Re L (by his next friend GE)

House of Lords
Lord Goff of Chieveley, Lord Lloyd of Berwick, Lord Nolan, Lord Steyn and Lord Hope of Craighead
25 June 1998

Persons suffering from mental disorder, who are unable to consent to treatment but who do not manifest objection to treatment, can be admitted informally to hospital under Mental Health Act 1983 s131(1). The admission, care and treatment of such persons is on the basis of the common law doctrine of necessity. Such persons are not 'detained' for the purposes of the tort of false imprisonment if not detained in fact, eg, if kept in an unlocked ward.

Facts

The applicant was 48 years of age and had suffered from autism since 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 about specific treatment. He had no sense of danger and had a history of self-harming behaviour. The applicant had been resident at Bournewood Hospital for about 30 years. In March 1994 he was discharged on a trial basis into the community but the hospital remained responsible for his treatment. He went to live with a Mr and Mrs Enderby who cared for him at their home and became fond of him. On 22 July 1997 the applicant had been at Cranstock Day centre when he became agitated, hitting himself on the head with his fists and banging his head against the wall. Mr and Mrs Enderby could not be contacted. The applicant's social worker recommended that the applicant be taken to hospital. A local GP administered a sedative which made the applicant calm and relaxed initially, but he became increasingly agitated after arriving at Bournewood Hospital and was assessed by a psychiatrist as requiring in-patient treatment. Bournewood Hospital admitted the applicant under Mental Health Act 1983 (MHA) s131(1) as an 'informal patient' and did not detain him under the MHA 1983. He was placed in an unlocked ward and appeared to be compliant. Had he resisted admission or subsequently attempted to leave he would have been detained under the MHA 1983. Mr and Mrs Enderby were unhappy about the applicant's admission and Bournewood Hospital's failure to arrange visits so that they could see the applicant and challenged the lawfulness of his admission and continued residence.

Held:

1 MHA 1983 s131(1) permits the admission into hospital of patients who lack capacity to consent and who do not positively object to admission, as well as patients who consent to admission.

2 The applicant might have been detained while taken by ambulance from the day centre to the hospital, in the sense that absent justification the tort of false imprisonment would have been committed. However, the applicant was not detained (Lords Nolan and Steyn dissenting) in that sense while at hospital in an unlocked ward even though he would have been sectioned had he attempted to leave, since there had been no actual restraint in fact upon the applicant's liberty.

3 Both the applicant's removal to hospital and his care and treatment while in hospital had been effected in accordance with the hospital's duty of care towards the applicant and in his best interests and had been justified by the common law doctrine of necessity.

Cases referred to in judgment:

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

Collins v Wilcock [1984] 1 WLR 1172; (1984) 128 SJ 660; (1984) 148 JP 692; [1984] 3 All ER 374; (1984) 79 Cr App R 229; [1984] Crim LR 481; (1984) 81 LS Gaz 2140, DC.

Dallinson v Caffery [1965] 1 QB 348; [1964] 3 WLR 385; 128 JP 379; 108 SJ 560; [1964] 2 All ER 610, CA.

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) 139 NLJ 789, HL

L, Re; sub nom *R v Bournewood Community and Mental Health NHS Trust ex p L* (1998) 1 CCLR 201; [1998] 2 WLR 764; [1998] 1 All ER 634; (1997) *Times*, 8 December, CA.

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 Coate (1722) Lofft 73.

R v Deputy Governor of Parkhurst Prison ex p Hague; Weldon v Home Office [1992] 1 AC 58; [1991] 3 WLR 340; [1991] 3 All ER 733; (1991) 135 SJLB 102; [1992] COD 69; (1993) 5 Admin LR 425; (1991) *Times*, 25 July; (1991) *Guardian*, 31 July; (1991) *Independent*, 4 September, HL

Scott v Wakem (1862) 3 F&F 328.

Syed Mahamad Yusuf-ud-Din v Secretary of State for India (1903) 19 TLR 496.

Symm v Fraser (1863) 3 F&F 859.

Legislation/guidance referred to in judgment:

Children Act 1989 — Mental Health Act 1959 s5 — Mental Health Act 1983 Parts IV and V and ss2 to 5, 20, 25A to 25J, 58, 117, 118, 121 and 131 — Mental Health (Amendment) Act 1982 — Mental Health (Scotland) Act 1984 s17 — Mental Health Act 1983: Code of Practice (Department of Health, 1993) paras 14.1 and 18.27.

This case also reported at:

[1998] 3 All ER 289.

Representation

J Grace QC and Andrew Grubb (instructed by Beachcroft Stanleys) appeared on behalf of the appellant.

Nigel Pleming QC and Rabinder Singh (instructed by the Solicitor, Department of Health) appeared on behalf of the Secretary of State for Health.

Michael Heywood (instructed by Lester Aldridge) appeared on behalf of the National Association of Nursing Homes.

R Gordon QC (instructed by Scott-Moncrieff, Harbour & Sinclair) appeared on behalf of the respondent.

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Judgment

LORD GOFF OF CHIEVELEY:

My Lords,

The respondent, Mr L, is 48 years old. He is autistic, and is profoundly mentally retarded. He is unable to speak, and his level of understanding is severely limited. It follows that he has always been incapable of consenting to medical treatment. He is frequently agitated; he has no sense of danger, and has a history of self-harming behaviour.

From the age of 13, for a period of over 30 years, he was a resident at the Bournewood Hospital, which is now run by the appellant NHS Trust. In March 1994, however, he was discharged on a trial basis into the community. He went to live with paid carers, Mr and Mrs E; but since he had not been finally discharged, the appellant Trust remained responsible for his care and treatment. Mr and Mrs E became very fond of him and, with their children, regarded him as one of the family.

On 22 July 1997, at the Cranstock Day Centre which was regularly attended by him, Mr L became particularly agitated, hitting himself on the head with his fists and banging his head against a wall. Mr and Mrs E could not be contacted. The Day Centre got in touch with a local doctor, who attended and administered a sedative. The social worker who had overall responsibility for him was also contacted. She attended and, on her recommendation, he was taken by ambulance to the Accident and Emergency Department at the Bournewood Hospital. As a result of the sedative given to him, he became calm and relaxed; but while at the Department he became increasingly agitated. He was assessed by a psychiatrist as being in need of in-patient treatment. He made no attempt to leave, and was transferred to the behavioural unit at the Hospital. His consultant, Dr Manjubhashini, decided that his best interests required that he should be readmitted for in-patient treatment. She considered whether it was necessary to detain him under the provisions of the Mental Health Act 1983 but decided that this was not necessary because he appeared to be fully compliant and did not resist admission. I shall have to refer to her evidence in more detail at a later stage. He was therefore admitted informally.

The doctors and staff at the Hospital responsible for treating Mr L regarded it as very important for his future that he should be returned to live with Mr and Mrs E as soon as practical. But Mr and Mrs E have unfortunately not been satisfied as to the Trust's motives. Dr Manjubhashini wrote to Mr and Mrs E explaining what was proposed, discussing meetings and visits by Mr and Mrs E to see Mr L, but no programme of visits was achieved. In the result, proceedings were commenced in the name of Mr L against the Trust. I add in parenthesis that, when this matter was coming before the Court of Appeal, the Court adjourned the hearing of the appeal to see if a suitable third party could achieve a reconciliation between Mr and Mrs E and those responsible for treating Mr L; but Mr and Mrs E took the view that it would still be preferable if the legal position was clarified and so the appeal proceeded.

I should however first refer to the proceedings before the judge of first instance, Owen J. Mr L applied for (1) judicial review of the appellant's decision to detain him on 22 July 1997, and the appellant Trust's ongoing decision to continue the respondent's detention; (2) a writ of *habeas corpus ad subjiciendum* directed to the appellant Trust; and (3) damages for false imprisonment and assault. On 9 October 1997 Owen J refused Mr L's applications. On 29 October 1997, after a hearing on that day, the Court of Appeal (Lord Woolf MR, Phillips and Chadwick LJJ) ([1998] 2 WLR 764; (1998) 1 CCLR 201) indicated that the appeal would be

allowed. The judgment of the Court was handed down on 2 December 1997. They held that Mr L had been detained by the appellant Trust, and that his detention was unlawful. They awarded Mr L £1 damages, and granted the appellant Trust leave to appeal to your Lordships' House.

On 31 October 1997, following the indication by the Court of Appeal that Mr L's appeal would be allowed, the appellant Trust regularised the position of Mr L by admitting him to the Hospital for treatment under section 3 of the Mental Health Act 1983, with the effect that he could be detained there for a period not exceeding 6 months (see section 20). On 5 November 1997 an application was made for his discharge; on 5 December 1997 he was released into the care of the Mr and Mrs E, and on 12 December he was discharged from the hospital.

Before Owen J and the Court of Appeal, the matter proceeded as follows. For Mr L, it was submitted that he had been wrongfully detained in the hospital without his consent. In answer to that submission, the appellant Trust argued, first, that he had been informally admitted under section 131(1) of the Act of 1983, which 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.*

It was further submitted that informal admission under section 131(1) does not require consent on the part of the patient, it being enough that he does not dissent from being admitted. Next, the appellant Trust submitted that, once Mr L had been lawfully admitted, the treatment he received was lawful under the common law doctrine of necessity. For Mr L, it was submitted that detention was a question of objective fact. On the evidence, he had in fact been detained. He had been physically taken to the Hospital; and Dr Manjubhashini had made it plain that, if he had resisted admission, she would certainly have detained him under the Act. Furthermore the comprehensive statutory regime ousted any common law jurisdiction under the doctrine of necessity. The judge accepted the argument of the appellant Trust. He held that Mr L had not in fact been detained; he had been informally admitted under section 131(1), which applied not only to persons who consented but also to those who, like him, did not dissent from their admission, and he had been free to leave until Dr Manjubhashini or somebody else took steps to 'section' him or otherwise prevent him from leaving. Furthermore, the statutory scheme under the Act of 1983 included section 131(1), which contemplated the exercise of common law powers.

The Court of Appeal, however, took a different view. They held that Mr L had in fact been detained. They said ([1998] 2 WLR 764 at p769; (1998) 1 CCLR 201 at p206C–D):

> *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.*

Next they concluded that the Act did indeed create a complete regime which excluded the application of the common law doctrine of necessity. In so holding, they invoked the decision of your Lordships' House in the Scottish case of *Black v*

Forsey 1988 SC(HL) 28. Section 131(1), they held, did not assist the appellant Trust, because it addresses only the position of a patient who is admitted and treated with consent. This seemed to them to be implicit from the wording of section 131(2). They accordingly allowed Mr L's appeal. It is from that decision that the appellant Trust now appeals to this House, with the leave of the Court of Appeal.

The Impact of the Court of Appeal's Judgment

There can be no doubt that the decision of the Court of Appeal has caused grave concern among those involved in the care and treatment of mentally disordered persons. As a result, three parties applied for, and were granted, leave to intervene in the appeal before this House. They were the Secretary of State for Health, the Mental Health Act Commission ('the Commission') and the Registered Nursing Homes Association ('the RNHA'). At the hearing of the appeal, the Secretary of State and the RNHA were represented by counsel (though counsel for the RNHA was in the event content to adopt the argument of counsel for the Secretary of State), and the Commission provided a written submission for the assistance of the Appellate Committee. I wish to express the gratitude of the Committee for the assistance provided to them in this way.

In the light of this assistance, I am able to summarise the position which has arisen following the Court of Appeal's judgment as follows. First and foremost, the effect of the judgment is that large numbers of mental patients who would formerly not have to be compulsorily detained under the Act of 1983 will now have to be so detained. Enquiries by the Commission suggest that 'there will be an additional 22,000 detained patients resident on any one day as a consequence of the Court of Appeal judgment plus an additional 48,000 admissions per year under the Act'. This estimate should be set against the background that the average number of detained patients resident on any one day in England and Wales is approximately 13,000. (Andrea Humphrey, a civil servant of the Department of Health, gave a figure of 11,000 for those detained under the Act at any time prior to the judgment.) The Commission considered it to be very likely that the majority of patients to whom the Court of Appeal judgment applied would be patients in need of long term care; and further considered that, if the judgment is held to apply to patients receiving medical treatment for mental disorder in mental nursing homes not registered to receive detained patients, the above estimates were likely to be very much higher. It is obvious that there would in the result be a substantial impact on the available resources; the Commission recorded that the resource implications were likely to be considerable, not only for the mental health services and professionals who have to implement the Act, but also for Mental Health Review Tribunals and for the Commission itself. These concerns were also reflected in the affidavit sworn by Andrea Humphrey of the Department of Health, following widespread consultation. Deep concern about the effect of the judgment was expressed, in particular, by the President of the Royal Society of Psychiatrists, and the Chairman of the Faculty for Psychiatry and Old Age of that Society; and also by the Executive Director of the Alzheimer's Disease Society. The various responses referred not only to the impact on the patients themselves, but also to the resource implications and to the effect on relatives and carers.

The Commission also stated that the Court of Appeal's judgment had given rise to a number of legal uncertainties. Two particular questions, described by the Commission as being 'of enormous practical importance', arose with regard to mental nursing homes, viz. whether such homes were required to be registered to

receive patients detained under the Act of 1983 before receiving patients like Mr L, and whether homes not so registered are now obliged to register or to discharge such patients from their care. The RNHA is particularly anxious about the position of elderly patients who lack the capacity to consent. The RNHA is concerned to know whether it is necessary for nursing homes who have or are likely to have such patients in their care to be so registered (which would have significant cost, staffing and other implications for the proprietors of such homes), or to decline to admit or keep such patients. Similar questions were raised by the Commission in relation to residential care homes, respite care and temporary care arrangements.

On the other hand, as the Commission stressed, another result of the Court of Appeal's judgment was that, if patients such as Mr L had to be compulsorily detained under the Act of 1983 in order to be admitted to hospital, they would reap the benefit of the safeguards written into the Act for the protection of patients compulsorily detained. It appears from the Commission's written submission that the lack of statutory safeguards for patients informally admitted to hospital has been a matter of concern for the Commission, and that this concern has been expressed not only by the Commission itself but also by the authors of authoritative textbooks on the subject. However, under section 121(4) of the Act of 1983 there is vested in the Secretary of State the power to 'direct the Commission to keep under review the care and treatment, or any aspect of the care and treatment, in hospitals and mental nursing homes of patients who are not liable to be detained under this Act'. During the course of the hearing, the Appellate Committee was assured by counsel for the Secretary of State that he has had the matter under consideration, but that hitherto he has not thought it right to exercise his power in this respect. In this connection, it is plain that he has to have regard to the resource implications of extension of the statutory safeguards to the very much larger number of patients who are informally admitted. At all events, this is a matter which is entirely for the Secretary of State, and not for your Lordships' House whose task is to construe, and to apply, the Act as it stands. To that task, I now turn.

Section 131(1) of the Act of 1983

Central to the argument advanced by Mr Pleming QC on behalf of the Secretary of State was the submission that, under the Act of 1983, persons suffering from mental disorder who are treated for their condition as in-patients in hospital fall into two categories:

(1) Those patients who are compulsorily, and formally, admitted into hospital, against their will or regardless of their will, who are detained or liable to be detained in hospital. This category may be called 'compulsory patients'. They may be admitted under section 2 of the Act of 1983 (admission for assessment); section 3 (admission for treatment); section 4 (admission for assessment in cases of emergency); or section 5 (admission of patients already in hospital).

(2) Those patients who enter hospital as in-patients for treatment either (a) who, having the capacity to consent, do consent ('voluntary patients') or (b) who, though lacking capacity to consent, do not object ('informal patients'). Both are admitted under section 131(1) without the formalities and procedures for admission necessary for detention under the Act. Strictly speaking, therefore, both groups could be described as informal patients, but it is convenient to confine that description to those who are not voluntary patients.

As Mr Pleming stressed, section 131(1) of the Act of 1983 is in identical terms to section 5(1) of the Mental Health Act 1959. Furthermore the Act of 1959 was enacted following the Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954–1957 (1957) Cmnd 169 ('the Percy Commission'), which recommended that compulsory detention should only be employed in cases where it was necessary to do so. The Percy Commission's views, and recommendation, on this point are to be found in paragraphs 289, 290 and 291 of their Report, which read as follows:

> *289. We consider compulsion and detention quite unnecessary for a large number, probably the great majority, of the patients at present cared for in mental deficiency hospitals, most of whom are childlike and prepared to accept whatever arrangements are made for them. There is no more need to have power to detain these patients in hospital than in their own homes or any other place which they have no wish to leave. We strongly recommend that the principle of treatment without certification should be extended to them. Such a step should help to alter the whole atmosphere of this branch of the mental health services. Many parents of severely sub-normal children at present feel that they lose all their rights as parents when their child is admitted to hospital and automatically becomes subject to compulsory detention there. We have no doubt that the element of coercion also increases the resentment of some feebleminded psychopaths, and of their parents, when they are placed under 'statutory supervision' or admitted to mental deficiency hospitals after leaving school, and that this makes it even more difficult than it need be to persuade them to regard these services in the same way as other social services and other types of hospital treatment, as services which are provided for their own benefit. Equally important, if the procedures which authorise detention become the exception rather than the rule, the attitude towards compulsion on the part of those administering the services should change. These procedures will no longer be a formality which must be gone through before any patient can be given the care he needs. It will be possible to consider the need for care and the justification for compulsion as two quite separate questions in a way which is not possible at present.*
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> *290. Admission to hospital without using compulsory powers should also be possible for considerably more mentally ill patients than are at present admitted as voluntary patients . . .*
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> *291. We therefore recommend that the the law and its administration should be altered, in relation to all forms of mental disorder, by abandoning the assumption that compulsory powers must be used unless the patient can express a positive desire for treatment, and replacing this by the offer of care, without deprivation of liberty, to all who need it and are not unwilling to receive it. All hospitals providing psychiatric treatment should be free to admit patients for any length of time without any legal formality and without power to detain . . .*

Here we find a central recommendation of the Percy Commission, and the mischief which it was designed to cure. This recommendation was implemented, in particular, by section 5(1) of the Act of 1959. That the Bill was introduced with that recommendation in mind is confirmed by Ministerial statements made in Parliament at the time: see *Hansard HL* vol 216, columns 668 and 669.

Following the enactment of the Act of 1959, section 5(1) was duly implemented in the manner foreshadowed by the Percy Commission, a practice which (as is plain from the evidence before the Committee) has been continued under section 131(1) of the Act of 1983, which is in identical terms. It is little wonder therefore

that the judgment of the Court of Appeal in the present case, which restricts section 131(1) to voluntary patients, should have caused the grave concern which has been expressed in the evidence, both (1) about the need, following the Court of Appeal's judgment, to invoke the power of compulsory detention in many cases, numbered in their thousands each year, which for nearly 40 years had not been necessary and would, on the view expressed by the Percy Commission, be wholly inappropriate, and (2) about doubts whether some categories of patients would or would not, in consequence of the judgment, require compulsory detention.

In the light of the statutory history Mr Gordon QC, for Mr L, recognised that section 5(1) of the Act of 1959 must have the meaning for which Mr Pleming contended; but he boldly suggested that section 131(1) of the Act of 1983 should be a given a different meaning, and be restricted to voluntary patients. This submission was primarily based upon certain provisions of the Mental Health (Amendment) Act 1982, which were incorporated in the Act of 1983, a consolidating Act. I trust that I will not be thought to fail to do justice to the skill with which Mr Gordon formulated and presented his argument if I say that it is, in my opinion, wholly untenable, bearing in mind not only that section 131(1) is in identical terms to section 5(1) of the Act of 1959, but that I have been able to discover no trace, either in the Act of 1982 or in the White Paper of November 1981 which preceded it (Reform of Mental Health Legislation (Cmnd. 8405)), of any intention to depart from, or modify, the recommendations of the Percy Commission upon which section 5(1) was founded, or to amend section 5(1) itself. On the contrary, it was expressly stated in the White Paper (see the Introduction, paragraph 3) that the Act of 1959 had worked well. The main objects of the Bill, as summarised in paragraph 5 of the Introduction, were that the Bill improved safeguards for detained patients, clarified the position of staff looking after them and removed uncertainties in the law. The main improvements, summarised in paragraph 6, had no bearing on the position of informal patients admitted under section 5(1) of the Act of 1959, as was borne out by the succeeding paragraphs of the White Paper and indeed by the Act of 1982 itself.

I should briefly refer to section 131(2) of the Act of 1983, which was relied on by the Court of Appeal in support of their construction of section 131(1). Subsection (2) reads:

> *(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)].*

The words which I have placed in square brackets were substituted by the Children Act 1989. The section in its original form was identical to section 5(2) of the Act of 1959, except that the word 'minor' was substituted in 1983 for the word 'infant'. It is plain, in my opinion, that subsection (2) can have no impact upon the admission of informal patients under subsection (1) which is concerned with patients who consent as well as those who do not object. It is the former category that subsection (2) addresses, with special reference to minors.

For these reasons, I am unable with all respect to accept the opinion of the Court of Appeal on the crucial question of the meaning of section 131(1). I wish to stress, however, that the statutory history of the subsection, which puts the matter beyond all doubt, appears not to have been drawn to the attention of the

Court of Appeal, and that they did not have the benefit, as we have had, of assistance from counsel appearing for the Secretary of State.

Treatment and Care of Informal Patients

I turn briefly to the basis upon which a hospital is entitled to treat, and to care for, patients who are admitted as informal patients under section 131(1) but lack the capacity to consent to such treatment or care. 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, as to which see the decision of your Lordships' House in *In re F (Mental Patient: Sterilisation)* [1990] 2 AC 1. It is not therefore necessary to find such justification in the statute 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.

Was the Respondent Unlawfully 'Detained'?

It is against this background that I turn to consider the question whether, as the Court of Appeal held, there has been any unlawful detention of Mr L in this case. I should record at once my understanding that the question is whether the tort of false imprisonment has been committed against Mr L; and I do not wish the use of the word 'detention' in this context to distract attention from the true nature of the question.

In the course of their judgment, the Court of Appeal stated (see [1998] 2 WLR 764 at p769: (1998) 1 CCLR 201 at p206C–D) that:

> *. . . 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.*

I observe however that no mention is here made of the requirement that, for the tort of false imprisonment to be committed, there must *in fact* be a complete deprivation of, or restraint upon, the plaintiff's liberty. On this the law is clear. As Atkin LJ said in *Meering v Grahame-White Aviation Co Ltd* (1919) 122 LT 44 at p54, 'any restraint within defined bounds which is a restraint in fact may be an imprisonment'. Furthermore, it is well settled that the deprivation of liberty must be actual, rather than potential. Thus in *Syed Mahamad Yusuf-ud-Din v Secretary of State for India* (1903) 19 TLR 496 at p497, Lord Macnaghten said that: 'Nothing short of actual detention and complete loss of freedom would support an action for false imprisonment.' And in *Meering*, at pp54–55, Atkin LJ was careful to draw a distinction between restraint upon the plaintiff's liberty which is conditional upon his seeking to exercise his freedom (which would not amount to false imprisonment), and an actual restraint upon his liberty, as where the defendant decided to restrain the plaintiff within a room and placed a policeman outside the door to stop him leaving (which would amount to false imprisonment). In cases such as the present it is, I consider, important that the courts should have regard to the ingredients of the tort as laid down in the decided cases, and consider whether those ingredients are in fact found to exist on the particular facts of the case in question. With that in mind, I turn to consider the facts of the present case.

I propose first to consider in detail the circumstances in which Mr L came to be admitted to hospital. These are described, in particular, in the affidavit sworn in these proceedings on 3 October 1997 by Dr Manjubhashini, who is the Clinical Director of Learning Disabilities, Deputy Medical Director and Consultant Psychiatrist of Learning Disabilities at the appellant Trust. She describes how Mr L has been well known to her since 1977. She was the Consultant responsible for his resettlement and trial discharge to Mr and Mrs E in 1994. At that time Mr L was fairly stable with no major behavioural problems. He was stabilised on medication. In March 1996 the community nurse in regular contact with him reported that there had been an escalation in his self-injurious behaviour; however at a review meeting in June 1996 Dr Manjubhashini assessed that it was not necessary for him to be readmitted to hospital and that his care should continue in the community if possible. It was on 22 July 1997 that the serious incident occurred which alerted Dr Manjubhashini and her colleagues to the fact that Mr L's self-injurious behaviour had increased in severity to such an extent that he required in-patient treatment. At this stage I propose to take the exceptional course of quoting a substantial passage from Dr Manjubhashini's affidavit:

At 11 o'clock on 22 July 1997 I was contacted by Ailsa Flinders, social worker and Mr L's case manager. She advised me that there had been an incident at Cranstock Day Centre, where Mr L had been attending since 1995, when Mr L 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 Mr L with a view to admitting him if necessary. One of my team members, Dr Perera, staff grade psychiatrist, attended the Accident & Emergency Department as requested. His notes state that he took a history from Mary Hendrick who was the team manager at Cranstock Day Centre who reported that since March 1997 Mr L'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 Perera later assessed Mr L 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 Perera assessed that Mr L required in-patient treatment and transferred Mr L to the Behavioural Unit. Dr Perera noted that Mr L 'makes no attempt to leave.' I recorded that we considered whether it was necessary to detain Mr L under the Mental Health Act 1983 ('the Act') 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 Mr 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 Managers. An appropriate framework of care and treatment was implemented.

Dr Manjubhashini then described how Mr and Mrs E were informed on 22 July of Mr L's admission, as was Mr L's next of kin. At first, with the agreement of Mr and Mrs E, it was arranged that they would not visit Mr L for a few days, in accordance with the usual clinical practice. On 23 July Dr Manjubhashini 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 Mr L's advocate. Mr L was again assessed. A programme of tests and observations was then put into effect. Dr Manjubhashini continued:

> *As Mr 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. Mr 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-operate 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. Mr L co-operated 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 post-poned and reviewed. Mr L is accomodated 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 Mr L'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 Mr L 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 Mr L stopped co-operating 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.*

In the light of this account, the following conclusions may be drawn. The first is that, as I have already recorded, although Mr L 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 Manjubhashini were taken. The second is that when, on 22 July, Mr L 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 Manjhubashini in particular, should intervene in these circumstances; certainly Mr and Mrs E, as Mr L's carers, could not assert any superior position. Third, I have no doubt that all the steps in fact taken, as described by Dr Manjubhashini, were in fact taken in the best interests of Mr L 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 it is of any touching of his person. There were times during the episode when it might be said that Mr L 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 Manjubhashini's statements to the effect that she would if necessary have taken steps compulsorily to detain Mr L 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 Manjubhashini, 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 Manjubhashini 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 Mr L 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 Manjubhashini 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 Mr L.

For these reasons, I would allow the appeal.

Two Subsidiary Points

There are however two subsidiary points which I wish to mention, one relating to the judgment of the Court of Appeal, and the other of a more general nature.

The first is that the Court of Appeal placed reliance on the decision of this House in the Scottish case of *Black v Forsey* 1988 SC(HL) 28 as providing authority for their conclusion. That case was concerned with the invocation of the common law to supplement the statutory power of compulsory detention to fill a lacuna which had appeared in the Scottish Act. This House held that the common law could not be invoked for that purpose, because the powers of detention conferred upon hospital authorities under the Mental Health (Scotland) Act 1984 were intended to be exhaustive. In my opinion, that decision has no relevance in the present case which is concerned with informal admission under the Act of 1983, and bringing a patient to hospital to enable him to have the benefit of such admission if he does not object to it. In this connection, I observe that section 17(2) of the Scottish Act, which is the equivalent to section 131(1) of the Act of 1983, was not referred to in *Black v Forsey*.

The second point relates to the function of the common law doctrine of necessity 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 *In re F (Mental Patient: Sterilisation)* [1990] 2 AC 1. I wish, however, to express my gratitude to counsel for the appellants, Mr John Grace QC and Mr Andrew Grubb, for drawing to our attention three earlier cases in which the doctrine was invoked, viz *R v Coate* (1772) Lofft 73, especially at p75 *per* Lord Mansfield; *Scott v Wakem* (1862) 3 F & F 328 at p333, *per* Bramwell B, and *Symm v Fraser* (1863) 3 F & F 859 at p883, *per* Cockburn CJ, all of which provide authority for the proposition that the common law permitted the

A 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
B on agency of necessity), in tort (see *In 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 signifcant 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
C law.

LORD LLOYD OF BERWICK:

My Lords,

I have had the advantage of reading in draft the speech prepared by my noble and learned friend, Lord Goff of Chieveley. For the reasons he gives I too would
D allow the appeal.

LORD NOLAN:

My Lords,

I too agree that this appeal should be allowed. For the reasons given by my
E noble and learned friend Lord Goff of Chieveley I am satisfied that the respondent Trust and its medical staff behaved throughout not only in what they judged to be the best interests of Mr L, but in strict accordance with their common law duty of care and the common law principle of necessity.

The first question before your Lordships, however, is whether it is correct to
F describe Mr L as having been detained during the period of his informal admission to the Bournewood Hospital: for if not, the appellant Trust has no case to answer. Owen J considered that Mr L was not detained. He said that Mr L '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 Manjubhashini or somebody
G else takes steps to "section" him or otherwise prevent him leaving'.

The Court of Appeal did not accept this view. They said (see (1998) 2 WLR 764 at p770 (1998) 1 CCLR 201 at p206G):

> *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*
H *in charge of him would not have permitted him to do so.*

My Lords, upon this point I agree with the Court of Appeal. Mr L, was closely monitored at all times so as to ensure that he came to no harm. It would have been wholly irresponsible for those monitoring him to let him leave the Hospital
I until he had been judged fit to do so.

Before your Lordships counsel for the appellant trust accepted that Owen J might have been wrong in describing Mr L as being 'free to leave'. He submitted, however, that in so far as Mr L's liberty was constrained, the constraint arose from his illness rather than from the wishes or actions of the hospital staff. Alter-
J natively he submitted that the question of detention could not arise unless and until Mr L tried to leave.

My Lords, in my judgment these submissions must fail in the light of the appellant Trust's own evidence, part of which is set out by the Court of Appeal at pp770–771 [see (1998) 1 CCLR 201 at p207] of the report. It will be sufficient for
K my purpose to quote from the letter written to Mr and Mrs E by Dr Manjubhashini on 6 August 1997 in which she said, amongst other things:

I would like to take the opportunity to stress, through this correspondence, that we, as a Clinical Team, within the Behavioural Unit of Bournewood NHS 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 dependant (sic) 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 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 (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.

After quoting from this and other letters the Court of Appeal concluded, at p771 of the report [(1998) 1 CCLR 201 at p207H–I]:

Mr and Mrs E 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.

My Lords, with that conclusion too I agree. I have laid some stress on the point not only because the individual's right to liberty, and the remedy of habeas corpus, lie at the heart of our law but because if Mr L, in the circumstances which I have described, was not detained then (leaving aside the question of his treatment, which is not in issue) there was no ground in law upon which the hospital and its staff could be called upon to justify their unwillingness to release him. I find it hard to believe that the medical profession in general would regard that as a satisfactory state of affairs.

In the event, as I have said, I am satisfied that this justification has been fully made out, and I would allow the appeal on that basis.

LORD STEYN

My Lords,

Fewer than 10 per cent of mentally disordered patients cared for in hospitals and mental nursing homes are admitted under the provisions of the Mental Health Act 1983. The rest of this group can be sub-divided into two sub-groups: the first and larger sub-group consists of patients capable of consenting to admission, who have so consented; the second subgroup comprises compliant but incapacitated patients, ie patients who are incapable of giving consent but do not express unwillingness to be admitted. Diagnostically there is usually no or virtually no difference between patients in the second sub-group (compliant incapacitated patients) and patients compulsorily admitted under the Act of 1983. If considerations of financial resources are put to one side, there can be

A no justification for not giving to compliant incapacitated patients the same quality and degree of protection as is given to patients admitted under the Act of 1983.

If the judgment of the Court of Appeal is upheld it would mean that in practice compliant incapacitated patients, such as 'L', could only be admitted to hospitals
B and mental nursing homes under the Act of 1983: *R v Bournewood Community and Mental Health NHS Trust, Ex parte 'L'* [1998] 2 WLR 764; (1998) 1 CCLR 201. On that basis the statutory safeguards would apply to them. Specifically, the beneficial consequences of the ruling of the Court of Appeal would be as follows:

C (1) Such patients could then only be admitted for assessment and detained (for 28 days) under section 2 or admitted for treatment and detained (for up to 6 months) under section 3 on the written recommendation of at least two doctors: see also section 4 dealing with emergency cases.

(2) Such patients would gain the protection of section 58 which requires either the patient's consent or a second medical opinion before certain forms of
D medical treatment are given.

(3) Such patients would have the advantage of applying to or being automatically referred to Mental Health Review Tribunals in accordance with the provisions of Part V of the 1983 Act.

E (4) Such patients would become entitled to after-care services provided by Health Authorities and Local Authorities under sections 25A–J and section 117.

(5) Such patients would have the benefit of the Code of Practice published by the Secretary of State: see section 118.

F (6) Such patients would be brought under the supervision of the Mental Health Act Commission: section 121. (For reasons which are not apparent, successive Secretaries of State have to date refused to extend the Commission's terms of reference in this way: see section 121(4).)

In any event, this is an extensive scheme of statutory safeguards which, on the
G basis of the judgment of the Court of Appeal, would also serve to protect compliant incapacitated patients.

If the House is compelled to reverse the decision of the Court of Appeal, it follows that compliant incapacitated patients will not have specific protections provided by the Act of 1983. It is, of course, true that health care professionals will
H almost always act in the best interests of patients. But Parliament devised the protective scheme of the Act of 1983 as being necessary in order to guard amongst other things against misjudgment and lapses by the professionals involved in health care. This point requires some explanation. A hospital psychiatrist who decides that a patient ought to be admitted to hospital and treated makes a
I judgment which may be controversial. The clinical question may arise whether the patient is in truth incapacitated. The importance of this issue is described by Grisso and Applebaum (*Assessing Competence to Consent to Treatment: A Guide to Physicians and Other Health Officials*, OUP, 1998) as follows (at page 1):

J *Competence is a pivotal concept in decision-making about medical treatment. Competent patients' decisions about accepting or rejecting proposed treatment are respected. Incompetent patients' choices, on the other hand, are put to one side, and alternative mechanisms for deciding about their care are sought. Thus, enjoyment of one of the most fundamental rights of a free society – the right to*
K *determine what shall be done to one's body – turns on the possession of those characteristics that we view as constituting decision-making competent.*

And the same authors have demonstrated how complex such an issue of competence may be: see also Applebaum, *Almost a Revolution, Mental Health Law and Limited Change*, OUP, 1994, Chapter 4. Yet on the issue of competence depends a patient's right of autonomy: compare, however, the psychiatric argument for a 'trade-off' between competence and the consequences of treating or not treating: Eastman and Hope, *The Ethics of Enforced Medical Treatment: The Balance Model, Journal of Applied Philosophy*, Vol 5, No. 1, 1998, 49. Moreover, the broad question of what is in an incompetent patient's best interests may involve a weighing of conflicting medical and social considerations. And, in regard to treatment, the moral right of the patient to be treated with dignity may pose acute problems. These are no doubt some of the reasons why Parliament thought it necessary to create a system of safeguards for those admitted under the Act of 1983. Parliament was not content in this complex and sensitive area to proceed on the paternalistic basis that the doctor is always right.

If the decision of the Court of Appeal is reversed almost all the basic protections under the Act of 1983 will be inapplicable to compliant incapacitated patients: see section 57(2) for an exception. The result would be an indefensible gap in our mental health law. In oral argument counsel for the Secretary of State for Health did not seek to justify such differential treatment on the grounds of resource implications. That is understandable. After all, how we address the intractable problems of mental health care for all classes of mentally incapacitated patients must be a touchstone of our maturity as a civilised society. Counsel for the Secretary of State did not seek to justify such differential treatment on the grounds of the views and wishes of health care professionals. That is also understandable. If protection is necessary to guard against misjudgment and professional lapses, the confident contrary views of professionals ought not to prevail. Professions are seldom enthusiastic about protective measures to guard against lapses by their members. And health care professionals are probably no different. But the law would be defective if it failed to afford adequate protective remedies to a vulnerable group of incapacitated mental patients.

For these reasons I would have wished to uphold the judgment of the Court of Appeal if that were possible. But as the issues were intensively probed in oral argument it became clear to me that, on a contextual interpretation of the Act of 1983, this course was not open to the House. Given the importance of the matter, I will explain my reasons. Two issues arose:

(1) Was 'L' detained?
(2) If he was detained, was his detention lawful?

The first is a question of fact and the second is a matter of pure law.

The Approach to be Adopted

Counsel for 'L' submitted that it would be wrong to conflate the two issues. Owen J and the Court of Appeal considered first the issue of detention in the common law sense and then the issue of justification under the statute. That was how the issues were formulated in the Agreed Statement of Facts and Issues lodged for the purpose of the present appeal. And the parties to the appeal, as well as the Secretary of State, addressed in their printed cases first that the issue of detention and then, on the assumption that there was a detention in the common law sense, the separate question of justification under the statute. In my view, the two issues should be considered separately, and that the issue of detention must be considered and determined before one can turn to the issue of justification: see *R v Deputy Governor of Parkhurst Prison, Ex parte Hague* [1992] 1 AC 58, at p162C-D,

per Lord Bridge of Harwich; and *Collins v Wilcock* [1984] 1 WLR 1172 *per* Robert Goff LJ. This is consistent with the rule that if a plaintiff proves an imprisonment, the burden is on the defendant to show that it was lawful. Moreover, the element of detention or imprisonment is a pure issue of fact for the jury and the element of justification is one in which the judge has a role to play: see *Dallinson v Caffery* [1965] 1 QB 348. The two issues must therefore be kept separate. If instead one turns straightaway to the lawfulness of the conduct of a defendant, one is not concentrating on the right question, namely *whether conduct which as a matter of fact amounts to detention or imprisonment is justified in law.* It is therefore essential in the present case to determine in the first place whether in the common law sense, as explained in the decided cases, there has been a detention of 'L'. Only if this question is answered in the affirmative, is it right to turn to the question of the lawfulness of the detention. To start with an enquiry into the lawfulness of conduct, or to conflate the two issues, is contrary to legal principle and authority. And such an approach tends to erode legal principles fashioned for the protection of the liberty of the individual.

Detention

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 1979 at the Day Centre 'L' 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 'L' 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 'L'. She did so, as she explained to the carers, in order to ensure that 'L' did not try to leave with them. The psychiatrist told the carers that 'L' would be released only when she, and other health care professionals, deemed it appropriate.

(5) While 'L' 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 'L' 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 'L', any possible resistance by him was overcome by sedation, by taking him to hospital, and by close supervision of him in hospital. And, if 'L' 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 'L' was free to go is a fairy tale.

At one stage counsel for the Trust suggested that 'L' was not detained because he lacked the necessary will, or more precisely the capacity to grant or refuse consent. That argument was misconceived. After all, an unconscious or drugged person can be detained: see *Meering v Grahame-White Aviation Co Ltd* (1919) 122 LT 44 at p53–54, *per* Atkin LJ, dictum approved in *Murray v Ministry of Defence* [1988] 1 WLR 692 at p701F-702F, *per* Lord Griffiths. In my view 'L' 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.

Justification

It is now necessary to consider whether there was lawful authority to justify the detention and any treatment of 'L'. 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: *In Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1, at p55H, *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 p75H. 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: see, however, David Feldman, Civil Liberties and Human Rights, 1993, p14–150 for a critical appraisal of *Re F*. 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) , Cmnd 169, para 291. 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. The marginal note reads 'Informal admission of patients'. Section 5(1) provides:

> *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.*

Counsel appearing on behalf of 'L' 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. And the same marginal note appears next to section 131. 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 'L' submitted that section 131(1), unlike its predecessor, only applies

A to consenting incapacitated 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. He relied in particular on the provisions of Part IV of the Act which are set out under the heading 'Consent to Treatment'. Part IV undoubtedly B contains safeguards going beyond those in the Act of 1959, and also expressly made some of its provisions only applicable to those 'liable to be detained under this Act,' and others applicable also to 'patients not liable to be detained under this Act'. These provisions are not inconsistent with the interpretation that the meaning of section 131(1) of the Act of 1983 is the same as the meaning of C section 5(1) of the Act of 1959. Making due allowance for the improved safeguards for detained patients in the Act of 1983, the differences relied on do not in truth touch on the issue before the House and do not warrant a radical reinterpretation of identical statutory wording. On orthodox principles of statutory interpretation the conclusion cannot be avoided that section 131(1) permits D 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.

About the principle of necessity, applied to a case such as that of 'L', there is a E qualification. It is asserted on behalf of the Secretary of State that such authority lapses if the patient insists on leaving. That is consistent with the Code of Practice: Mental Health Act 1983 (1993): it provides that 'it is important that informal patients understand their right to leave hospital': para 14.1, and see also para 18.27. But the Code of Practice cannot overrule the width of principle of necessity, F which might in some cases authorise further detention of such a patient. If such cases arise, the court will not be able to give effect to the policy of the Code of Practice. This is an unsatisfactory position in an area of supreme importance to personal liberty. In any event, it follows from my conclusion that the principle of necessity has been preserved by section 131(1). The detention and treatment of G 'L' was lawful.

The Effect of the Decision of the House of Lords

The general effect of the decision of the House is to leave compliant incapacitated patients without the safeguards enshrined in the Act of 1983. This is an unfortunate result. The Mental Health Act Commission has expressed concern H about such informal patients in successive reports. And in a helpful written submission the Commission has again voiced those concerns and explained in detail the beneficial effects of the ruling of the Court of Appeal. The common law principle of necessity is a useful concept, but it contains none of the safeguards of the Act of 1983. It places effective and unqualified control in the hands of the hospital I 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 J that such patients are diagnostically indistinguishable from compulsory patients, there is no reason to withhold the specific and effective protections of the Act of 1983 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 K law is under active consideration.

Conclusion

I would allow the appeal.

LORD HOPE OF CRAIGHEAD:

My Lords,

I have had the advantage of reading in draft the speech which has been prepared by my noble and learned friend, Lord Goff of Chieveley. I agree with it, and for the reasons which he has given I also would allow the appeal.