether a child or an adult) who cannot consent to the operation: *Re B. (A Minor) (Wardship: Sterilisation)* [1988] AC 199 and *Re F. (Mental Patient: Sterilisation)* [1990] 2 AC 1. The second is the discontinuance of artificial nutrition and hydration for a patient in a vegetative state: *Airedale NHS Trust v. Bland* [1993] AC 789, 805. Further guidance about sterilisation and vegetative state cases is given below. In all other cases, doctors and carers should seek advice from their own lawyers about the need to apply to the court. In the Official Solicitor's view, applications should be made where there are disputes or difficulties as to either the patient's capacity or the patient's best interests. Guidelines were handed down by the Court of Appeal in *St George's Healthcare NHS Trust v. S.; R. v. Collins and Others, ex parte S.* [1998] 2 FLR 728, 758-760. It was stressed in that case that a declaration made without notice would be ineffective and ought not to be made.

...

THE EVIDENCE

7. The claimant must adduce evidence going to both capacity and best interests.

(i) Capacity

The court has no jurisdiction unless it is established that the patient is incapable of making a decision about the matter in issue. The test of capacity to consent to or refuse treatment is set out in *Re M.B. (Medical Treatment)* [1997] 2 FLR 426, 437. ...

(ii) Best interests

In any medical case, the claimant must adduce evidence from a responsible medical practitioner not only (1) that performing the particular operation would not be negligent but also (2) that it is necessary in the best interests of the patient: *Re A. (Male Sterilisation)* [2000] 1 FLR 549, 555. The court's jurisdiction is to declare the best interests of the patient on the application of a welfare test analogous to that applied in wardship: *Re S. (Sterilisation: Patient's Best Interests)* [2000] 2 FLR 389, 403. The judicial decision will incorporate broader ethical, social, moral and welfare considerations (*ibid.*, 401). Emotional, psychological and social benefit to the patient will be considered: *Re Y. (Mental Patient: Bone Marrow Transplant)* [1997] Fam 110. The court will wish to prepare a balance sheet listing the advantages and disadvantages of the procedure for the patient. If potential advantages and disadvantages are to be relied on then the court will wish to assess in percentage terms the likelihood of them in fact occurring: *Re A. (Male Sterilisation)* [2000] 1 FLR 549, 560."

74. A practice direction (issued by the High Court with the approval of the Lord Chief Justice and the Lord Chancellor on 14 December 2001 and entitled "Declaratory proceedings: incapacitated adults") pointed out that

proceedings which involved its jurisdiction to grant declarations as to the best interests of incapacitated adults were more suited to the Family Division and that the note detailed in the preceding paragraph provided valuable guidance in relation to such proceedings and “should be followed”.

F. Proposed legislative reform

75. Further to the publication (in December 2000) of a White Paper on reforming the mental health legislation, a draft Mental Health Bill and a consultation paper were published in June 2002. The objective of the bill, as described in the consultation paper, was twofold: to provide a legal structure for requiring mentally disordered persons to submit to compulsory treatment without necessarily requiring them to be detained in hospital and bringing the law more closely into line with modern human rights law (notably the case-law of the European Convention on Human Rights). Part 5 of the bill (sections 121-39) was entitled “Informal treatment of patients not capable of consenting” and provided for specific safeguards for qualifying patients.

76. Steps were also taken towards developing legislation on the broader question of incapacity. Having published a consultation paper in December 1997 entitled “Making decisions on behalf of mentally incapacitated adults”, the Government published its proposals in October 1999. It was proposed that legislation provide for a general authority enabling a person acting reasonably to make decisions on behalf of an incapacitated person and in the incapacitated person’s best interests. The general authority would extend to decisions about care and welfare, including medical decisions.

77. Subsequently, a Mental Capacity Bill was introduced in the House of Commons on 17 June 2004. On the assumption that additional safeguards for the care of incapacitated patients would be most appropriately included in legislation on capacity rather than on mental health, this bill provides for a detailed statutory framework to empower and protect vulnerable people incapable of making their own decisions and for safeguards not currently available under the common law.

78. In particular, the Mental Capacity Bill sets out in statutory form a number of common-law principles, including that everything done must be in the best interests of the patient and in a manner least restrictive of the patient’s rights. It sets down detailed tests for the assessment of capacity and best interests. The bill creates new mechanisms for the appointment, where appropriate, of a designated decision-maker to act on behalf of an incapacitated patient and to be consulted on any decision made: either a lasting power of attorney (which allows the appointment of someone to act on one’s behalf in the case of future loss of capacity) or a court-appointed deputy (who can make decisions on welfare, health care and financial matters as determined by the court). Two new public bodies are also proposed by the bill to support the statutory framework: a new court of

protection (for dispute resolution on matters such as capacity and best interests) and a public guardian (a registered authority with supervisory responsibilities as regards the designated decision-makers described above). The bill also provides for the input of an independent consultee (for a person lacking capacity who has no one who can be consulted about his or her best interests), allows individuals to make an “advance decision” to refuse treatment should they lose capacity in the future and creates a new criminal offence of “ill-treatment or neglect of a person lacking capacity”.

THE LAW

I. ALLEGED VIOLATION OF ARTICLE 5 § 1 OF THE CONVENTION

79. The applicant’s complaints under this provision concerned his time in the hospital as an “informal patient” between 22 July and 29 October 1997, which he maintained amounted to a “deprivation of liberty” within the meaning of Article 5 § 1 of the Convention. He asserted that that detention was neither “in accordance with a procedure prescribed by law” nor “lawful” because he was not of unsound mind; the doctrine of necessity did not reflect the criteria for a valid detention under Article 5 § 1 (e) and lacked precision; and there were insufficient safeguards against arbitrary detention on grounds of necessity. He added that he remained of sound mind during his subsequent detention under the 1983 Act (from 29 October to 12 December 1997). The relevant parts of Article 5 § 1 of the Convention provide:

“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 ...;

...”

A. Whether the applicant was “deprived of his liberty” from 22 July to 29 October 1997

1. The parties’ submissions

80. The Government explained that acceptance by the Court that the applicant was “detained” would run counter to the long-held wish of the United Kingdom to avoid the formal statutory procedures of compulsory

psychiatric committal for incapacitated patients unless absolutely necessary, the informality, proportionality and flexibility of the common-law doctrines being considered distinctly preferable.

A finding that the present applicant was “detained” would mean that the care of incapacitated but compliant persons elsewhere (even in a private house or nursing home) would be considered detention, a conclusion which would have onerous legal and other implications for such patients and for any person or organisation having responsibility for their care and welfare. In addition, a person already suffering from a socially difficult illness must not unnecessarily suffer the additional stigma of being “sectioned”. Accordingly, just as incapacitated persons requiring medical treatment could be admitted and treated in hospital informally in their best interests, so too should incapacitated persons requiring psychiatric treatment. Moreover, consensual non-imposed treatment was considered more likely to attract a degree of cooperation from the patient and to be therefore more beneficial therapeutically. Furthermore, informal admission and treatment in an incapacitated patient’s best interests meant that that person was treated with the required dignity. These considerations explained the provisions of the new draft Mental Health Bill (paragraphs 75-77 above). The Government therefore hoped that the Court’s judgment would be consistent with these policy aims and would not require States to apply the full rigour of a statutory regime of involuntary committal to all incapacitated patients requiring psychiatric treatment.

81. As a further preliminary submission, the Government considered that the case should be examined on the basis of a presumption that all professionals involved with the care of the applicant acted in good faith and in what they considered to be his best interests in circumstances where he could not act for himself and was totally dependent.

82. Turning specifically to whether the applicant was “detained”, the Government relied on the test outlined in *Ashingdane v. the United Kingdom* (judgment of 28 May 1985, Series A no. 93, p. 19, § 41). The House of Lords had applied this test to resolve the essential question of fact, finding that the applicant had not been “detained”, and the Court should not go back on such domestic findings of fact.

83. Applying this test, the Government reasoned that, if one took the case of a person who plainly had the capacity to consent to psychiatric treatment, the regime in the hospital was clearly one which did not amount to a deprivation of liberty. The regime applied to the applicant was not materially different and could not be considered to amount to a deprivation of liberty simply because he lacked capacity. In any event, the applicant did not object to being in hospital. While he might have been detained if he had attempted to leave hospital, an intention to detain someone in the future does not amount to detention for the purposes of Article 5. Indeed, since the lucidity of an individual with a psychiatric disorder might vary over time,

one could not base a finding of detention merely on a mental state if the underlying regime remained the same. Further, whether the applicant was in the carers' home or in the hospital was not, in itself, relevant to the determination of whether there had been a deprivation of liberty, since it was the nature of the restrictions that was relevant. Those restrictions did not amount to involuntary detention but rather to necessary and proper care for someone with the applicant's needs.

84. The Government relied on *Nielsen v. Denmark* (judgment of 28 November 1988, Series A no. 144) and *H.M. v. Switzerland* (no. 39187/98, § 48, ECHR 2002-II). As in *Nielsen*, the hospital remained responsible for the applicant's treatment and, in particular, was obliged to take decisions in his best interests and on his behalf even after his trial discharge to his carers in 1994. *H.M. v. Switzerland* was, in their view, the most recent expression by the Court of its opinion on the question of whether or not a person could be considered to have been "detained" in circumstances where he or she was unable to express clearly whether or not they wished to be in the relevant institution.

85. In the Government's opinion, none of the factors to which the applicant referred amounted, alone or together, to a deprivation of liberty.

As to the doors of the relevant unit being locked, the Government noted that this allegation could have been, but was not, made in the domestic proceedings and the Court should not be required to resolve such a disputed fact. In any event, the Government noted the affidavit evidence of Dr M. (see paragraph 41 above) and the finding by Lord Goff (see paragraph 42 above) that the doors were unlocked, together with the failure by the Commissioner to come to any conclusion on this point. Indeed, this factor needed to be carefully approached in the context of mentally disordered patients incapable of looking after themselves as their care might inevitably include locking doors temporarily as a precaution, in order to prevent them from harming themselves. In addition, there was some evidence that the applicant had not been denied access to his carers as he alleged.

86. The applicant maintained that the Convention notion of detention was more flexible than that of the House of Lords and included notions of psychological detention, potential detention (perceived threat of restraint) and the removal of the means of escape. He also agreed that the *Ashingdane* test had to be applied in order to determine in a specific case whether a person had been detained so that the type, duration, effects and manner of implementation of the measure in question had to be examined.

As to the type of detention, the hospital was an authorised "detaining institution", the conditions of which were to be distinguished from those of his home with his carers. As to the duration, he was detained for four months and twenty-one days for assessment whereas an involuntary admission for assessment under section 2 of the 1983 Act is for a maximum of twenty-eight days and for treatment under section 3 of the 1983 Act is for

a maximum of six months. The effect on the applicant of his stay in the hospital was a marked deterioration in his well-being. As to the manner of implementation, the applicant maintained (as did Lord Steyn in the House of Lords – see paragraph 46 above) that, for a number of reasons detailed by him, the idea that he was free to leave was a “fairy tale”.

87. Accordingly, he considered the question of whether the doors of the relevant unit had been locked not to be, in itself, determinative of whether he had been deprived of his liberty within the meaning of Article 5 § 1 of the Convention. However, he continued to maintain as a matter of fact that the doors had been locked and explained why he had not challenged the hospital’s evidence on this point in the domestic proceedings. Once he raised the point before the Commissioner, the evidence was to the effect that the doors had been locked for most of the time.

88. He maintained that *Nielsen* (cited above) was distinguishable because the applicant in that case was a minor who had been admitted on the basis of parental consent and detained for as long as consent lasted (type of measure). He was not medicated and was able to visit and be visited (manner of implementation). *H.M. v. Switzerland* (cited above) was also distinguishable: in that case, the applicant was in a terrible state before admission and improved thereafter to the extent that she agreed to stay in the institution (effect of the measure). The relevant foster home was an open institution, H.M. had freedom of movement (indeed, her freedom of movement was enhanced by the care in the institution) and she could maintain contact with the outside world (manner of implementation). While the applicants’ situation in *Nielsen* and *H.M. v. Switzerland* fell short of “detention” by reference to the *Ashingdane* criteria, his own regime fell within that category.

2. The Court’s assessment

89. It is not disputed that in order to determine whether there has been a deprivation of liberty, the starting-point must be the concrete situation of the individual concerned and account must be taken of a whole range of factors arising in a particular case such as the type, duration, effects and manner of implementation of the measure in question. The distinction between a deprivation of, and a restriction upon, liberty is merely one of degree or intensity and not one of nature or substance (see *Guzzardi v. Italy*, judgment of 6 November 1980, Series A no. 39, p. 33, § 92, and *Ashingdane*, cited above, p. 19, § 41).

90. The Court observes that the High Court and the majority of the House of Lords found that the applicant had not been detained during this period, while the Court of Appeal and a minority of the House of Lords found that he had. Although this Court will have regard to the domestic courts’ related findings of fact, it does not consider itself bound by their legal conclusions as to whether the applicant was detained or not, not least

because the House of Lords considered the question from the point of view of the tort of false imprisonment (see paragraph 39 above) rather than the Convention concept of “deprivation of liberty” in Article 5 § 1, the criteria for assessing those domestic and Convention issues being different.

In this latter respect, considerable emphasis was placed by the domestic courts, and by the Government, on the fact that the applicant was compliant and never attempted, or expressed the wish, to leave. The majority of the House of Lords specifically distinguished actual restraint of a person (which would amount to false imprisonment) and restraint which was conditional upon his seeking to leave (which would not constitute false imprisonment). The Court does not consider such a distinction to be of central importance under the Convention. Nor, for the same reason, can the Court accept as determinative the fact relied on by the Government that the regime applied to the applicant (as a compliant incapacitated patient) did not materially differ from that applied to a person who had the capacity to consent to hospital treatment, neither objecting to their admission to hospital. The Court reiterates 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 (see *De Wilde, Ooms and Versyp v. Belgium*, judgment of 18 June 1971, Series A no. 12, p. 36, §§ 64-65), especially when it is not disputed that that person is legally incapable of consenting to, or disagreeing with, the proposed action.

91. Turning therefore to the concrete situation, as required by *Ashingdane*, the Court considers the key factor in the present case to be that the health care professionals treating and managing the applicant exercised complete and effective control over his care and movements from 22 July 1997, when he presented acute behavioural problems, to 29 October 1997, when he was compulsorily detained.

More particularly, the applicant had been living with his carers for over three years. On 22 July 1997, following a further incident of violent behaviour and self-harm at his day-care centre, the applicant was sedated before being brought to the hospital and subsequently to the IBU, in the latter case supported by two persons. His responsible medical officer (Dr M.) indicated clearly that, had the applicant resisted admission or subsequently tried to leave, she would have prevented him from doing so and would have considered his involuntarily committal under section 3 of the 1983 Act (see paragraphs 12, 13 and 41 above). Indeed, as soon as the Court of Appeal indicated that his appeal would be allowed, he was compulsorily detained under the 1983 Act. The correspondence between the applicant’s carers and Dr M. (see paragraphs 23-30 above) reflects both the carers’ wish to have the applicant immediately released to their care and, equally, the clear intention of Dr M. and the other relevant health care professionals to exercise strict control over his assessment, treatment,

contacts and, notably, movement and residence; the applicant would only be released from the hospital to the care of Mr and Mrs E. as and when those professionals considered it appropriate. While the Government suggested that “there was some evidence” that the applicant had not been denied access to his carers, it is clear from the above-noted correspondence that the applicant’s contact with his carers was directed and controlled by the hospital, his carers not visiting him after his admission until 2 November 1997

Accordingly, the concrete situation was that the applicant was under continuous supervision and control and was not free to leave. Any suggestion to the contrary is, in the Court’s view, fairly described by Lord Steyn as “stretching credulity to breaking point” and as a “fairy tale” (see paragraph 46 above).

92. The Court would therefore agree with the applicant that it is not determinative whether the ward was “locked” or “lockable” (the evidence before the House of Lords and the Commissioner appearing to differ on this point). In this regard, it notes that the applicant in *Ashingdane* was considered to have been “detained” for the purposes of Article 5 § 1 (e) even during a period when he was in an open ward with regular unescorted access to the unsecured hospital grounds and the possibility of unescorted leave outside the hospital (pp. 13-14, § 24, and pp. 19-20, § 42).

93. Considerable reliance was placed by the Government on *H.M. v. Switzerland* (cited above), in which it was held that the placing of an elderly applicant in a foster home, to ensure necessary medical care as well as satisfactory living conditions and hygiene, did not amount to a deprivation of liberty within the meaning of Article 5 of the Convention. However, each case has to be decided on its own particular “range of factors” and, while there may be similarities between the present case and *H.M. v. Switzerland*, there are also distinguishing features. In particular, it was not established that H.M. was legally incapable of expressing a view on her position. She had often stated that she was willing to enter the nursing home and, within weeks of being there, she had agreed to stay. This, combined with a regime entirely different to that applied to the present applicant (the foster home was an open institution which allowed freedom of movement and encouraged contact with the outside world), leads to the conclusion that the facts in *H.M. v. Switzerland* were not of a “degree” or “intensity” sufficiently serious to justify the finding that she was detained (see *Guzzardi*, cited above, p. 33, § 93).

The Court also finds a conclusion that the present applicant was detained consistent with *Nielsen* (cited above), on which the Government also relied. That case turned on the specific fact that the mother had committed the applicant minor to an institution in the exercise of her parental rights (see *Nielsen*, pp. 23-24, § 63, and pp. 24-25, § 68), pursuant to which rights she could have removed the applicant from the institution at any time. Although

the Government noted that the hospital retained responsibility for the present applicant following his release in 1994, the fact that the hospital had to rely on the doctrine of necessity and, subsequently, on the involuntary detention provisions of the 1983 Act demonstrates that the hospital did not have legal authority to act on the applicant's behalf in the same way as Jon Nielsen's mother.

94. The Court therefore concludes that the applicant was "deprived of his liberty" within the meaning of Article 5 § 1 of the Convention from 22 July 1997 to 29 October 1997.

B. Whether the detention was "in accordance with a procedure prescribed by law" and "lawful" within the meaning of Article 5 § 1 (e)

1. Whether the applicant was of unsound mind

(a) The parties' submissions

95. The Government observed that the applicant had been detained in his best interests for psychiatric assessment and treatment on the basis of the common-law doctrine of necessity. This was unanimously established by the House of Lords, which finding should not be reviewed by the Court.

96. The Government pointed out that it was common ground during the domestic proceedings that the applicant was of unsound mind and required detention for treatment until he could be released to his carers, and it was not for the Court, given its subsidiary function, to substitute its own judgment for that of the medical experts but rather to ensure that those expert opinions had an objective and reliable basis. There was no reason why the domestic courts could not have reviewed whether the facts of the case justified detention, a review which could have included an examination of whether what was done in the interests of the applicant had been reasonably done. The Government did not accept that the Commissioner's conclusion amounted to a finding, as claimed by the applicant, that he was not of "unsound mind"; there was no express finding to that effect and such a conclusion could not be drawn from the contents of his report.

97. The applicant maintained that there was no legal basis for his detention because, while he may have been suffering from a mental disorder on 22 July 1997 and the circumstances that led to his being taken to the hospital on that day amounted to an emergency, his mental disorder was not of such a nature or degree as to justify his subsequent admission to the hospital's IBU or, alternatively, it ceased to be of such a degree shortly thereafter. Since there was no domestic court examination of whether he was of unsound mind within the meaning of Article 5 § 1 (e) and

Winterwerp v. the Netherlands (judgment of 24 October 1979, Series A no. 33), the State could not discharge its burden of proof and establish that there was a legal basis for his detention.

In this respect, he pointed out that, while the domestic courts might have concluded that the hospital had acted in good faith and reasonably in his best interests, and while the Commissioner may not have found that the hospital acted irresponsibly or maliciously, the Commissioner found it difficult to understand why the applicant had not been released to his carers on 22 July 1997 or at least the following day. The Court was not being requested to overturn the findings of the domestic courts but rather to prefer the conclusion of the Commissioner as the only body to have made findings on the applicant's state of mind after a proper assessment of the evidence.

(b) The Court's assessment

98. The Court reiterates that an individual cannot be deprived of his liberty on the basis of unsoundness of mind unless three minimum conditions are satisfied: he must reliably be shown to be of unsound mind; the mental disorder must be of a kind or degree warranting compulsory confinement; and the validity of continued confinement depends upon the persistence of such a disorder (see *Winterwerp*, cited above, pp. 17-18, § 39; *Luberti v. Italy*, judgment of 23 February 1984, Series A no. 75, pp. 12-13, § 27; *Johnson v. the United Kingdom*, judgment of 24 October 1997, *Reports of Judgments and Decisions* 1997-VII, p. 2419, § 60; and *Hutchison Reid v. the United Kingdom*, no. 50272/99, § 48, ECHR 2003-IV). The national authorities have a certain margin of appreciation regarding the merits of clinical diagnoses since it is in the first place for them to evaluate the evidence in a particular case: the Court's task is to review under the Convention the decisions of those authorities (see *Luberti* and *Winterwerp*, cited above, pp. 12-13, § 27, and p. 18, § 40, respectively).

99. In this connection, the Court notes that the applicant has not suggested that the relevant health care professionals acted other than in good faith, responsibly and in what they considered to be his best interests. He had had a long history of serious behavioural problems and special care requirements, and had been treated in the hospital for over thirty years following which he was discharged in 1994 on a trial basis only. There is evidence of increasingly difficult behavioural problems before July 1997 (see paragraphs 13, 14 and 39 above). It was not disputed that the applicant was suffering from a mental disorder on 22 July 1997, that he was agitated, self-harming and controllable with sedation only while in the day-care centre or that he had given rise to an emergency situation on that day. Having regard to the detailed consideration of the matter by Dr M. (who had cared for the applicant since 1977) and by the other health care professionals on that day (see paragraphs 12, 13 and 39 above) together with the day-care centre's report (see paragraph 14), the Court considers

that there is adequate evidence justifying the initial decision to detain the applicant on 22 July 1997.

Thereafter, Dr M.'s correspondence with Mr and Mrs E. is demonstrative of a detailed assessment of the applicant and the consistent clinical view, maintained throughout the relevant period, of Dr M. and other health care professionals involved that the applicant required admission for such assessment and treatment. Dr G. was briefed by the applicant's carers and he expressed the same view in his report of August 1997. On the basis of the material before them, the judges of the House of Lords were unanimous in finding his detention to be justified on the grounds of necessity in his best interests. Lord Goff relied on the above-mentioned affidavit of Dr M. in which she opined that the applicant required admission for assessment and treatment and would have been considered for involuntary committal under the 1983 Act if he had tried to leave (see paragraphs 39-41 above). As noted above, once the possibility of his leaving arose in October 1997, the formal procedures for his committal were put in place (section 5(2) of the 1983 Act) followed by a committal under section 3 of that Act, which latter procedure required two medical certificates attesting to the necessity of his committal for treatment for a mental disorder (see paragraph 54 above). Finally, the fact that he was, in the report dated 27 November 1997, found to be suffering from a mental impairment which no longer warranted confinement clearly does not undermine the validity of the prior assessments to the contrary. Indeed, following this first independent clinical indication that detention was no longer warranted, the applicant was released.

100. Given the above, the Court considers that the Commissioner's later and differing view as to the necessity for the applicant's detention provides limited support to the applicant. The Commissioner was not competent to review clinical decisions (see paragraphs 55-56 above), his examination covered welfare and social concerns broader than the strict clinical diagnoses and his principal concerns related to perceived delays in assessing the applicant in the hospital, the possibility of his being assessed at home and the manner in which the relationship with his carers had been handled by the hospital.

101. In such circumstances and on the material before it, the Court finds that the applicant has been reliably shown to have been suffering from a mental disorder of a kind or degree warranting compulsory confinement which persisted during his detention between 22 July and 5 December 1997.

2. Lawfulness and protection against arbitrary detention

(a) The Government's submissions

102. Noting that the House of Lords had unanimously accepted that the applicant had been detained in his best interests for psychiatric assessment

and treatment on the basis of the doctrine of necessity, the Government argued that the doctrine of necessity was sufficiently precise and its consequences adequately foreseeable as to constitute “law” within the meaning of the Convention.

103. In the first place, they argued that the Court had accepted that it was impossible, especially in a common-law system, for there to be absolute certainty in the formulation and application of certain rules of law. It had also been accepted that unwritten law, so long as it was sufficiently precise, could satisfy the requirements of Article 5 § 1 of the Convention. Indeed, the Government observed that the common law had the benefit of flexibility and evolution, so the fact that the Court of Appeal applied the doctrine of necessity in a particular way after the applicant’s detention did not mean that it would not have done so earlier if requested. It would be wrong therefore to characterise the doctrine of necessity (and notions of best interests, necessity and reasonableness) as too uncertain for the purposes of the lawfulness requirement of Article 5 § 1, not least because similar notions are used in many States’ systems and in the Convention system itself.

104. Secondly, the Government maintained that the doctrine of necessity was a well-established doctrine reaching as far back as the eighteenth century, and its precision was demonstrated by the thorough and authoritative examination in 1990 (see *Re F. (Mental Patient: Sterilisation)*, cited above) and by its subsequent application prior to and in the present case. In particular, the doctrine of necessity required the establishment of: a lack of capacity; the best interests of the patient (such interests being long-recognised as including considerations wider than the strictly medical, such as ethical, social, moral and welfare needs – see *Re F. (Adult: Court’s Jurisdiction)*, cited above, and the practice note and direction of May 2001, paragraphs 59-61 and 73-74 above); and that the proposed action was an objectively reasonable step to take. Professionals had to act in strict accordance with their common-law duty of care (Lord Nolan, paragraph 44 above).

105. As to the applicant’s submission concerning a conflict between the position outlined in *R.-B. (A Patient) v. Official Solicitor, sub nom Re A. (Male Sterilisation)* and paragraph 15.21 of the Mental Health Act Code of Practice 1999 (see paragraphs 62 and 72 above), the Government pointed out that the Code amounted to guidance, it did not purport to be an authoritative statement of the law and it was open to anyone to obtain a court decision as to whether the Code provisions were accurate or not. In addition, there was no need for a definition of “compliant”, as suggested by the applicant, as it was a word of ordinary usage. Moreover, the Government considered that the Court of Appeal’s decision in *Re F. (Adult: Court’s Jurisdiction)* (cited above) did not break new ground in the High

Court's "best interests" declaratory powers but simply applied the House of Lords' decision in the present case.

106. The Government were further of the view that it was not relevant whether, as the applicant submitted, the doctrine of necessity extended beyond the treatment of those with a mental disorder; what was important was that it reflected in substance the *Winterwerp* criteria for lawful detention under Article 5 § 1 (e) (see paragraph 98 above) as it was only where a mental disorder was considered to be of a nature sufficiently serious to warrant hospital treatment that a doctor could have reasonably concluded that the person was to be retained in hospital for treatment on grounds of necessity.

107. Finally, they considered that there was no risk of arbitrary detention because of the availability of judicial review (combined with a writ of habeas corpus), which action would require the authorities to demonstrate that the facts justified the detention under the doctrine of necessity (see the Government's submissions under Article 5 § 4, paragraphs 126-30 below). In this manner, the doctrine of necessity could be considered to incorporate adequate judicial guarantees and safeguards.

(b) The applicant's submissions

108. The applicant mainly argued that at the relevant time the concepts of "best interests" and "necessity" were imprecise and unforeseeable.

109. As to the breadth of the test of best interests, he maintained that the case-law at the time of his detention (see *Bolam v. Friern Hospital Management Committee* and *Re F. (Mental Patient: Sterilisation)*, cited above) indicated that the question of a patient's best interests was a purely clinical one to be judged by a narrow "not negligent" test. This test came under much criticism from, among others, the Law Commission, which led to a consultation paper which was, in turn, adopted by the government in large part in its Green Paper "Making decisions" in October 1999. The proposals therein were not put into effect in legislation and the test was not expanded until *R.-B. (A Patient) v. Official Solicitor, sub nom Re A. (Male Patient: Sterilisation)* (cited above), when the Court of Appeal ruled that the concept of best interests required compliance with two duties: not to act negligently (to act in accordance with a practice accepted at the time by a reasonable body of medical opinion skilled in the particular form of treatment in question – the "*Bolam*" test), and a separate duty to act in the individual's best interests. The applicant pointed out that paragraph 15.21 of the later Mental Health Act Code of Practice 1999 contradicted this case-law development, thus rendering even more complex the already difficult "best interests" assessment.

110. As to the extent of the High Court's jurisdiction, the applicant noted that it was not until *Re F. (Adult: Court's jurisdiction)* (cited above), that it was established that the courts' jurisdiction in this area was more

analogous to a wardship jurisdiction (and therefore capable of addressing long-term and broader welfare questions, such as residence and contacts of incapacitated adults) as opposed to a narrower declaratory jurisdiction (whether a course of action would be criminal or tortious and essentially covering lawfulness questions only).

111. The applicant also criticised the lack of precision in the law resulting from the absence of any definition of the term “compliance”. This was important given that “compliance” determined whether treatment would be given under the doctrine of necessity or under the 1983 Act.

112. The applicant further maintained that the elements of the doctrine of necessity, even if foreseeable, did not equate with the criteria for lawful detention under Article 5 § 1 (e) developed in *Winterwerp* (cited above, pp. 17-18, § 39) and compared unfavourably with the criteria for involuntary psychiatric committal outlined in section 3 of the 1983 Act. He suggested that it was possible for a person to be detained under the doctrine of necessity without an examination of whether he or she had been reliably shown by objective medical expertise to be suffering from a mental disorder of a kind or degree warranting compulsory confinement.

113. Finally, the applicant contended that the doctrine of necessity did not contain sufficient safeguards against arbitrary or mistaken detention and submitted that this was a particularly serious deficiency when the underlying criteria for the deprivation of liberty were themselves imprecise and unforeseeable, when the law bestowed – through that lack of precision – a wide discretionary power and when the person in question was vulnerable.

(c) The relevant principles

114. The Court reiterates that the lawfulness of detention depends on conformity with the procedural and the substantive aspects of domestic law, the term “lawful” overlapping to a certain extent with the general requirement in Article 5 § 1 to observe a “procedure prescribed by law” (see *Winterwerp*, cited above, pp. 17-18, § 39). Further, given the importance of personal liberty, the relevant national law must meet the standard of “lawfulness” set by the Convention which requires that all law be sufficiently precise to allow the citizen – if need be with appropriate advice – to foresee, to a degree that is reasonable in the circumstances, the consequences which a given action might entail (see *S.W. v. the United Kingdom*, judgment of 22 November 1995, Series A no. 335-B, pp. 41-42, §§ 35-36; *Steel and Others v. the United Kingdom*, judgment of 23 September 1998, *Reports 1998-VII*, p. 2735, § 54; and *Kawka v. Poland*, no. 25874/94, § 49, 9 January 2001). The Court has outlined above (see paragraph 98) the three minimum conditions for the lawful detention of an individual on the basis of unsoundness of mind of Article 5 § 1 (e) of the Convention.

115. Lastly, the Court reiterates that it must be established that the detention was in conformity with the essential objective of Article 5 § 1 of the Convention, which is to prevent individuals being deprived of their liberty in an arbitrary fashion (see, among many authorities, *Wassink v. the Netherlands*, judgment of 27 September 1990, Series A no. 185-A, p. 11, § 24, and, more recently, *Assanidze v. Georgia* [GC], no. 71503/01, § 170, ECHR 2004-II). This objective, and the broader condition that detention be “in accordance with a procedure prescribed by law”, require the existence in domestic law of adequate legal protections and “fair and proper procedures” (see *Winterwerp*, cited above, pp. 19-20, § 45, and *Amuur v. France*, judgment of 25 June 1996, *Reports* 1996-III, pp. 851-52, § 53).

(d) The Court’s assessment

116. The Court considers it clear that the domestic legal basis for the applicant’s detention between 22 July and 29 October 1997 was the common-law doctrine of necessity: the House of Lords may have differed on whether his admission and stay in hospital amounted to detention, but it was unanimous in finding that he had been admitted to hospital pursuant to that doctrine. In addition, the Court considers that, when the doctrine of necessity was applied in the area of mental health, it accommodated the minimum conditions for the lawful detention of those of unsound mind outlined in paragraph 98 above.

117. In this connection, the Court has noted that as early as 1772 the common law permitted detention of those who were a potential danger to themselves in so far as this was shown to be necessary. In the early 1990s necessity was the recognised legal basis for the consideration of authorisations for certain medical treatment (sterilisation and artificial nutrition and hydration) of incapacitated individuals (see paragraph 57 above). *Re S. (Hospital Patient: Court’s Jurisdiction)* and *Re S. (Hospital Patient: Foreign Curator)* together with *Re C. (Mental Patient: Contact)*, reported in 1993 and 1996, resulted in declarations being made as to the best interests of incapacitated individuals pursuant to the doctrine of necessity where there was a conflict over certain welfare issues (see, in particular, the judgment of Lady Justice Butler-Sloss in *Re F. (Adult: Court’s Jurisdiction)*, paragraphs 59-61 above).

In addition, all the judges of the House of Lords in the present case relied on *Re F. (Mental Patient: Sterilisation)* in unanimously concluding that the admission and treatment of an incapacitated compliant patient could be justified on the basis of the doctrine of necessity. Lord Goff, delivering the main judgment, had “no doubt” about this conclusion. Moreover, all counsel before the House of Lords were in agreement as to the precise elements of the doctrine of necessity to be applied (Lord Steyn, paragraph 47 above). These were “simply” that: (i) there must be a necessity to act when it is not practicable to communicate with the assisted person, and (ii) that the action

taken must be such as a reasonable person would in all circumstances take, acting in the best interests of the assisted person. Furthermore, as is clear from the statistics provided by the Mental Health Act Commission to the House of Lords, the applicant was one of thousands of compliant incapacitated patients detained each year on the basis of the doctrine of necessity. Finally, the Court does not consider that the lack of a definition of “compliant” rendered the applicant’s detention unforeseeable: the majority of the House of Lords expressed no particular difficulty in applying the notion of compliance in the present case.

118. It is true that, at the time of the applicant’s detention, the doctrine of necessity and, in particular, the “best interests” test were still developing. Clinical assessments of best interests began to be subjected to a double test (the *Bolam* “not negligent” test together with a separate duty to act in a patient’s best interests). Broader welfare matters were also introduced in the “best interests” assessment (see *Re F. (Adult: Court’s Jurisdiction)* and *R.-B. (A Patient) v. Official Solicitor, sub nom Re A. (Male Sterilisation)* – paragraphs 59-62 above). It is therefore true that each element of the doctrine might not have been fully defined in 1997. This is reflected in, for example, the conflict between the views of Lady Justice Butler-Sloss in *R.-B. (A Patient)*, cited above, and paragraph 15.21 of the Mental Health Act Code of Practice 1999 (see paragraphs 62 and 72 above).

119. Whether or not the above allows the conclusion that the applicant could, with appropriate advice, have reasonably foreseen his detention on the basis of the doctrine of necessity (see *The Sunday Times v. the United Kingdom (no. 1)*, judgment of 26 April 1979, Series A no. 30, pp. 31-33, §§ 49 and 52), the Court considers that the further element of lawfulness, the aim of avoiding arbitrariness, has not been satisfied.

120. In this latter respect, the Court finds striking the lack of any fixed procedural rules by which the admission and detention of compliant incapacitated persons is conducted. The contrast between this dearth of regulation and the extensive network of safeguards applicable to psychiatric committals covered by the 1983 Act (see paragraphs 36 and 54 above) is, in the Court’s view, significant.

In particular and most obviously, the Court notes the lack of any formalised admission procedures which indicate who can propose admission, for what reasons and on the basis of what kind of medical and other assessments and conclusions. There is no requirement to fix the exact purpose of admission (for example, for assessment or for treatment) and, consistently, no limits in terms of time, treatment or care attach to that admission. Nor is there any specific provision requiring a continuing clinical assessment of the persistence of a disorder warranting detention. The appointment of a representative of a patient who could make certain objections and applications on his or her behalf is a procedural protection accorded to those committed involuntarily under the 1983 Act and which

would be of equal importance for patients who are legally incapacitated and have, as in the present case, extremely limited communication abilities.

121. The Court observes that, as a result of the lack of procedural regulation and limits, the hospital's health care professionals assumed full control of the liberty and treatment of a vulnerable incapacitated individual solely on the basis of their own clinical assessments completed as and when they considered fit: as Lord Steyn remarked, this left "effective and unqualified control" in their hands. While the Court does not question the good faith of those professionals or that they acted in what they considered to be the applicant's best interests, the very purpose of procedural safeguards is to protect individuals against any "misjudgments and professional lapses" (Lord Steyn, paragraph 49 above).

122. The Court notes, on the one hand, the concerns regarding the lack of regulation in this area expressed by Lord Steyn (see paragraph 47 above), Lady Justice Butler-Sloss (see paragraph 61 above) and the Law Commission in 1995 (see paragraphs 66-68 above). On the other hand, it has also noted the Government's understandable concern (outlined in paragraph 80 above) to avoid the full, formal and inflexible impact of the 1983 Act. However, the current reform proposals set out to answer the above-mentioned concerns of the Government while at the same time making provision for detailed procedural regulation of the detention of incapacitated individuals (see, in particular, the Mental Capacity Bill described in paragraphs 77-78 above).

123. The Government's submission that detention could not be arbitrary within the meaning of Article 5 § 1 because of the possibility of a later review of its lawfulness disregards the distinctive and cumulative protections offered by paragraphs 1 and 4 of Article 5; the former strictly regulates the circumstances in which one's liberty can be taken away, whereas the latter requires a review of its legality thereafter.

124. The Court therefore finds that this absence of procedural safeguards fails to protect against arbitrary deprivations of liberty on grounds of necessity and, consequently, to comply with the essential purpose of Article 5 § 1. On this basis, the Court finds that there has been a violation of Article 5 § 1 of the Convention.

II. ALLEGED VIOLATION OF ARTICLE 5 § 4 OF THE CONVENTION

125. The applicant complained that the procedures available to him as an informal patient for the review of the legality of his detention (judicial review combined with a writ of habeas corpus) did not comply with the requirements of Article 5 § 4 of the Convention, which provision reads as follows:

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

A. The parties’ submissions

126. The Government considered this submission to be incorrect. An action in judicial review (combined with a writ of habeas corpus) allowed an assessment of the essential conditions (within the meaning of *Winterwerp* and Article 5 § 1 (e) of the Convention) bearing on the lawfulness of his detention.

127. In particular, those domestic proceedings were sufficiently flexible to allow the court to examine the objective medical evidence to establish whether the *Winterwerp* conditions had been met. Relying on domestic jurisprudence which in turn relied on the judgment of the Court of Appeal in *Reg. v. the Ministry of Defence, ex parte Smith* ([1996] Queen’s Bench Reports 517), the Government argued that at the relevant time the courts could have interfered with an executive decision where they were satisfied that the decision was unreasonable in the sense that it was beyond the range of responses open to a reasonable decision-maker. The human rights context was important and the more substantial the interference with human rights, the more the court would require by way of justification before it would find the interference to be reasonable (the “super-Wednesbury” test). The flexibility of judicial review was demonstrated, in particular, by the significant developments immediately prior to the Human Rights Act 1998 and since incorporation (as demonstrated by cases concerning the compulsory treatment of patients, including *R. (Wilkinson) v. Broadmoor Special Hospital Authority*, cited above). These developments were, in the Government’s opinion, not so much a result of incorporation as of flexibility of the common law and its procedures.

128. While judicial review may not have allowed the courts to substitute their views for the clinical expert views expressed, the Government noted that Article 5 § 4 did not require this (see *E. v. Norway*, judgment of 29 August 1990, Series A no. 181-A). The Court’s judgment in *X v. the United Kingdom* (judgment of 5 November 1981, Series A no. 46) could, according to the Government, be distinguished in that the relevant review therein was of a decision to detain taken on the basis of legislative provisions whereas the present case concerned the review of a decision to detain on the basis of the common law. In the latter case, the domestic courts could review the facts said to justify detention on a more intrusive basis. The Government contested, as contrary to a fundamental principle of English law, the applicant’s suggestion that the legal burden rested on him to prove that his detention was unlawful.

129. The Government also explained why they considered the judicial review/habeas corpus procedure to be sufficiently “speedy” and to constitute a periodic control at reasonable intervals. They maintained that Article 5 § 4 did not require the review to be automatic (see *X v. the United Kingdom*, cited above, pp. 22-23, § 52).

130. Finally, the Government added that a patient could also bring a civil claim for damages for negligence, false imprisonment and/or trespass to the person (assault), which actions would be “likely” to cause the hospital to “justify its treatment” of the patient without his or her consent. They suggested that the applicant could also have brought declaratory proceedings in the High Court to obtain a declaration as to what would have been in his best interests.

131. The applicant contended that he did not have a domestic review available to him of the existence and persistence of the essential conditions for the lawfulness of his detention.

132. The MHRT could provide such a review under the 1983 Act, but the applicant had not been detained under that Act.

133. Judicial review proceedings (combined with a writ of habeas corpus) were clearly insufficient at the time of his detention and remained so even after incorporation.

Prior to incorporation, habeas corpus only lay against a decision which was unlawful on the grounds of strict “illegality” or lack of jurisdiction. More importantly, the courts would rarely in judicial review interfere with primary findings of fact made by a public authority, particularly where that authority had a particular expertise. Even the more intense review (the “super-Wednesbury” test) did not amount to an examination as to whether the authority was correct in acting as it did, but rather whether it had acted “unreasonably” or “irrationally” (see *Smith and Grady*, cited above, §§ 137-38). Finally, the legal burden of proof was on him to establish that his detention was unlawful, whereas Article 5 § 4 required the State to establish the lawfulness of detention under domestic law and under Article 5 § 1 (e) of the Convention. As to the Government’s attempt to distinguish *X v. the United Kingdom*, the applicant pointed out that they had not referred to a single case where the domestic courts had examined on the merits the lawfulness of a patient’s detention under the doctrine of necessity. Indeed, in his own domestic proceedings there was much untested affidavit evidence and no independent psychiatric evidence was obtained by the court as to whether detention was appropriate. Judicial review and habeas corpus procedures were simply not appropriate for the resolution of disputed facts, oral evidence and cross-examination being rarely used.

Since incorporation, the applicant noted that the domestic courts had developed the intensity of their review on judicial review. However, he considered it telling that, even if that review was more intense when human rights were involved (the “super-Wednesbury” test) and even if it included a

proportionality test (see *R (Daly) v. Home Secretary* [2001] 2 Appeal Cases 532), it still did not amount to an adequate review of the continuing presence of the essential conditions for the lawfulness of detention. In this connection, he pointed out that the courts had only once conducted a full merits review since incorporation (see *R. (Wilkinson) v. Broadmoor Special Hospital Authority*, cited above, where the Court of Appeal specifically recognised the shift in approach to a merits review after incorporation in order to investigate and resolve medical issues and related Convention rights).

In any event, he argued that judicial review/habeas corpus proceedings could not be heard sufficiently speedily or constitute a periodic control at reasonable intervals if the process was to be regularly used by all informal patients. Finally, such proceedings did not amount to the automatic review required by Article 5 § 4 (see *Megyeri v. Germany*, judgment of 12 May 1992, Series A no. 237-A, pp. 11-12, § 22).

134. Finally, the applicant recognised that the High Court's inherent jurisdiction in private-law claims to make "best interests" declarations had developed so that it had now become something akin to a wardship jurisdiction and that that might go some way to satisfying the requirements of Article 5 § 4. However, those developments post-dated his period of detention (see *Re F. (Adult: Court's Jurisdiction)*, cited above) and, indeed, post-dated incorporation (see *R. (Wilkinson) v. Broadmoor Special Hospital Authority*, cited above). In any event, a "best interests" application would still not satisfy Article 5 § 4 as the onus was on the patient to bring the application.

B. The Court's assessment

1. General principles

135. Article 5 § 4 guarantees the right of an individual deprived of his liberty to have the lawfulness of that detention reviewed by a court in the light, not only of domestic-law requirements, but also of the text of the Convention, the general principles embodied therein and the aim of the restrictions permitted by paragraph 1: the structure of Article 5 implies that the notion of "lawfulness" should have the same significance in paragraphs 1 (e) and 4 in relation to the same deprivation of liberty. This does not guarantee a right to review of such scope as to empower the court, on all aspects of the case, to substitute its own discretion for that of the decision-making authority. The review should, however, be wide enough to bear on those conditions which are essential for the lawful detention of a person, in this case, on the ground of unsoundness of mind (see *X v. the United Kingdom*, cited above, p. 25, §§ 57-58; *Ashingdane*, cited above,

p. 23, § 52; *E. v. Norway*, cited above, pp. 21-22, § 50; and *Hutchison Reid*, cited above, § 64).

2. Application to the present case

136. The Government mainly argued that an application for leave to apply for judicial review of the decision to admit and detain, including a writ of habeas corpus, constituted a review fulfilling the requirements of Article 5 § 4 of the Convention. The applicant disagreed.

137. The Court considers that the starting-point must be *X v. the United Kingdom* (cited above, pp. 22-26, §§ 52-59), where the Court found that the review conducted in habeas corpus proceedings was insufficient for the purposes of Article 5 § 4 as not being wide enough to bear on those conditions which were essential for the “lawful” detention of a person on the basis of unsoundness of mind since it did not allow a determination of the merits of the question as to whether the mental disorder persisted. The Court is not persuaded by the Government’s argument that *X v. the United Kingdom* can be distinguished because it concerned detention pursuant to a statutory power: no authority has been cited and no other material adduced to indicate that the courts’ review of detention based on the common-law doctrine of necessity would indeed have been more intrusive.

138. Nor does the Court find convincing the Government’s reliance on the development of the “super-Wednesbury” principles of judicial review prior to the entry into force of the Human Rights Act 1998 in October 2000. Those principles were outlined and applied in the domestic judgment in *Reg. v. the Ministry of Defence, ex parte Smith* (cited above). In the subsequent application to this Court by the same applicant, it was found that, even if his essential complaints under Article 8 of the Convention had been considered by the domestic courts, the threshold at which those courts could have found to be irrational the impugned policy excluding homosexuals from the armed forces had been placed so high that it effectively ruled out any consideration by the domestic courts of the question whether the interference with the applicant’s rights answered a pressing social need or was proportionate to the national security and public-order aims pursued, principles which lay at the heart of the Court’s analysis of complaints under Article 8. The Court concluded that the remedy of judicial review, even on a “super-Wednesbury” basis, could not therefore constitute an effective remedy (within the meaning of Article 13) for a breach of Mr Smith’s rights under Article 8 (see *Smith and Grady*, cited above, §§ 35 and 129-39).

139. The Court considers that it can equally be concluded for the purposes of Article 5 § 4 (the *lex specialis vis-à-vis* Article 13 in terms of entitlement to a review of the lawfulness of detention (see *Nikolova v. Bulgaria* [GC], no. 31195/96, § 69, ECHR 1999-II) that, even with the application of the “super-Wednesbury” principles on judicial review, the bar

of unreasonableness would, at the time of the applicant's domestic proceedings, have been placed so high as effectively to exclude any adequate examination of the merits of the clinical views as to the persistence of mental illness justifying detention. This is indeed confirmed by the decision of the Court of Appeal, in a case where the necessity of medical treatment was contested by the patient (see *R. (Wilkinson) v. the Responsible Medical Officer Broadmoor Hospital*, cited in paragraph 63 above), that pre-incorporation judicial review of necessity in accordance with the "super-Wednesbury" criteria was not sufficiently intrusive to constitute an adequate examination of the merits of the relevant medical decisions.

140. For these reasons, the Court finds that the requirements of Article 5 § 4 were not satisfied, as suggested by the Government, by judicial review and habeas corpus proceedings. It is not necessary therefore to examine the applicant's additional submissions that those proceedings did not satisfy the requirements of that Article because, *inter alia*, the burden of proof was on the detainee or because such proceedings did not provide "speedy" and "periodic control" at "reasonable intervals".

141. The Government also contended, without elaboration, that a dissatisfied patient could bring a civil claim for damages for negligence, false imprisonment and for trespass to the person (technical assault consequent on detention for treatment), which actions would be "likely" to cause the hospital to justify its treatment of the patient without consent. The Government then proposed, without further detail, that the applicant could have relied on the declaratory jurisdiction of the High Court.

However, the applicant did not allege that the relevant health professionals were negligent, but rather that they had been incorrect in their diagnosis. His own action in false imprisonment and assault did not involve the submission of expert evidence by each of the parties or any assessment by the courts of that expertise and no case, decided at or around the relevant time, has been cited where such expertise was requested or such a merits review was carried out. As to seeking declaratory relief from the High Court, the Government have not cited any case decided around the relevant time where the High Court accepted that there was a "serious justiciable issue" to be examined by it in a case such as the present one where the patient was readmitted and detained for assessment and treatment (which treatment was not of an exceptional nature) on the basis of a consensus amongst the health professionals that admission was necessary (see, in particular, the Practice Note and Direction 2001 – paragraph 73 above).

142. In such circumstances, the Court concludes that it has not been demonstrated that the applicant had available to him a procedure which satisfied the requirements of Article 5 § 4 of the Convention. There has therefore been a violation of this provision.

III. ALLEGED VIOLATION OF ARTICLE 14 OF THE CONVENTION TAKEN IN CONJUNCTION WITH ARTICLE 5

143. The applicant further complained under Article 14 of the Convention taken in conjunction with Article 5 that he was discriminated against as an “informal patient”. Article 14 reads as follows:

“The enjoyment of the rights and freedoms set forth in [the] Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.”

144. While the Government accepted that the applicant’s complaints fell within the scope of Article 5, they argued that he had not suffered a discriminatory difference in treatment. In their view, there was an objective and reasonable difference between informal patients and those requiring compulsory detention and there was a reasonable relationship of proportionality between the means chosen to regulate both situations and the legitimate aims sought to be achieved. The applicant alleged a discriminatory difference in treatment between compliant and non-compliant incapacitated patients. Only the latter were treated on an involuntary basis and attracted the full protection of the 1983 Act.

145. The Court considers that this complaint does not give rise to any issue separate from those already examined by it under Article 5 §§ 1 and 4 of the Convention, which provisions the Court has found to have been violated. It does not therefore find it necessary also to examine the complaint under Article 14 of the Convention taken in conjunction with Article 5.

IV. APPLICATION OF ARTICLE 41 OF THE CONVENTION

146. Article 41 of the Convention provides:

“If the Court finds that there has been a violation of the Convention or the Protocols thereto, and if the internal law of the High Contracting Party concerned allows only partial reparation to be made, the Court shall, if necessary, afford just satisfaction to the injured party.”

A. Non-pecuniary damage

147. The applicant claimed 10,000 pounds sterling (GBP) in compensation for non-pecuniary damage arising from the violations of Article 5 §§ 1 and 4 of the Convention. He pointed out that his complaints under Article 5 § 1 were mainly of a substantive nature. As to Article 5 § 4,

he maintained that the Court should follow the line of cases in which an award for non-pecuniary damage in terms of distress and frustration was made even though there had been no underlying unlawful detention or substantive violation (see, *inter alia*, *Delbec v. France*, no. 43125/98, § 42, 18 June 2002, and *Laidin v. France (no. 1)*, no. 43191/98, § 34, 5 November 2002). The Government maintained that a finding of a violation of Article 5 §§ 1 and 4 of the Convention would constitute sufficient just satisfaction.

148. The Court notes that the violations established of Article 5 §§ 1 and 4 are of a procedural nature. In *Nikolova* (cited above, § 76) the question of making an award for non-pecuniary damage was raised in the context of procedural violations of Article 5 §§ 3 and 4 of the Convention. The Court noted that in some earlier cases relatively small awards for non-pecuniary damage had been made but that, in more recent cases, the Court had declined to accept such claims (see, *inter alia*, *Pauwels v. Belgium*, judgment of 26 May 1988, Series A no. 135, p. 20, § 46; *Brogan and Others v. the United Kingdom* (Article 50), judgment of 30 May 1989, Series A no. 152-B, pp. 44-45, § 9; *Huber v. Switzerland*, judgment of 23 October 1990, Series A no. 188, p. 19, § 46; and *Hood v. the United Kingdom* [GC], no. 27267/95, §§ 84-87, ECHR 1999-I).

In *Nikolova*, the Court endorsed the principle, outlined in certain of the above-mentioned cases, that just satisfaction could be awarded only in respect of damage resulting from a deprivation of liberty that the applicant would not have suffered if he or she had had the benefit of the guarantees of Articles 5 §§ 3 and 4 and, further, it confirmed that it would not speculate as to whether or not the applicant would have been detained if there had been no violation of the Convention. The Court therefore concluded in *Nikolova* that the finding of a violation was sufficient just satisfaction as regards any frustration suffered by the applicant on account of the absence of adequate procedural guarantees.

149. The Court does not see any reason to depart from the position outlined in *Nikolova* concerning just satisfaction for any distress and frustration suffered by the applicant as a result of the established procedural violations of the rights guaranteed by Article 5 of the Convention.

The awards in respect of non-pecuniary damage in *Hutchinson Reid* (cited above) and in the series of French cases to which the applicant has referred followed findings of, *inter alia*, unreasonable delay in the domestic proceedings determining applications for release from detention. This is consistent with the award of compensation for non-pecuniary damage following a finding of unreasonable delay under Article 6 § 1 of the Convention: despite the procedural nature of such a violation, it is accepted that there can be a causal link between the violation (delay) and the non-pecuniary damage claimed (see, more recently, *Mitchell and Holloway v. the United Kingdom*, no. 44808/98, § 69, 17 December 2002).

150. Accordingly, the Court considers that the finding of a violation of Article 5 §§ 1 and 4 of the Convention constitutes sufficient just satisfaction.

B. Costs and expenses

151. The applicant claimed reimbursement of approximately GBP 40,000 for costs and expenses. The Government considered this sum excessive.

The applicant claimed GBP 20,000 (exclusive of value-added tax – “VAT”) for his representation by Queen’s Counsel at the oral hearing in Strasbourg. He also claimed GBP 12,161.25 (inclusive of VAT) in respect of the work completed by junior counsel, the relevant fee note referring to work done from the application stage to the hearing, to an hourly rate of GBP 150 and to 113 hours’ work. The Government did not take issue with the fact that two counsel had been briefed, but were concerned about duplication of work. In addition, they considered the sum claimed for Queen’s Counsel to be excessive, noting that no fee note or voucher had been submitted and that, if the hourly rate was GBP 200, Queen’s Counsel was claiming for 100 hours’ work solely to represent the applicant at the oral hearing. As to junior counsel’s fees, the Government considered the hourly rate excessive and did not accept that the case warranted 113 hours’ work. They proposed a total sum of GBP 20,000 (inclusive of VAT) as regards all counsels’ fees.

The applicant also claimed GBP 4,542.55 (inclusive of VAT) in solicitors’ fees, and the Government considered this to be a reasonable figure.

152. The Court reiterates that it must ascertain whether the sum claimed for costs and expenses was actually and necessarily incurred and is reasonable as to quantum (see, among other authorities, *Witold Litwa v. Poland*, no. 26629/95, § 88, ECHR 2000-III). While it is noted that the applicant did not submit any voucher concerning the fees of Queen’s Counsel (see *Ciborek v. Poland*, no. 52037/99, § 63, 4 November 2003), the Court acknowledges that he must have incurred certain costs in this connection given that counsel’s appearance and submissions on the applicant’s behalf at the oral hearing in Strasbourg (see *Migoń v. Poland*, no. 24244/94, § 95, 25 June 2002). As to junior counsel, the Court notes his involvement from the beginning of the application, but also notes that certain substantial complaints under Articles 3, 8 and 13 were declared inadmissible (see *Nikolova*, cited above, § 79). The detailed breakdown of the applicant’s solicitors’ costs is also noted and that the Government considered the claim in that respect to be reasonable.

153. Having regard to all the circumstances, the Court considers it reasonable to award the applicant 29,500 euros (EUR) for his costs and

expenses (inclusive of VAT), less EUR 2,667.57 received by way of legal aid from the Council of Europe, the final sum of EUR 26,832.43 to be converted into pounds sterling at the date of settlement.

C. Default interest

154. The Court considers it appropriate that the default interest should be based on the marginal lending rate of the European Central Bank, to which should be added three percentage points.

FOR THESE REASONS, THE COURT UNANIMOUSLY

1. *Holds* that there has been a violation of Article 5 § 1 of the Convention as regards the lack of protection against arbitrary detention;
2. *Holds* that there has been a violation of Article 5 § 4 of the Convention;
3. *Holds* that these findings of violation constitute in themselves sufficient just satisfaction for any non-pecuniary damage sustained by the applicant;
4. *Holds*
 - (a) that the respondent State is to pay the applicant, within three months from the date on which the judgment becomes final according to Article 44 § 2 of the Convention, EUR 29,500 (twenty-nine thousand five hundred euros) in respect of costs and expenses (inclusive of VAT), less EUR 2,667.57 (two thousand six hundred and sixty-seven euros fifty-seven cents) received by way of legal aid from the Council of Europe, the final sum of EUR 26,832.43 (twenty-six thousand eight hundred and thirty-two euros forty-three cents) to be converted into pounds sterling at the date of settlement; and
 - (b) that from the expiry of the above-mentioned three months until settlement simple interest shall be payable on the above amount at a rate equal to the marginal lending rate of the European Central Bank during the default period plus three percentage points;
5. *Dismisses* the remainder of the applicant's claim for just satisfaction.

Done in English, and notified in writing on 5 October 2004, pursuant to Rule 77 §§ 2 and 3 of the Rules of Court.

Michael O'BOYLE
Registrar

Matti PELLONPÄÄ
President