Re L

Court of Appeal
Lord Woolf MR and Phillips and Chadwick LJJ
2 December 1997

A person unable to consent to remaining in premises is detained if those who control the premises intend him/her to remain and are able to prevent him/her leaving. Detention for the treatment of mental disorder is unlawful unless there is compliance with the provisions of the Mental Health Act 1983.

Facts

The applicant was 48 years of age and had suffered from autism from birth. He was unable to speak and required 24-hour care. He was unable to go outside alone. He had no ability to communicate consent or dissent to treatment or to express a preference to reside in one place rather than another, although he was able to manifest unhappiness as to specific treatment. The applicant had been resident at Bournewood Hospital for about 30 years. In March 1994 he went to live with a Mr and Mrs Enderby who cared for him at their home and became fond of him. He could on occasions become agitated but Mr and Mrs Enderby had been able to cope without assistance. On 22 July 1997 the applicant had been at Cranstock Day Centre when he became agitated. Mr and Mrs Enderby could not be contacted and he was taken to Bournewood Hospital. Bournewood Hospital admitted the applicant as an 'informal patient' and did not detain him under the Mental Health Act 1983 (MHA). It was, however, clear on the evidence that had the applicant resisted admission he would have been detained under the MHA 1983. Regrettably, but understandably, Mr and Mrs Enderby were unhappy about the applicant's admission and Bournewood's failure to arrange visits so that they could see the applicant. As a result the applicant did not have any contact with Mr and Mrs Enderby between his admission on 22 July 1997 and the hearing in the Court of Appeal on 2 December 1997.

Held:

1 A person is detained in law if those who have control over the premises in which he is have the intention that he shall not be permitted to leave those premises and have the ability to prevent him from leaving. The applicant was unable to express a choice or active dissent as to the environment in which he lives. However, whether or not a person is detained is an objective question of fact. It was plain from the evidence that had the applicant attempted to leave the hospital he would not have been permitted to do so, but would have been detained under the MHA 1983. If Bournewood Hospital would not release the applicant into the custody of those who had been caring for him for over three years, as the hospital clearly would not, then the hospital was not prepared to let him leave at all: *Murray v Ministry of Defence* [1988] 1 WLR 692 followed.

2 Bournewood Hospital could not justify its detention of the applicant by reference to the common law doctrine of necessity, because that doctrine has been impliedly repealed in relation to the detention of persons who require treatment for mental disorder by provisions of the MHA 1983. The rights of a hospital to detain a patient for treatment for mental disorder are to be found in, and only in, the MHA 1983: *Black v Forsey* (1988) *Times*, 31 May applied. Hospitals are only allowed to admit persons for treatment if they comply with the MHA 1983.

3 The legal position is, however, different where a mentally impaired person is

A subjected to restraints amounting to detention which are imposed simply to prevent him/her from sustaining harm in situations not covered by the MHA 1983. It must be strongly arguable that the doctrine of necessity would entitle whoever has care of a person such as the applicant to detain him/her in such circumstances to prevent him/her from harming him/herself.

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Cases referred to in judgment:

Black v Forsey (1988) *Times*, 31 May, HL.

F v West Berkshire Health Authority; sub nom *F, Re; F (Mental Patient: Sterilisation), Re* [1990] 2 AC 1; [1989] 2 WLR 1025; (1989) 133 SJ 785; [1989] 2 FLR 376; (1989)
C 139 NLJ 789, HL.

Meering v Grahame-White Aviation Co Ltd (1920) 122 LT 44.

Murray v Ministry of Defence [1988] 1 WLR 692; (1988) 132 SJ 852; [1988] 2 All ER 521, HL.

R v Kirklees MBC ex p C (A Minor) [1993] 2 FLR 187; [1993] 2 FCR 381; [1993] Fam
D Law 455; (1993) *Times*, 25 March, CA.

S-C (Mental Health: Habeas Corpus), Re; sub nom *Simpson-Cleghorn, Re* [1996] QB 599; [1996] 2 WLR 146; [1996] 1 All ER 532; [1996] 1 FLR 548; [1996] 2 FCR 692; (1996) 29 BMLR 138; [1996] Fam Law 210; (1995) *Times*, 4 December, CA.

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Legislation/guidance referred to in judgment:

Mental Health Act 1983 ss1 to 8, 117 and 131 – Mental Health (Scotland) Act 1984 – RSC Ord 53 r7.

F **This case also reported at:**

Not elsewhere reported.

Representation

R Gordon QC and P Bowen (instructed by Scott-Moncrief, Harbour & Sinclair)
G appeared on behalf of the appellant.

J Grace QC (instructed by Beachcroft Stanleys) appeared on behalf of the respondent.

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Judgment

H **LORD WOOLF MR:** This is a judgment of the Court. This appeal raises difficult issues which could have a far reaching effect on the present approach to the reception, care and treatment of many mentally disordered patients. It also raises issues of considerable significance to the appellant 'L' who is 48 and who has suffered from autism since his birth. The appeal is against the dismissal by Owen J
I on 9th October 1997 of L's application for:

(1) Judicial Review of:

(i) the decision of the Bournewood Community and Mental Health NHS Trust 'to detain the appellant on 22 July 1997 and the Trust's ongoing decision to continue the Appellant's retention', and

J *(ii) a writ of* Habeas Corpus Ad Subjiciendum *directed to the Respondent.*

On the application for Judicial Review the relief sought was certiorari to quash the decisions of the Trust, a declaration that the Trust's retention of the appellant is unlawful and mandamus requiring the Trust to release L forthwith. Damages
K for false imprisonment and assault are also claimed.

Owen J granted leave to appeal against his decision on 10 October 1997 and a

Notice of Appeal was served on 15 October 1997. The appeal was heard on 30 October 1997 and at the end of the appeal the Court intimated that the appeal would be allowed but having regard to the importance of the issues involved the Reasons would be delivered later. This Judgment sets out those Reasons.

At the centre of this appeal are L's unfortunate disabilities. He cannot speak and he lacks the capacity to instruct Solicitors and so these proceedings are being brought by Doreen Franklin, his cousin and next friend. L's needs are complex and he requires 24-hour care. He sometimes injures himself, he has no sense of danger, he cannot go out alone, he needs to be reminded to go to the toilet and he may occasionally push people with his hands. He has no ability to communicate consent or dissent to treatment (though he can manifest unhappiness as to specific treatment). He is unable to express preference to residing at one place rather than another. For the purposes of the issues on this appeal L was regarded as being unable to express either consent or dissent to detention.

The facts giving rise to the present proceedings are largely not in dispute and are set out in detail in the papers which are before the Court. The position can be summarised as follows.

For a period approaching 30 years prior to March 1994 L had been a long-term resident at the Bournewood Hospital which is now run by the Trust. In March 1994 he went to live with Mr and Mrs Enderby at their home in Send, Surrey. They were his carers. They are very fond of him and together with their children and other professionals responsible for his care regarded L as 'one of the family'. On 22 July 1997 L was at the Cranstock Day Centre. He had been attending there on a weekly basis. He can on occasions become agitated and this happened on that day. Mrs Enderby called them his 'tantrums' and it appears that a tantrum can happen about every four days. However Mr and Mrs Enderby are capable of coping with incidents when they occur. During the four years L was living with them Police were not called and L had not needed to be admitted to hospital.

On 22 July 1997 while L was at the Cranstock Day Centre Mr and Mrs Enderby could not be contacted. The day centre, when L became agitated, contacted a local doctor who attended and administered a sedative. Ailsa Flinders, the care worker who had overall responsibility for L for many years, was also contacted. She attended and recommended that he should be taken to the St Peter's Accident and Emergency Unit at the Bournewood Hospital. As a result of the sedative that he had been given L had become calm and relaxed; but while at the accident and emergency unit he became increasingly agitated and eventually under supervision of the doctor he was taken to the mental health behavioural unit at the hospital. He has remained at the hospital ever since.

At the hospital he has been under the care of the Clinical Director of Learning Disabilities and Consultant Psychiatrist for the Trust. Her Affidavit is before us. She describes how in the Spring of 1996 an assessment had to be made of L as his self-injurious behaviour had escalated. At that time she was of the view that it was not necessary for him to be re-admitted to hospital and that his care should continue in the community if at all possible. Subsequently it was decided that it could be appropriate to transfer L's care to the Northdowns Community Team. On 22 July, the process of formulating an appropriate care plan involving the Northdowns Community Team was in the process of being completed. But there were delays due to the need for the necessary funding arrangements to be put in place. Dr Manjubhashini describes the incident on 22 July 1997 as 'serious' but states that because L was 'quite compliant' and had 'not attempted to run away' the view was taken that he could be admitted as an 'informal patient' and that he

A did not need to be detained under the Mental Health Act 1983. She does say however that if L had resisted admission she would certainly have detained him under that Act since she was 'firmly of the view that he required in-patient treatment'. Since L has been at the hospital an appropriate framework of care and treatment has been implemented. She goes on to say that:

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> *As L 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 co-operate. L 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 co-*
C *operate with the attempts that were made to carry out a CT scan and ECG, which were necessary in view of his old history of fits and temporal lobe abnormality, on the 5 and 6 August 1997 and so these tests were abandoned.*

She refers to other assessments which were made and says that if L showed any
D signs of distress the assessments were postponed and reviewed. She adds that:

> *Although he cannot communicate verbally, patients with disorders such as L's can communicate their distress by, refusing meals, not sleeping, crying, not co-operating with any tasks such as washing and bathing and going up to the door*
E *and pushing it or turning the handle. L has not demonstrated distress in any of these forms but has adapted well to his environment and appears contented.*

She states in her Affidavit which was sworn on 3 October 1997 that 'L's behaviour is still fluctuating' and that he still needs further treatment to alleviate his problems.

F Mr Grace QC who appears on behalf of the Trust made it clear that the Trust and the doctors and the staff responsible for treating L regard it as being very important for L's future that he should be returned to live with Mr and Mrs Enderby as soon as this is practical. The relationship with Mr and Mrs Enderby is of the greatest importance to him. The plans which were being prepared in July
G 1997 can then be implemented.

However, understandably but regrettably, Mr and Mrs Enderby are not satisfied as to the Trust's motives. There have been difficulties of communication. There are in evidence the letters which have been written by Dr Manjubhashini to Mr and Mrs Enderby explaining what is proposed, discussing meetings and visits by
H the Enderbys to see L; but no programme for visits has been achieved, so L has not had the benefit of contact with the Enderbys since he was admitted on 22 July 1997.

Having read the papers for this appeal, the Court was concerned at what appeared to be a breakdown in relations between the Enderbys and those respon-
I sible for L at the hospital. There was therefore an adjournment at the suggestion of the Court to see whether a suitable third party could not achieve the reconciliation, which is clearly needed in L's interests, between the Enderbys and those responsible for treating L. The Trust suggested the names of two people who Mr Gordon QC, appearing for L in these proceedings, accepted were of great distinc-
J tion in the field but he explained that the Enderbys took the view that it would still be preferable if the legal position was clarified and therefore the appeal proceeded. It may be that steps have been taken to resolve this problem between the hearing and the giving of this judgment. If they have not we would strongly urge the parties to take up the offers which have been made in the long-term interests
K of L.

The Issues

The case made on behalf of L is founded on the premise that he is being detained by the Trust. It is contended that this detention is unlawful in that no authorisation for it can be found either in statute or in the common law.

The Trust deny that L is detained. They contend that the circumstances in which he was admitted to and remains in Bournewood Hospital involve no breach of law on their part. He was informally admitted to the hospital and remains in it without any restraint. He has simply not chosen to leave.

Alternatively, they contend that if L's presence as an in-patient amounts to detention, such detention is not unlawful because they can rely upon the common law doctrine of necessity to justify giving treatment to L in accordance with his own best interests. They do not seek to justify having L in their care by reference to any power conferred by the Mental Health Act 1983 ('the 1983 Act'). They contend that the 1983 Act leaves untouched their entitlement to admit and treat patients in accordance with the common law.

These contentions raise the following three issues:

(1) Is L detained? If so:
(2) Can L's detention be justified by the common law doctrine of necessity? If not:
(3) What is the appropriate relief that the Court should grant?

Is L Detained?

In the 4th Edition of Hoggett's Mental Health Law, p.9, the author describes as 'the de facto detained':

> *. . . those elderly or severely disabled patients, who are unable to exercise any genuine choice, but do not exhibit the active dissent which provokes professionals to invoke the compulsory procedures.*

This description aptly fits L. He has not chosen to leave the hospital because he is incapable of choice as to the environment in which he lives. In those circumstances is he 'detained' as a matter of law? This is no easy question.

On behalf of the Trust Mr Grace Q.C. accepted that whether a person is detained is a question of objective fact, which does not depend on the presence or absence of consent or knowledge. He referred us to a passage in the speech of Lord Griffiths in *Murray v Ministry of Defence* [1988] 1 WLR 692 at 701–2 approving the following passage in the judgment of Atkin LJ in *Meering v Grahame-White Aviation Co Ltd* (1920) 122 LT 44 at 53–4:

> *It appears to me that a person could be imprisoned without his knowing it, I think a person can be imprisoned while he is asleep, while he is in a state of drunkenness, while he is unconscious, and while he is a lunatic. Those are cases where it seems to me that the person might properly complain if he were imprisoned, though the imprisonment began and ceased while he was in that state. Of course, the damages might be diminished and would be affected by the question whether he was conscious of it or not. So a man might in fact, to my mind, be imprisoned by having the key of a door turned against him so that he is imprisoned in a room in fact although he does not know that the key has been turned. It may be that he is being detained in that room by persons who are anxious to make him believe that he is not in fact being imprisoned, and at the same time his captors outside that room may be boasting to persons that he is imprisoned, and it seems to me that if we were to take this case as an instance supposing it could be proved that Prudence had said while the plaintiff was*

waiting: 'I have got him detained there waiting for the detective to come in and take him to prison' – it appears to me that that would be evidence of imprisonment. It is quite unnecessary to go on to show that in fact the man knew that he was imprisoned. If a man can be imprisoned by having the key turned upon him without his knowledge, so he can be imprisoned if, instead of a lock and key or bolts and bars, he is prevented from, in fact, exercising his liberty by guards and warders or policemen. They serve the same purpose. Therefore it appears to me to be a question of fact. It is true that in all cases of imprisonment so far as the law of civil liberty is concerned that 'stone walls do not a prison make', in the sense that they are not the only form of imprisonment, but any restraint within defined bounds which is a restraint in fact may be an imprisonment.

In our judgment a person is detained in law if those who have control over the premises in which he is have the intention that he shall not be permitted to leave those premises and have the ability to prevent him from leaving. We have concluded that this was and is the position of L. In concluding that L was not detained, Owen J said this:

Detention is defined (OED) as kept in confinement or custody. I agree that if in fact the applicant has been detained it matters not whether he knows it or not but there must be some restraint within defined bounds. In some ways the position may be likened to that when a suspect attends a police station to 'help with police enquiries'. At that stage he is not detained although detention might follow on very quickly after an indication by the suspect that he was leaving. Likewise, only more strongly, here it can be said that the applicant has at all times been free to leave because that is a consequence of an informal admission, and he will continue to be free to leave until Dr Manju or somebody else takes steps to section him or otherwise prevent his leaving. In other words there will be no restraint of the applicant until he has attempted to leave and the respondent, by its agent, has done something to prevent this.

We do not consider that the Judge was correct to conclude that L was 'free to leave'. We think that it is plain that had he attempted to leave the hospital, those in charge of him would not have permitted him to do so. In her Affidavit, when dealing with L's admission, Dr Manjubhashini said:

If [L] had resisted admission I would certainly have detained him under the 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 Perera, Ward Staff, other professionals and Care Services Manager. An appropriate framework of care and treatment was implemented.

On the 23rd July 1997 Dr Manjubhashini wrote to Mr and Mrs Enderby saying this:

Following admission he is now being closely monitored and investigated which is part of our assessment procedure.

I saw [L] very early this morning and he appears comfortable and the staff reported that [L] has complied with all care plan needs and has not shown any agitation to the change in environment. Obviously he was given some medication last night but this will allow the staff from the Behavioural Team to do an appropriate assessment.

I know that Ailsa Flinders has explained to you that perhaps it will be wise for you not to visit [L] until the staff feel that it will be okay for you to do so, based on the Clinical Team's views. I am grateful to you for accepting this clinical decision.

This is our normal protocol and please rest assured that this does not reflect on you or the care that you have provided for [L]. Unfortunately we do not want to face the scenario where, following your visit, he may expect to return with you. He is not at the moment clinically fit for discharge.

On the 6th August she wrote again a letter which contained the following statements:

I would like to take the opportunity to stress, through this correspondence, that we, as a Clinical Team, within the Behavioural Unit of Bournewood N.H.S. Trust, are here, primarily to provide the treatment for [L], who was admitted under our care, as an emergency. It will be extremely irresponsible of us not to provide [L] 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 [L], 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.

. . . [L] has been admitted to The Behavioural Unit 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 there, this is no '1 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 [L] is being treated within the Behavioural Unit 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.

On the 2nd September, in a further letter, she summarised the position as follows:

Given the picture that is emerging it is our considered clinical opinion (opinion of the Behavioural Unit Clinicians) that we treat [L] as a full referral to the Intensive Behavioural Unit service and his care and treatment will now be handled in line within our established Operational Policy.

Mr and Mrs Enderby had looked after L, 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 L into the custody of his carers they were not prepared to let him leave the hospital at all. He was and is detained there.

Is L's Detention Justified under the Common Law Doctrine of Necessity?

It is the contention of those acting for L that there is no scope in this case for the Trust to invoke the common law doctrine of necessity because the 1983 Act provides a statutory regime which covers precisely the position of L. They submit that the authorities clearly demonstrate that this statutory regime is the exclusive source of a hospital's right to detain a patient for mental treatment. These submissions lead us first to consider the relevant statutory provisions before turning to the authorities relied upon.

The 1983 Act

The 1983 Act consolidates the provisions of the 1959 Act as substantially amended by the Mental Health (Amendment) Act 1982. The changes in the law which were made between the passing of the 1959 Act and the 1983 Act were the subject of considerable consultation and the amendments which were made involved in some areas of the law a new approach. However, the 1983 Act did not purport to be nor is it an exhaustive code. The 1983 Act is however extensive in its application to those who require treatment for mental disorders. Section 1(1) sets out that:

> *The provisions of this Act shall have effect with respect to the reception, care and treatment of mentally disordered patients, the management of their property and other related matters.*

Section 2 then defines mental disorder. There is no doubt that L's disabilities fall within this definition.

Section 2 enables a patient who has been admitted to a hospital for assessment to 'be detained for a period not exceeding 28 days beginning with the day on which he is admitted' but it expressly provides that he 'shall not be detained after the expiration of that period unless before it has expired he has become liable to be detained by virtue of a subsequent application, order or direction under the following provisions' of that Act (s2(4)). Section 2(2) sets out the purpose for which a patient can be admitted for assessment. He can be admitted to a hospital and detained there if:

> *(a) he is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and*
> *(b) he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons.*

The admission has to be founded on the written recommendation in the prescribed form of two medical practitioners (s2(3)).

On the facts, subject to compliance with the requirements of section 2(3) on the 22nd July it would have been possible to have admitted L under section 2.

Section 3 is important and we should set out the relevant parts of the section :

> *(1) A patient may be admitted to a hospital and detained there for the period allowed by the following provisions of this Act in pursuance of an application (in this Act referred to as 'an application for admission for treatment') made in accordance with this section.*
> *(2) An application for admission for treatment may be made in respect of a patient on the grounds that –*
> *(a) he is suffering from mental illness, severe mental impairment, psychopathic disorder or mental impairment and his mental disorder is of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and*
> *(b) in the case of psychopathic disorder or mental impairment, such treatment is likely to alleviate or prevent a deterioration of his condition; and*
> *(c) it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section.*

Again there are requirements as to the written recommendations of two registered medical practitioners (s3(4)).

Section 4 contains a procedure for the admission of a patient in cases of 'urgent necessity'. All that needs to be done is to note the existence of this power which was not invoked in this case.

Section 5 makes it clear that an application can be made for the formal admission of a patient who is already in hospital.

Section 6 deals with the effects of an application for admission and makes it clear that if the necessary procedures are complied with the application 'shall be sufficient authority for the managers to detain the patient in the hospital in accordance with the provisions' of the Act (s6(2)).

Guardianship is dealt with in sections 7 and 8. An application may be made if a patient is suffering from mental disorder and 'it is necessary in the interests of the welfare of the patient or for the protection of other persons that the patient should be so received' (s7(2)(b)). The guardian may either be a local social services authority or any other person.

Where guardianship application is duly made and is accepted by the Secretary of State it confers the following authority on a person who is a guardian 'to the exclusion of any other person' (s8(1)):

(a) the power to require the patient to reside at a place specified by the authority or person named as guardian;
(b) the power to require the patient to attend at places and times so specified for the purpose of medical treatment, occupation, education or training;
(c) the power to require access to the patient to be given, at any place where the patient is residing, to any registered medical practitioner, approved social worker or other person so specified.

The Act contains numerous provisions to protect the position of those who are admitted and being treated in a hospital under the provisions of section 2(6). We need not refer to these in detail, but they include the right to apply to the independent Mental Health Review Tribunal which has powers to order the discharge of patients. There are also the provisions of section 117 to which Mr Gordon attaches importance because they deal with the after-care of the patient and place duties on the relevant authorities to assist in re-establishing the patient into the community. This could be an important responsibility in the case of L.

Finally we turn to provisions upon which the Trust relies as demonstrating that the statutory provisions that we have just set out do not displace those principles of common law which (as they contend) entitled them to admit, and entitle them to treat, L as an 'informal patient':

***131.**–(1) Nothing in this Act shall be construed as presenting 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.*

(2) In the case of a minor who has attained the age of 16 years and is capable of expressing his own wishes, any such arrangements as are mentioned in subsection (1) above may be made, carried out and determined [even though there are one or more persons who have parental responsibility for him (within the meaning of the Children Act 1989)].

We turn now to the relevant authorities. The starting point must be the principles set out by Sir Thomas Bingham MR in *Re S-C* [1996] 1 All ER 532 at p534/5:

A *No adult citizen of the United Kingdom is liable to be confined in any institution against his will, save by the authority of the law. That is a fundamental constitutional principle, traceable back to Ch29 of Magna Carta 1297 and before that to Ch39 of Magna Carta 1215. There are, of course, situations in which the law sanctions detention. The most obvious is in the case of those suspected or con-*
B *victed of crime. Powers then exist to arrest and detain. But the conditions in which those powers may be exercised are very closely prescribed by statute and the common law . . . Mental patients present a special problem since they may be liable, as a result of mental illness, to cause injury either to themselves or others. . . . Powers therefore exist to ensure that those who suffer from mental*
C *illness may, in appropriate circumstances, be involuntarily admitted to mental hospitals and detained. But, and it is a very important but, the circumstances in which the mentally ill may be detained are very carefully prescribed by statute. Action may only be taken if there is clear evidence that the medical condition of a patient justifies such action, and there are detailed rules prescribing the classes of*
D *person who may apply to a hospital to admit and detain a mentally disordered person.*

In *Re S-C* the legitimacy of the detention of a patient in a mental hospital was in issue, but no contention was advanced that this was justified at common law
E under the principle of necessity. Nonetheless, we think it clear that Sir Thomas Bingham MR considered that it was statute and statute alone that provided authority for a hospital to detain a mental patient.

A similar view is implicit in observations made by Lord Brandon in *Re F* [1990] 2 AC 1. The context of those observations is particularly relevant, for the case con-
F cerned the common law right to carry out an operation of sterilisation on a mentally disordered patient when this was necessary for her own benefit.

In *Re F* the House of Lords distinguished between treating patients for conditions relating to their mental disorder and conditions other than their mental disorder. The significance of the distinction was made clear by Lord Brandon at
G p55 A/B. He drew attention to the 'restrictions or conditions on the giving to mentally disordered persons of certain kinds of treatment for their mental disorder' under the Act. He then added:

The Act, however, does not contain any provisions relating to the giving of treatment to patients for any conditions other than their mental disorder. The result is
H *that the lawfulness of giving any treatment of the latter kind depends not on statute but the Common Law.*

In relation to the treatment permissible at Common Law he went on to say:

A doctor can lawfully operate on, or give other treatment to, adult patients who
I *are incapable for one reason or another of consenting to his doing so, provided that the operation or other treatment concerned is in the best interests of such patients. The operation or other treatment will be in their best interests if, but only if, it is carried out in order to save their lives, or to ensure improvement or prevent deterioration in their physical or mental health.*

J Later Lord Brandon added:

In the case of adult patients suffering from mental disability, they will normally, in accordance with the scheme of the Mental Health Act 1983, be either in the care of guardians, who will refer them to doctors for medical treatment, or of
K *doctors at mental hospitals in which the patients either reside voluntarily or are detained compulsorily. It will then again be the duty of the doctor concerned to*

use their best endeavours to do, by way of either an operation or other treatment, that which is in the best interests of such patients.

It appears that Lord Brandon was only contemplating two situations in which normally a person would be an in-patient in a mental hospital. One where there was consent and the second where the statute had been invoked. Lord Brandon does not, and we are unable to, identify what would be an abnormal situation.

The next case to which reference should be made is *R v Kirklees Metropolitan Borough Council ex parte 'C'* [1993] 2 FLR 187. 'C' was not in a position to give consent to treatment for a mental disorder. However, in these circumstances the Local Authority was entitled to give consent on her behalf and the Authority gave that consent. The action against the Authority therefore was unsuccessful. However Lloyd LJ and Stuart-Smith LJ both presupposed that either a patient would be admitted for treatment under section 3 or he would be a voluntary patient: that is a patient who had himself consented or in respect of whom, if he lacked the ability to consent, someone else had given consent on his behalf. In the case of 'C' the Authority was in the position to give the consent. There having been no guardian appointed in relation to L there is nobody who can give consent on his behalf. In the course of argument the question was canvassed as to whether the Courts could give consent. That they could not do so was made clear by Lord Bridge in *Re 'F'* to which reference has already been made (p51 F/H). But there is a difference between treatment for physical condition and treatment for mental illness, as was made clear by Stuart-Smith LJ in the *Kirklees* case. He said:

In some cases of mental illness, the patient, because of his condition, is both a danger to himself and others and is incapable or unwilling to consent to enter hospital for assessment of his condition or treatment for it. In such cases the provisions of ss.2 and 3 of the Mental Health Act 1983 can be invoked to compel admission without consent. Secondly, there is a possibility that those mental patients who purport to consent to treatment on a voluntary basis either do not, because of their condition, fully understand what they are doing, or subsequently assert that they never consented. In those cases, s.131 of the Act affords some protection to the hospital. . . . but it is limited to patients as defined by s.145 of the Act, that being a person suffering, or appearing to suffer, from mental disorder, and in this case W was not a patient as defined, and she was not treated for mental disorders. That section has therefore no application.

L is not even in the position of purporting to consent to treatment. He had done nothing which could be construed as conferring authority on the hospital to retain him for that purpose.

The final case to which reference need be made is the most relevant. It is the decision of the House of Lords in *Black v Forsey* (unreported except at (1988) *Times*, 31 May). The Act which was under consideration was the Mental Health (Scotland) Act 1984 which is the Scottish equivalent of the 1983 Act. In that case the doctors were acting on behalf of the Board as here they are acting on behalf of the Trust. Lord Keith accepted that at Common Law an individual had power to detain a mentally disordered person in the case of necessity but he rejected the contention that the doctors were in the same position. At page 7 of the transcript he said this:

In my opinion it is impossible to reach any other conclusion than that the powers of detention conferred upon hospital authorities by the scheme were intended to be exhaustive. Procedure is laid down for emergency, short-term and long-term detention. The period of short-term detention might reasonably be expected to be

A *long enough for an application for long-term detention to be submitted to and approved by the sheriff under section 18.*

The Scottish legislation has an equivalent provision to section 131 of the 1983 Act but Lord Keith regarded the provisions of the Scottish legislation comparable to those dealing with statutory provisions under the 1983 Act as being 'absolutely B inconsistent with a possible view that the legislature intended that a hospital authority should have a Common Law power to detain a patient otherwise than in accordance with the statutory scheme.' He added:

That scheme contains a number of safeguards designed to protect the liberty of C *the individual. It is not conceivable that the legislature, in prohibiting any successive period of detention under provisions containing such safeguards, should have intended to leave open the possibility of successive periods of detention not subject to such safeguards. I would therefore hold that any common law power of detention which a hospital authority might otherwise have possessed has been* D *impliedly removed.*

Although we recognise that the Common Law powers in Scotland are not necessarily the same as those in England, there appears to be no justification for not applying the logic of Lord Keith's reasoning to the position in England.

E Our conclusion is that the right of a hospital to detain a patient for treatment for mental disorder is to be found in, and only in, the 1983 Act, whose provisions apply to the exclusion of the common law principle of necessity. Section 131, which preserves the right to admit a patient informally, addresses the position of a patient who is admitted and treated with consent. This seems implicit from the wording of section 131(2). We think that the position was accurately stated in the F 1978 Command Paper No 7320, 'Review of the Mental Health Act 1959'.

1.5 It may be helpful to set out the position of informal patients as the Government sees it. An informal patient enters hospital on his doctor's advice to receive the care and treatment he is advised is necessary or desirable and he will nor- G *mally stay in hospital until discharged by the consultant. These are voluntary acts on his part. He can insist on leaving hospital if he wishes and can decline to accept a particular form or course of treatment. If he does so the consultant may, of course, refuse to continue to accept responsibility for treating him but that does not affect the patient's right to insist on leaving or to refuse treatment.*

H *1.6 There is nothing in the Act which authorises or implies that an informal patient may be compelled without his consent to enter hospital or to receive treatment . . .*

We also note the pragmatic advice given in paragraph 1.8:

I *1.8 Where the patient does not have the mental capacity to know what is taking place an absence of objection on his part cannot in law be taken either as implying or withholding consent to admission. In practice of course, in such cases, admission to hospital is unlikely to be challenged so long as it is evident to all* J *concerned that the staff have acted in the best interests of their patient. It may however be prudent to record reasons for admission. Where there is any doubt or likelihood of dispute, for example from relatives, as to whether a proposed admission is in the patient's best interests the appointment of a guardian under the Mental Health Act, who can give or withhold consent on the patient's behalf,* K *should be considered. Failing that, the patient should not be admitted to hospital except under compulsory powers.*

The Trust has admitted L and is detaining him for treatment for mental disorder without his consent and without the formalities required by the 1983 Act. It follows that they have acted and are acting unlawfully.

We should make it clear that we have, in this case, been concerned with the admission and detention in hospital for treatment for a mental disorder. It is that special situation for which the 1983 Act makes provision, and nothing in our judgment should be taken as applicable to the situation where a mentally impaired person is subjected to restraints amounting to detention which are imposed simply to prevent him from sustaining harm.

It appears plain on the evidence that L is someone whose liberty needs to be restricted for his own safety. It seems that he would not be likely to attempt to leave the custody of whoever is looking after him; but, were this not so a degree of restraint would seem necessary on occasions. There must be many suffering from mental disability who are in the same predicament. Under the 1959 Act, a guardianship order gave the guardian the same powers that a parent has over a child, so that statutory authority could have been obtained under that Act that would, it seems to us, have rendered it lawful to impose the degree of restraint necessary for the patient's own safety or welfare. That is no longer the case. The powers of a guardian have been drastically curtailed under the 1983 Act. In these circumstances, it must be at least arguable that the doctrine of necessity entitles whoever has the care of a person such as L to take steps which amount, in law, to his detention.

It follows from our judgment that the whole approach of the Trust in this case was based on a false premise. It was based on the belief that they were entitled to treat L 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. On the evidence they would undoubtedly have complied with the statutory requirements, but for their belief that this was not necessary.

The Common Law powers of necessity can be exercised by an individual to protect someone who is ill whether his illness is due to physical or mental causes. But, where the 1983 Act covers the situation, no necessity to act outside the Statute can arise. The Trust'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.

A troubling feature of this appeal is that the Trust is not alone in misinterpreting the effect of the Act. Apparently there could be many patients, especially those suffering from dementia, who are in the same position as L. This is no doubt partly a consequence of opinions expressed in the authoritative text books which support what has happened in this case (Mental Health Law, Hoggett, 4th Ed (1996) p9 and Mental Health Act Manual, Jones, 5th Ed (1996) p340). We have differed from those opinions. The current practice cannot justify a disregard of the Act. This is especially true because of the undesirable consequences which can follow a practice which bypasses the safeguards which the Act provides for patients who are statutorily detained.

For the future one result of this appeal is that the legal position should be clear. The Trust had to deal with an emergency. In a future emergency, where a person is in L's position, the Trust will have to decide whether or not it should exercise its statutory powers. If it decides not to exercise its statutory powers then it will not be able to admit the patient for treatment of his mental illness. This does not mean that the Trust will have to turn such a patient away. The Trust will be perfectly entitled to look after the patient to prevent him from harming himself until other arrangements which are reasonably satisfactory can be made.

Remedy

It follows from our judgment that L is entitled to the declarations sought. The Court approaches the application for habeas corpus with a natural concern as to the consequences of ordering the discharge of a patient who is unable to care for himself and cannot safely be allowed to wander at large. As Sharpe on Habeas Corpus, 2nd Ed., observes at p157:

> *. . . the courts have, on occasion, taken a rather paternalistic attitude in these cases and refused to order discharge unless it were also shown that the applicant was not actually dangerous to himself or herself or others.*

Some time has elapsed since we indicated, at the conclusion of the argument, that his appeal would be allowed. We do not know the present position. In particular, we do not know whether, in the interim, those treating [L] have exercised their statutory powers under section 3 of the 1983 Act; or whether, further treatment as an in-patient being considered no longer necessary, [L] may have been (or be about to be) released back into the devoted care of Mr and Mrs Enderby. In these circumstances we think it necessary to hear further argument before deciding whether an Order for Habeas Corpus should now be made.

The application before us includes a claim for damages in respect of false imprisonment and assault. We accept, of course, that it must follow from the reasoning already set out in this judgment that, for part if not all of the time that [L] has been held at the Bournewood Hospital as an informal patient since 22nd July 1997, he has been deprived of his liberty in circumstances which would give rise to a claim in tort; and that the tort of false imprisonment is actionable even without proof of special damage. We note the observations of Lord Griffiths in *Murray v Ministry of Defence* [1988] 1 WLR 692 at p703A–B that a person who is unaware that he has been imprisoned and who has suffered no harm can normally expect to recover nominal damages only. We note, also, that the claim is not made in proceedings begun by Writ, but on an application for judicial review made under Order 53 RSC. On an application under Order 53 the Court is empowered to award damages if the conditions set out in rule 7(1)(a) and (b) are satisfied – as they are in the present case. In all the circumstances of this case we would only be prepared to award nominal damages but we express the hope that, now that the legal position has been clarified by this judgment, it will be recognised that no advantage would be likely to result from that course .

Order: Appeal allowed.
Respondent to pay Appellant's costs here and below.
Nominal damages to be awarded in the sum of £1.
Leave granted to appeal to the House of Lords.
Legal Aid Taxation.
Reporting restrictions.