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IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

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KING'S BENCH DIVISION
(JUDICIAL REVIEW)

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IN THE MATTER OF AN APPLICATION BY THE BELFAST HEALTH AND SOCIAL CARE TRUST FOR LEAVE TO APPLY FOR JUDICIAL REVIEW

AND IN THE MATTER OF A DECISION OF THE REVIEW TRIBUNAL UNDER THE MENTAL CAPACITY ACT (NORTHERN IRELAND) 2016

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Gregory McGuigan KC with Sarah Gallen (instructed by Breen Rankin Lenzi, Solicitors) on behalf of the Patient, as a Notice Party
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Steven McQuitty KC (instructed by the Departmental Solicitor) for the Department of Health, the Notice Party

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ROONEY J

Introduction

[1] By an application for leave to apply for judicial review, the Belfast Health and Social Care Trust ("the Trust"), challenges a decision of the Review Tribunal made on 5 April 2023, in which the Tribunal revoked a Deprivation of Liberty ("DoL") authorisation in respect of a person "P" under section 51 of the Mental Capacity Act (Northern Ireland) 2016 ("MCA 2016"). The written reasons for the decision of the Tribunal were issued on 18 April 2023.

[2] On 14 April 2023, pursuant to an application brought by the Trust, the High Court made a Declaratory Order as follows:

> "The plaintiff Trust has the permission of the court to deprive "P" (the patient) of his liberty at [a named

> residential care facility], notwithstanding the decision of the Review Tribunal dated 5 April in proceedings under Chapter 7 of the Mental Capacity Act (NI) 2016, but at all times in accordance with the 2016 Act and pending further Order of this court or further application by the Trust under the Act."

[3] The judicial review proceedings (and the consolidated application under this court's declaratory jurisdiction) focuses upon the interpretation of the MCA 2016 and the operation of the DoL authorisation framework in Part 2 and Schedule 1 of the Act. The central issue of the judicial review relates to the lawfulness of the Review Tribunal's decision to revoke the DoL authorisation of 5 April 2023 and, the consequences of that decision, including the utilisation of a declaratory order as a "stop-gap" measure to regularise P's ongoing care plan pending clarification of the legal position in these proceedings.

Factual background

[4] P is profoundly disabled and requires care and assistance with all aspects of his life. P is the sole resident of a purpose-built bungalow in a residential care facility. This service is registered with RQIA to provide domiciliary care for residents with learning disabilities. His care plan is extensive and provides 336 hours of support per week from two day staff and two night staff each day. P is under continuous supervision due to the risk to his safety. He does not have capacity to make his own decisions and to maintain his own safety. He lives in a secured establishment. By reason of the necessary measures contained within his care plan, for the purposes of Article 5 ECHR, P is deprived of his liberty. There is no alternative "less restrictive" way to appropriately care for P that avoids the deprivation of his liberty.

[5] On 13 October 2021, a Trust Panel authorised P's detention under Schedule 1 of the MCA 2016. On 19 October 2021, the Attorney General, having considered the relevant papers, decided that the criteria for detention appeared to be met and did not refer to the Review Tribunal the question as to whether the authorisation was appropriate.

[6] On 13 April 2022, the Trust Panel granted an extension of the authorisation of P's detention under section 37 of the MCA 2016. On 15 April 2022, the Attorney General, having considered the papers, referred to the Review Tribunal the question as to whether the continued authorisation was appropriate. The Attorney General noted that P displayed unsettled behaviour and was reported to often pace up and down communal corridors, push staff and throw objects at staff.

[7] On 26 May 2022, the Review Tribunal considered the referral under section 47 of the MCA 2016 from the Attorney General and decided to take no action in respect of the DoL authorisation. This decision was one of three possible disposals available

to the Review Tribunal under section 51(1) of MCA 2016. The decision was supported by a detailed Statement of Reasons dated 3 June 2022.

[8] On 7 October 2022, the Trust Panel granted an extension of the authorisation of the DoL under section 38 of the MCA 2016. On 11 October 2022, the Attorney General, having considered the papers decided to refer to the Review Tribunal the question as to whether the authorisation for the DoL, as extended, was appropriate. Significantly, the Attorney General noted that P had been admitted to hospital in March 2022 due to an accidental overdose of his prescribed lithium medication. Furthermore, although P was believed to have benefited from his move to the premises in question, he continued to experience periods when he was more agitated which extended for a number of weeks.

[9] The Review Tribunal conducted a hearing on 30 November 2022. The hearing was adjourned for the following reasons, namely:

(i) to permit P to avail of legal representation.

(ii) to give the Trust an opportunity to provide further information to enable the Tribunal to adjudicate on the referral.

(iii) to enable the legal representative for the Trust and the legal representative for P to furnish the Review Tribunal with information and written legal submissions on the relevant statutory criteria under the MCA 2016.

(iv) to enable the nominated person (NP), if she so wished, to furnish a written statement to the Review Tribunal in respect of P's DoL; and

(v) to facilitate relisting of the matter as an oral hearing.

[10] At a videolink oral hearing on 27 January 2023, the matter was again adjourned and scheduled to proceed on 28 February 2023. The adjournment decision and directions of the Review Tribunal were dated 7 February 2023.

[11] At the adjourned hearing on 23 February 2023, the Review Tribunal extended the time limits for the submissions of evidence and rescheduled the oral hearing for 5 April 2023. The decision to adjourn was in response to an application by the Trust and with the consent of the legal representatives.

[12] On 4 April 2023, the legal representative for P sought an adjournment of the oral hearing scheduled for 5 April 2023. The Review Tribunal refused the application to adjourn due to the fact that the hearing had been arranged well in advance and also the gravity of the issues under consideration. On 5 April 2023, following a video link oral hearing, the Tribunal analysed the totality of the evidence and reached a unanimous decision to revoke the authorisation in respect of P's DoL. In reaching its decision, the Review Tribunal considered the evidence in the context

of the relevant criteria contained in Schedule 1 para 10 of the MCA 2016. Whether the Review Tribunal lawfully considered the relevant criteria is the major bone of contention in these judicial review proceedings.

Grounds of challenge

[13] The grounds of challenge are set out in the amended Order 53 Statement. In essence, it is submitted that the decision of the Review Tribunal to revoke the DoL authorisation was unlawful on the grounds that it failed to correctly interpret and apply the relevant criteria as set out in Schedule 1 para 10(a) of the MCA 2016 and, when interpreting the legislation, the Review Tribunal failed to take into consideration the Deprivation of Liberty Safeguards Code of Practice (November 2019) and, in particular, paras 15(1)-(3) thereof. It is also submitted that the Review Tribunal, in its decision to revoke the DoL authorisation, acted irrationally and disproportionately in its application of the criteria as stated in Schedule 1 para 10(a) MCA 2006 and, specifically in respect of its failure to acknowledge the steps taken by the Trust in the period September 2022 to April 2023 to address the concerns in respect of medication errors.

The relief sought

[14] The applicant seeks the following relief:

(a) A declaration that the Review Tribunal has erred in law in finding that the criterion in Schedule 1 para 10(a) of the MCA 2016 was not met and that the DoL authorisation should be revoked.

(b) An order of certiorari quashing the decision of the Tribunal.

(c) In the alternative to orders at (a) and (b) above, that the challenged decision remains in force and that the applicant Trust is not constrained by law from making an application under the Deprivation of Liberty provisions of the MCA 2016 for a DoL authorisation in respect of 'P' notwithstanding the decision of the Review Tribunal dated 5 April 2023.

Statutory framework

[15] The Review Tribunal is a statutory agency constituted under Article 70 of the Mental Health (NI) Order 1986, as renamed by section 274 of the MCA 2016. Its predecessor was the Mental Health Review Tribunal.

[16] A summary of the relevant statutory provisions under the MCA 2016 is detailed by the Court of Appeal *In The matter of an application by the Northern Health and Social Care Trust for JR* [2024] NICA 44 at paras [4]-[9].

[17] For the purpose of these proceedings, this court will concentrate its analysis on the criteria for detention amounting to a DoL as set out in Schedule 1 paragraph 10 of the MCA 2016 and the general powers of the Tribunal in relation to DoL authorisations.

[18] Schedule 1 of the MCA 2016 regulates, inter alia, DoL authorisations made by the Trust (see paras 1 and 2(2)(b)). The relevant criteria for a DoL detention are specified in paragraph 10 of Schedule 1 which reads as follows:

> "In relation to detention of P in a place in circumstances amounting to a deprivation of liberty, the criteria for authorisation are that—
>
> (a) appropriate care or treatment is available for P in the place in question;
>
> (b) failure to detain P in circumstances amounting to a deprivation of liberty in a place in which appropriate care or treatment is available for P would create a risk of serious harm to P or of serious physical harm to other persons;
>
> (c) detaining P in the place in question in circumstances amounting to a deprivation of liberty would be a proportionate response to—
>
> (i) the likelihood of harm to P, or of physical harm to other persons; and
>
> (ii) the seriousness of the harm concerned;
>
> (d) P lacks capacity in relation to whether he or she should be detained in the place in question; and
>
> (e) it would be in P's best interests to be so detained."

[19] In respect of these proceedings, the relevant statutory provision relating to the powers of the Tribunal under Schedule 1 is as specified in section 51 of the MCA 2016, which reads as follows:

> "**Powers of Tribunal in relation to authorisation under Schedule 1**
>
> 51—(1) Where an application or reference to the Tribunal is made under this Chapter in relation to an authorisation

under Schedule 1, the Tribunal must do one of the following—

(a) revoke the authorisation;

(b) if the authorisation authorises more than one measure (as defined by subsection (4)), vary the authorisation by cancelling any provision of it which authorises a measure;

(c) decide to take no action in respect of the authorisation.

(2) In the case of an authorisation under paragraph 15 of Schedule 1, the Tribunal—

(a) may vary the authorisation only if satisfied that the criteria for authorisation are met in respect of each measure that will remain authorised by the authorisation;

(b) may decide as mentioned in subsection (1)(c) only if satisfied that the criteria for authorisation are met in respect of each measure that is authorised by the authorisation.

(3) In the case of an interim authorisation under paragraph 20 of Schedule 1, the Tribunal—

(a) may vary the authorisation only if satisfied that there is a good prospect of it being established that the criteria for authorisation are met in respect of each measure that will remain authorised by the authorisation;

(b) may decide as mentioned in subsection (1)(c) only if satisfied that there is a good prospect of it being established that the criteria for authorisation are met in respect of each measure that is authorised by the authorisation.

(4) For the purposes of this section each of the following is a "measure"—

(a) the provision to P of treatment specified by the authorisation;

(b) the detention of P in a place in circumstances amounting to a deprivation of liberty;

(c) a requirement to attend at a particular place at particular times or intervals for the purpose of being given treatment specified by the authorisation;

(d) a community residence requirement.

(5) In this section "the criteria for authorisation", in relation to a measure, means the criteria for authorisation for that measure as set out in Part 3 of Schedule 1.

(6) In paragraphs 11(a) and 12(a) and (b) of that Schedule as they apply for the purposes of this section, the references to imposing a requirement include continuing the requirement."

[20] It is readily apparent from section 51(1)(a)-(c) that there are three options available to the Review Tribunal, namely:

(a) revoke the authorisation;

(b) if the authorisation authorises more than one measure, vary the authorisation by cancelling any provision of it which authorises a measure;

(c) decide to take no action in respect of the authorisation.

[21] Section 51(2)(b) provides that a Tribunal can only decide to take no action where they are satisfied that the authorisation criteria are met in respect of the measure. Also significantly, if the Review Tribunal decides that the authorisation criteria are not satisfied, then it must revoke the authorisation.

[22] As considered in more detail below, the focus of attention for the Review Tribunal was whether, at the material time relating to P's DoL detention, appropriate care or treatment was available for P in the place in question.

The Review Tribunal's decision

[23] The decision of the Review Tribunal to revoke P's DoL authorisation is contained within a detailed Statement of Reasons dated 18 April 2023, following an oral hearing on 5 April 2023. In essence, the Review Tribunal was not satisfied that appropriate care or treatment was available for P in the place in question, resulting in the DoL authorisation being revoked in accordance with Schedule 1 paragraph 10(a) of the MCA 2016. Accordingly, the Review Tribunal did not proceed to

adjudicate and reach a decision as to whether the criteria for authorisation as contained within Schedule 1 paragraphs 10(b), 10(c), 10(d) and 10(e) were satisfied.

[24] In reaching its decision, the Review Tribunal considered, inter alia, the following written evidence, namely (a) the forms and documents relating to the Trust's authorisation and extension authorisation; (b) the additional evidence submitted to the Tribunal by the Trust in the form of statements compiled pursuant to Rule 6 of the Mental Health Review Tribunal (NI) Rules 1986; (c) the responses to the adjourned decisions and directions of the Review Tribunal; (d) the written submissions and legal arguments provided by the legal representative for the Trust dated 12 January 2023 and 4 April 2023; (e) the written submissions and legal arguments provided by the legal representative for P dated 26 February 2023 and 26 March 2023; and (f) the statement of reasons given by the Review Tribunal dated 26 May 2022 following the AG's referral of the first extension authorisation.

[25] At the oral hearing, the Trust and P were represented by legal representatives. P's nominated person (his sister) was not in attendance. Oral evidence was received from Trust witnesses, namely JB, the Senior Practitioner MCA Team; CD, West Belfast Adult Learning Disability Services (P's community social worker and key worker).

[26] The Trust's legal representative, relying on the written and oral evidence, submitted that P would be at significant risk of harm if not deprived of his liberty. The forms contained within the written evidence revealed that P lacked capacity regarding his care and treatment, and accordingly, the DoL measures were proportionate to the risks outlined in the written evidence placed before the Tribunal. In essence, it was in P's best interests to be deprived of his liberty.

[27] It was further submitted on behalf of the Trust that appropriate care and treatment was available for P in the relevant establishment. Although it was acknowledged that there had been several medication errors, it was asserted that appropriate measures have been put in place to manage P's medication, to include the instigation of a Serious Event Audit (SEA). It was emphasised that medication administration was not the only element of the care or the treatment available and provided to P. In particular, it was submitted that P had full-time input and supervision from trained staff, which included support, assistance, encouragement, redirection and supervision in respect of his mobility, personal care, continence needs, unsettled behaviour, provision of meals, nutrition, hydration and general monitoring of his mental health and activities of daily living.

[28] P's legal representative submitted that P was a vulnerable man with complex medical needs and medication regime. Although P's legal representative alluded to concerns regarding a lithium overdose to P, she highlighted that changes had taken place to P's treatment and submitted that the criterion for P's DoL authorisation as set out in paragraph 10(a) was satisfied.

[29] The Review Tribunal consisted of three highly experienced members, including a legally qualified president and a consultant psychiatrist. It was clear to this court that the Tribunal carried out a most comprehensive review of the written and oral evidence particularly at paras [20] to [35] of the Statement of Reasons. The written evidence included an analysis of Form 15, namely a statement completed by the Responsible Person, Form 4 which related to P's care plan and Form 14 which was completed by the medical practitioner of the MCA Team.

[30] The Responsible Person gave oral evidence to the Tribunal. Although references were made to the medication errors in Form 15 and Form 4, the Tribunal stated at para [22] that it would have expected "a more comprehensive analysis of the impact of medication mismanagement for P and for the MCA statutory criteria…in accordance with the evidence and with the information set out in the document entitled 'Summary of [P] medication errors and risk management arrangements.'" It was also clear that the Tribunal were not impressed with the oral evidence of the Responsible Person, stating that overall, she did not demonstrate a comprehensive understanding of P's circumstances.

[31] The Tribunal were also critical of the forms completed by the medical practitioner. The medical practitioner did not attend and give evidence at the oral hearing. The Tribunal concluded that, in relation to the written evidence provided by the medical practitioner, "a diligent comprehensive analysis of accurate information of P's circumstances and care and treatment did not appear to have been carried out." The Tribunal's view was that serious consideration had not been given to the medication errors which had occurred by the date of the completion of Form 14 and also those errors which had occurred by the date of the addendum report. As stated in para [23]:

> "…the Tribunal had some difficulty in accepting how it was proper to omit a reference in the Form 14 to the then reported accidental overdose of prescribed lithium medication. Similarly, it was difficult to accept how the fact that the accidental overdose allegedly happened over six months prior to [the medical practitioner's] assessment warranted an omission to record the overdose. Of significance, was the view that an accidental overdose of medication and reference to lithium toxicity were not deemed to be relevant considerations for a medical practitioner who is tasked with making a declaration that in his opinion the criteria for continuation are met in respect of the deprivation of liberty and that the authorisation is extended for a 12-month period."

[32] The Tribunal concluded that, having analysed the totality of the evidence, the opinion of the medical practitioner was not reliable and did not support a finding

that the criterion for P's DoL authorisation pursuant to paragraph 10(a) was satisfied.

[33] At para [25] the Review Tribunal further stated as follows:

> "*The administration of medication as prescribed, ensuring compliance with a medication regime and avoiding administering incorrect medication to a person are fundamental to the provision of appropriate care or treatment.* Since P's admission to [the care facility] in November 2021 and to date, there have been eight documented medication errors. There was one lithium overdose, not two. The errors relate to different medications and for a variety of reasons… The Trust placed some reliance on their assertion that P had not come to harm because of medication errors and as stated by [MD] in her oral evidence, that medication errors occurred in other settings. The Tribunal determined that these factors do not necessarily translate to a finding that there is appropriate care or treatment available for P in [the care facility]. Rather, they go some way to support a contrary finding, especially in the context of the multiplicity of errors and the vulnerability of P." [emphasis added]

[34] The Tribunal further stated at para [26]:

> "…P is vulnerable. He has a diagnosis of severe learning disability, autism and bipolar affective disorder. P is non-verbal. He cannot verbally express his needs or feelings or if he is in pain. Staff who are familiar with him determine if he is in pain by relying on an interpretation of his behaviours and presentation. P also suffers from epilepsy and hypothyroidism. The list of his medications is extensive. [The medical practitioner] opines in Form 14 that P *is likely to suffer serious harm to his mental health from various factors including not getting his prescribed medication*. The Tribunal formed the view that compliance with the medication and administration of the proper medication were essential for P's safety and well-being and in his management of P's physical health and of P's mental health."

[35] Furthermore, at para [30] the Tribunal stated as follows:

> "The Tribunal was surprised at the lack of clarity and finality surrounding the measures undertaken in respect

> of the Serious Event Audit (SEA), the Serious Adverse Incident (SAI), adult safeguarding and the reporting to RQIA. It appears from the oral evidence of [MD] that there is no SIA investigation currently open, contrary to the statements throughout the paperwork, and that the report of the SIA is being finalised and may be available in *approximately June time, the summer time*. According to her oral evidence, it is getting signed off by senior management responsible for supported living who *are making sure that everything is accurate and shared*."

[36] In written submissions to this court dated 3 October 2023, the Trust has attempted to minimise the medication errors and to highlight remedial measures that it took. This submission is made despite the Tribunal's criticism that the remedial measures were ineffective and also that, even after a review by the Tribunal, a further medication error occurred in February 2023. In my judgement, the Trust's attempt to minimise the medication errors and to provide some justification for the acts and omissions of the Trust during the relevant period is seriously flawed.

[37] It is the view of this court that the analysis of the evidence as conducted by the Tribunal and provided in their Statement of Reasons is not open to criticism. The Tribunal succinctly summarised the evidential analysis at para [32]:

> "32. There has been a multiplicity of medication errors from November 2021 to February 2023. There is a paucity of concrete evidence to suggest that the errors have been managed and continue to be managed, as suggested by the Trust, whether by protection plans, risk assessments, updated care plans and the input of senior management and governance and health and social care professionals. The Tribunal determined that the fact that medication errors continued in the context of the imposition of preventative measures, during an ongoing SEA and throughout the Tribunal proceedings, supported a finding that the problems with medication mismanagement were not being properly addressed or effectively remedied."

[38] Based on a thorough consideration of the evidence, the Tribunal concluded that it could not be satisfied, applying the criterion in Schedule 1 Paragraph 10(a) of the MCA 2016, that appropriate care or treatment was available for P and, accordingly, revoked the DoL authorisation.

The respondent's submissions

[39] The respondent submits that judicial review proceedings involve an audit of the legality of the Tribunal's decision and that it is not the function of the court to conduct a rehearing. In this case, it is submitted that there is no evidence that the Tribunal's decision was based on a finding of fact or inference from the facts which was perverse or irrational. There is no evidence that the Tribunal took into consideration irrelevant factors or disregarded relevant factors. Based on the Tribunal's findings of fact, there is no basis for the argument that the Tribunal's decision was "plainly wrong" or "perverse" (see *TF v NIPSO* [2022] NICA 17 at [43]).

[40] The respondent emphasises that the Review Tribunal is a three-person specialist body consisting of a medical member, a legally qualified chair/president and an experienced member. It is submitted that the courts correctly follow a policy of judicial restraint when considering the decisions of expert Tribunal members. In *TCM's Application* [2013] NICA 31, a case concerning the Special Educational Needs and Disability Tribunal, Morgan LCJ, said at para [33]:

> "[33] The issues faced by the tribunal were clearly well within their expertise and the balance reached by them in terms of the assessment of the educational needs of the child against all the background facts is one that should not be lightly disturbed. The respect which should be shown to decisions of expert tribunals was recently acknowledged by Lord Hope in *Eba v Advocate General for Scotland* [2011] UKSC 29 at paragraph 47."

[41] Accordingly, the respondent submits that there is no basis for the applicant's argument that the Review Tribunal misinterpreted the statutory test in Schedule 1 paragraph 10 MCA 2016 or that the decision was irrational and/or disproportionate.

The applicant's submissions

[42] The applicant Trust submits that the Tribunal's interpretation of the ambit of Schedule 1 paragraph 10(a) MCA 2016 was unlawful. The Department of Health (as Notice Party) and the applicant argue that interpretation of Schedule 1 paragraph 10(a) MCA 2016 must be considered in light of the recent decision of the Grand Chamber of the European Court of Human Rights in *Rooman v Belgium* [2019] ECHR 105. In summary, it is submitted that the Grand Chamber in *Rooman* in its interpretation of Article 5(1)(e) ECHR stated that, in respect of the DoL of persons suffering from mental disorders, "it is essential to verify whether a link has been maintained between the initial aim of detaining the applicant and the appropriateness of the treatment provided to him: only if this condition is fulfilled can the deprivation of liberty be considered lawful."

[43] The Department of Health submit that a Tribunal should only conclude that appropriate care or treatment is not available for P in the place in question under paragraph 10(a) if it is satisfied, on the basis of the evidence, that the link between the purpose of the detention and the conditions of detention (including care and treatment) has been severed. According to the Department of Health, this is a relatively high threshold, and the Tribunal is not empowered to apply a higher degree of scrutiny than is necessary to ensure the DoL does not breach Article 5 ECHR. In essence, if the evidence establishes that medication is provided routinely and through an individualised package of care or treatment in the place of detention, a Tribunal should generally be slow to hold that paragraph 10(a) is not satisfied, even if there have been some medication errors in the past. However, the Department of Health does accept that such a determination will invariably depend upon the specific factual circumstances of each case, including, inter alia, the precise nature of the errors, the frequency of the errors, the gravity and consequences for the detained person and how the errors have been addressed so as to prevent or mitigate against further errors in the future.

[44] An evaluation of this submission inevitably requires an analysis of the facts in *Rooman* and the relevant judgment.

[45] The applicant in *Rooman* was a Belgian national, belonging to a German-speaking minority. He was convicted in 1997 of a multitude of offences, including several sexual offences against children. He was sentenced to prison for these crimes and relapses until 2004 when he was held in compulsory confinement in a social protection facility. Medical reports held that Mr Rooman required psychiatric and medical assistance and that such assistance ought to be carried out in German because this was the only language spoken by the applicant. There was no institution in Belgium able to comply with his requirements. The applicant made requests for discharge before the Commission de Défense Sociale (CDS). These requests were rejected on the basis that there were no improvements in the applicant's mental health, and he still posed a potential danger to society if released.

[46] Mr Rooman brought a claim before the European Court of Human Rights (ECtHR) claiming that his compulsory confinement entailed a violation of Articles 3 and 5(1) of the Convention as Belgium failed to provide psychiatric and psychological treatment in the facility in which he was detained because of the described language barrier. The Grand Chamber held that from the beginning of 2004 until August 2017, there was a violation of Article 3 of the Convention. The court reaffirmed that torture and inhuman or degrading treatment are prohibited 'irrespective of the circumstances of the victim's behaviour.' Article 3 of the Convention requires that detainees enjoy conditions compatible with human dignity, which include the security of their health and well-being during imprisonment. The court noted that the right to obtain medical treatment does not necessarily mean that it must be in the language of the patient. However, in mental health cases, the use of language is decisive for therapy. Based on the applicant's declarations that the treatment must be carried out in German, the court observed that during this period

the Belgian authorities failed to provide adequate mental health treatment to Mr Rooman. From August 2017 until the date of the judgment, there had been no violation of Article 3 of the Convention since during this period an 'appropriate treatment' level was reached and the authorities were showing a willingness to remedy the situation.

[47] From the beginning of 2004 until August 2017, the Grand Chamber concluded there had been a violation of Article 5 of the Convention. Although States have a margin of appreciation in determining the content of the treatment that is offered and administered to detainees, the court noted that Article 5(1) does not guarantee to a person in compulsory confinement the right to receive treatment in his or her language. However, the court found that the Belgian authorities had failed to provide adequate psychiatric treatment. Moreover, the fact that an illness seems incurable is not an excuse for the state to not provide effective treatment. Therefore, the court found a violation of Article 5 of the Convention because of the lack of correlation between the DoL and the lack of competent mental health treatment required by the applicant.

[48] From August 2017 until the date of the judgment, there had been no violation of Article 5 of the Convention. Considering the margin of appreciation, the court noted that the Belgian authorities had adopted a multi-disciplinary and coherent approach to provide for therapeutic care for the applicant and, therefore, maintained a link between the purpose of the DoL and the conditions of the detention.

[49] The Grand Chamber at paras [205]-[211], sought to clarify and refine the principles in its case law regarding the meaning of the obligation on state authorities to provide treatment for the mental health of persons in compulsory confinement. At para [210], the Grand Chamber stated as follows:

> "…the deprivation of liberty contemplated by Article 5(1)(e) has a dual function: on the one hand, the social function of protection, and on the other a therapeutic function that is related to the individual interest of the person of unsound mind in receiving an appropriate and individualised form of therapy or course of treatment."

[50] It is clear from the judgment that the ECtHR has gradually, through its case law, expanded the scope of Article 5(1)(e), to include a wider interpretation of the meaning to be given to the applications contained in this article.

[51] As stated by the Grand Chamber in paras [208] and [209]:

> "208. Analysis of the Court's case-law, particularly as developed over the past fifteen years, *shows clearly that it should now be considered that there exists a close link between the "lawfulness" of the detention of persons suffering from*

> *mental disorders and the appropriateness of the treatment provided for their mental condition.* While this requirement was not yet set out in the first judgments delivered in this area (see *Winterwerp*, § 51, and *Ashingdane*, §§ 47 and 48, cited above), from which it appeared that the therapeutic function of compulsory confinement was not as such guaranteed under Article 5, *the current case-law clearly indicates that the administration of suitable therapy has become a requirement in the context of the wider concept of the "lawfulness" of the deprivation of liberty. Any detention of mentally ill persons must have a therapeutic purpose, aimed specifically, and in so far as possible, at curing or alleviating their mental-health condition,* including, where appropriate, bringing about a reduction in or control over their dangerousness. The Court has stressed that, irrespective of the facility in which those persons are placed, they are entitled to be provided with a suitable medical environment accompanied by real therapeutic measures, with a view to preparing them for their eventual release (see paragraphs 199 and 201 above)."

[52] In respect of the nature and scope of treatment provided, the Grand Chambers stated at para [209]:

> "209. As to the scope of the treatment provided, the Court considers that the level of care required for this category of detainees must go beyond basic care. *Mere access to health professionals, consultations and the provision of medication cannot suffice for a treatment to be considered appropriate and thus satisfactory under Article 5. However, the Court's role is not to analyse the content of the treatment that is offered and administered.* What is important is that the Court is able to verify whether an individualised programme has been put in place, taking account of the specific details of the detainee's mental health with a view to preparing him or her for possible future reintegration into society (see paragraph 203 above). In this area, the Court affords the authorities a certain latitude with regard both to the form and the content of the therapeutic care or of the medical programme in question." (emphasis added)

[53] No submission has been advanced by the parties in these proceedings that the provisions within the MCA 2016 in relation to the criteria for detention amounting to DoL are non-compliant with Article 5 ECHR. Rather, it is submitted that the decision in *Rooman* can assist in the interpretation of Schedule 1 paragraph 10 and, in

particular, the meaning of the appropriate care or treatment of the person detained. As stated in para [209], the Grand Chamber considered that the level of care must go beyond basic care. Access to health professionals is not enough. The provision of medication cannot suffice for a treatment to be considered appropriate, rather, as stated by the Grand Chamber, what is important is that the court is able to verify whether an individualised programme has been put in place, taking account of the specific details of the detainee's mental health. In this regard, the state authorities have a degree of latitude regarding the form and content of the therapeutic care or course of treatment.

[54] It is my view that the provisions contained within Schedule 1 of the MCA 2016 satisfy the DoL provisions as contemplated by Article 5(1)(e) ECHR. The dual functions are evident, namely the social function of protection and also the therapeutic function that is related to the individual interest of the person of unsound mind in receiving that appropriate and individualised form of therapy or course of treatment.

[55] Turning to the facts of this case, the Tribunal did not analyse the specific content and nature of the treatment and medication that was offered and administered to P. Rather, correctly in my view, the Tribunal, in the context of the scope of the care and treatment provided, which included the provision of medication, was critical of the fact that there had been medication errors which had continued. The respondent acknowledged that the medication errors had occurred. However, despite this acknowledgment and further direction from the Tribunal to implement a plan to cure the defect, the medication errors prevailed.

[56] As stated by the Tribunal at para [25], "the administration of medication as prescribed, ensuring compliance with the medication regime and avoiding administering incorrect medication to a person are fundamental to the provision of appropriate care or treatment." The Trust's medical officer specifically stated in Form 14 that P is likely to suffer serious harm to his mental health from various factors including not getting his prescribed medication. As stated in *Rooman*, Article 5(1)(e) ECHR requires a consideration of the appropriate and individualised form of therapy or course of treatment to the person of unsound mind. In reaching its conclusions, it is my decision that the Tribunal were correct to form the view that the administration of an appropriate medication system and ensuring compliance with prescribed medication was part and parcel of a proper assessment as to whether appropriate care or treatment was available for P and essential for P's safety and well-being in the management of P's physical and mental health.

[57] The Trust and the Department of Health has referred this court to the Code of Practice published in November 2019 pursuant to section 288 of the MCA 2016. Section 289 of the MCA 2016 provides that a person acting in any of the ways specified in subsection (2) must have regard to any relevant Code of Practice.

[58] The Code at 15.2 et seq under the heading of "What can the Tribunal consider?", states as follows:

> "15.2. The Review Tribunal can only consider the care arrangements amounting to a deprivation of liberty. A decision to authorise a deprivation of liberty relates only to the care arrangements in the place where the person who lacks capacity is. It does not include where the person should live, the treatment the person should receive or any other aspects of the care or treatment that is not directly relating to a deprivation of liberty. An application, or referral, to the Tribunal can therefore not relate to those aspects of the person's care and treatment.
>
> 15.3 Other aspects of the care and treatment may be of great importance to the person, or to the nominated person. However, during the first phase of commencement of the Mental Capacity Act only aspects relating to deprivation of liberty are included. These other aspects of the care and treatment are not within the remit of the Mental Capacity Act and therefore not within the jurisdiction of the Tribunal. There are, of course, other methods for the person, and others, to challenge decisions, including seeking declaratory orders from the High Court."

[59] This court has not been asked to decide whether the stated provisions of the Code and its interpretation of Schedule 1 paragraph 10 of the MCA 2016 complies with Article 5 of the ECHR and the ECtHR's interpretation of Article 5(1)(e) in *Rooman*. In any event, on the factual circumstances as presented to the Tribunal, it is clear that in its decision to revoke the DoL authorisation, the Tribunal did not refer to the specifics of the care and treatment that P was receiving but, rather, focused on the administration of P's medication as prescribed by the Trust. The fact that incorrect medication was administered to P and that medication errors continued, was directly connected to the DoL criterion, namely the provision of appropriate care or treatment.

[60] In *Rooman*, treatment appropriate to the applicant's state of health and the absence of any effective action by the state authorities to guarantee such treatment meant that the applicant's DoL from 2004 to 2017 was not in an institution that was capable of providing him with treatment appropriate for his health condition. The court emphasised that state authorities must ensure, having regard to the applicant's vulnerability and his diminished ability to take decisions, that all necessary initiatives are taken to secure effective care, including psychiatric and psychological treatment and welfare assistance in accordance with the requirements of Article 5(1)(e) of the Convention. Plainly, on the facts, the link between the purpose of the

applicant's detention and the availability of effective care and treatment had been severed.

[61] The Department of Health, as supported by the Trust, submit that the factual circumstances in *Rooman* indicate that a high threshold must be reached before there will be a violation of Article 5. Accordingly, it follows that not every failure in care or treatment will be sufficient to sever the link between the purpose of the detention and the conditions contained within the institution designed to provide suitable care and treatment.

[62] Turning to the facts of this case, the Department of Health and Trust argue that the stated failures and mistakes in respect of the care or treatment provided to the applicant were not sufficient to sever the link between the purpose of the detention and the appropriateness of the care or treatment, particularly since it was clear that the Trust had put in place an individualised programme of care and treatment.

[63] Section 306 of the MCA 2016 defines "deprivation of liberty" as having the same meaning as in Article 5(1) ECHR. Section 24-27 of the MCA 2016 considers the effect of an act or acts, which taken together, amount to a DoL. In the Explanatory Notes to the MCA 2016, the following is stated in respect of sections 24-27:

> "The Act aims to address the legislative gap in Northern Ireland for such deprivations of liberty of persons who lack capacity in relation to them, in a way that avoids many of the difficulties encountered in other jurisdictions and takes account of developments in ECHR and domestic case law. Section 24 provides that only certain kinds of deprivation of liberty can have the protection from liability afforded by section 9 and, even then, they must be authorised by either a HSC trust panel under Schedule 1 or by the making of a report under Schedule 2 (relating to a short term detention for examination) unless the situation is an emergency. The criteria for detention are set out in paragraph 10 to Schedule 1 and paragraph 2(3) to Schedule 2. The prevention of serious harm condition set out in section 25 – a further safeguard - must also be met. This applies even if the situation is an emergency."

[64] It is clear from the above that the implementation of the MCA 2016 with regard to DoL was specifically designed to be compatible with Article 5 of the ECHR and the evolving relevant case law. Therefore, the decision of the Grand Chamber in *Rooman* and its interpretation of Article 5(1)(e) remains pertinent, not only in relation to the HSC Trust panel who authorises a DoL but also the Tribunal who reviews the DoL authorisation.

[65] Having carefully considered the Tribunal's decision in this case in the context of the judgment of the Grand Chamber in *Rooman*, it is my view that the Tribunal's decision was correct in principle and on the facts. An individualised programme had been put in place for P, which included the provision of medication. The Tribunal correctly did not engage in an assessment as to the appropriateness of the medication. The Tribunal were correct to form the view that administration of the proper medication regime and a system to ensure compliance with medication were essential for P's well-being and safety, and fundamental to the provision of appropriate care or treatment. The Tribunal were correct to conclude on the basis of the written and oral evidence that the Trust had demonstrated a lack of urgency in effectively addressing the shortcomings in P's care and treatment, particularly with regard to the administration of incorrect medication and also the failure to impose measures capable of preventing medication errors. The multiplicity of medication errors from November 2021 to February 2023, the fact that medication errors continued in the context of the position of preventative measures supported the Tribunal's finding that the problems with medication mismanagement had not been properly addressed or effectively remedied. Accordingly, on the facts, the Tribunal was justified in reaching a conclusion that appropriate care or treatment was not available for P in the place in question and, furthermore, that the DoL authorisation should be revoked. Applying the test in *Rooman,* the stated failures and mistakes in respect of the failure to comply with the medication regime were, on the facts of this case, sufficient to sever the link between the purpose of P's detention and the appropriateness of his care or treatment.

[66] The Tribunal's evaluative judgement of the factual circumstances is consistent with the Grand Chamber's interpretation of Article 5(1)(e) ECHR in *Rooman*. Plainly, each case will depend on the specific factual circumstances which will include, in cases involving medication errors, the nature of the said errors, their frequency, the gravity of the errors and their consequences for the detained person and, of course, any remedial measures taken to prevent or mitigate against future errors.

SF v Avon and Wiltshire Mental Health Partnership NHS Trust [2024] 1 WLR 1540

[67] After the conclusion of these proceedings and oral submissions, the Trust made an application for leave of the court to introduce a further legal authority, namely the decision of the Upper Tribunal in England & Wales in *SF v Avon and Wiltshire Mental Health Partnership NHS Trust* [2024] 1 WLR 1540, on the basis that it was potentially relevant to the issues in these proceedings, particularly in relation to the definition of "appropriate care or treatment" in paragraph 10 of Schedule 1 of the MCA 2016. The respondent did not object to the court considering this authority. Accordingly, leave was granted.

[68] In *SF*, the patient who suffered from a mental disorder was detained for treatment under section 3 of the Mental Health Act 1983 in a hospital operated by the NHS Trust. The patient's mother sought to discharge the patient under section 23 of the 1983 Act, but the patient's discharge was barred by a report from the

responsible clinician pursuant to section 25 of the 1983 Act. The patient's mother then applied to the First-tier Tribunal for the patient's discharge on the basis that for the purposes of section 72(1)(b)(iia) "appropriate medical treatment" was not available for the patient. Despite finding that the treatment provided to the patient was not tailored to her diagnosis and that essential psychosocial work was not available to her, the tribunal nevertheless refused the application on the grounds that interventions which had the purpose of containing the risk of physical harm to the patient and those who cared for her, amounted to "appropriate medical treatment."

[69] The patient's mother's appeal to the Upper Tribunal was successful. The court stated that, when deciding whether "appropriate medical treatment" was available for a patient under section 72(1)(b)(iia) of the Mental Health Act 1983, the tribunal had to take into consideration what it knew about the patient's mental disorder and their symptoms and manifestations, since what amounted to "appropriate medical treatment" differed from patient to patient, according to their individual circumstances and needs. Therefore, generic medical treatment that was not tailored to the particular patient or was not appropriate to that patient's particular needs could not amount to "appropriate medical treatment" under section 72(1)(b)(iia). Furthermore, having regard to the definition of "medical treatment" in section 145(4) of the 1983 Act, the tribunal would have to be satisfied, in order to find that appropriate medical treatment was available for a patient, that the available treatment at least had the purpose of alleviating, or preventing a worsening of, the patient's mental disorder, or one or more of its symptoms or manifestations. Thus, treatment that was provided for the purpose of maintaining physical safety, without treating the patient's mental disorder itself, could not amount to "appropriate medical treatment" within section 72(1)(b)(iia).

[70] The decision in *SF* relates to compulsory detention for treatment under section 3 of the Mental Health Act 1983 which is broadly analogous to detention for treatment under Article 12 of the Mental Health (Northern Ireland) Order 1986. *SF* considered the compulsory detention of a patient due to mental illness in which the consideration is whether the patient was at risk of harm to himself, or others and medical treatment is warranted. As observed by the respondent, the MCA 2016 refers to "appropriate care *or* treatment" whilst the Mental Health Act 1983 in England & Wales refers to "appropriate treatment." DoL authorisations under the MCA 2016 will not always be for the purpose of treatment (eg elderly people in nursing homes). Detention under the Mental Health Act has a medical treatment element. Clearly, there are significant differences between the two pieces of legislation. For this reason, the respondent submits that the definition of "appropriate treatment" under the Mental Health Act 1983 is of limited assistance.

[71] The Trust argues that consideration of the phrase "appropriate medical treatment", albeit in the context of the Mental Health Act 1983 in England & Wales, is capable of providing assistance to this court in its interpretation of the phrase

"appropriate care and treatment" as contained in Schedule 1 MCA 2016. In *SF* at para [50], Judge Church stated:

> "50. 'Appropriate medical treatment' can only mean treatment that is appropriate to the relevant patient's particular needs. While it is accepted that to satisfy the requirement in section 72(1)(b)(iia) the treatment available need not be the best or the most comprehensive treatment that could be provided, but it cannot be the case that treatment that is wholly inadequate for a patient's needs can satisfy that test."

[72] Furthermore, at para [52], Judge Church stated as follows:

> "52. My interpretation of the proper meaning of 'appropriate medical treatment' in MHA is consistent with the approach that the Grand Chamber of the European Court of Human Rights took in *Rooman v Belgium* [2019] ECHR 105 ("*Rooman*") when it considered the requirements of Article 5(1)(e) of the European Convention on Human Rights in the context of the detention of mental health patients. The court emphasised that the deprivation of liberty contemplated by Article 5(1)(e) has a "dual function":
>
> > 'on the one hand, the social function of protection, and on the other a therapeutic function that is related to the individual interest of the person of unsound mind in receiving an appropriate and individualised form or therapy or course of treatment.' (see paragraph [210] of *Rooman*)
>
> 53. The court said that "real therapeutic measures" were required:
>
> > 'Mere access to health professionals, consultations and the provision of medication cannot suffice for a treatment to be considered appropriate and thus satisfactory under Article 5 …'
>
> Rather, what was required was:
>
> > '… an individualised programme … taking into account the specific details of the

> detainee's mental health with a view to preparing him or her for possible future reintegration into society.'" (see paragraph [209] of *Rooman*).

[73] In my judgement, Judge Church is correct in his interpretation of "appropriate medical treatment" as treatment that is appropriate to the relevant patient's particular needs. 'Appropriate' should be given its ordinary and natural meaning in the context of the factual circumstances. I also agree that Judge Church's interpretation of the proper meaning of "appropriate medical treatment" is consistent with the Grand Chamber's interpretation of the requirements of Article 5(1)(e) of the Convention.

[74] In many respects, the decision in *SF* and the interpretation of "appropriate medical treatment" in the context of *Rooman* adds further support, in my judgement, to the Tribunal's decision in this case as discussed above. The care and treatment available to P, taking into consideration the administration of the medication regime, was plainly not appropriate in light of the failure to comply with the provision of medication and P's individualised programme designed by the Trust. For the reasons given above, the Tribunal has carefully considered and analysed the relevant evidence and correctly applied the statutory criteria to the established facts and evidence. The decision to revoke P's DoL authorisation was made in the lawful exercise of the Tribunal's powers under the MCA 2016. The Tribunal, before reaching its decision, was not referred to the judgments in *Rooman v Belgium* [2019] ECHR 105 and *SF v Avon and Wiltshire Mental Health Partnership NHS Trust* [2024] 1 WLR 1540. This omission is not a criticism of the legal representatives who appeared before the Tribunal, since ultimately the hearing was designed to deal with factual matters in the context of domestic legislation, namely the MCA 2016. As stated above in paras [23] to [38], the Tribunal's evaluative judgement of the factual circumstances is consistent with the Grand Chamber's interpretation of Article 5(1)(e) ECHR in *Rooman*.

[75] In conclusion, on the basis of the analysis above and for the reasons given, I dismiss the applicant's challenge to the decision of the Review Tribunal to revoke the DoL authorisation. The Review Tribunal, in reaching its decision, did not err in law in its interpretation of Schedule 1 paragraph 10(a) of the MCA 2016.

The inherent jurisdiction of the High Court to make a Declaratory Order

[76] In *Belfast Health & Social Care Trust v PT and Anor* [2017] NIFam 1, McBride J considered the history and ambit of the inherent jurisdiction of the High Court to make declaratory orders, particularly in relation to matters involving mental health, welfare and social care issues. At paras [20]-[21], McBride J stated as follows:

> "[20] The doctrine of *parens patriae* provides the legal basis for surrogate decision-making on behalf of

incapacitated adults. This jurisdiction was first exercised by the Crown and was later transferred to the Chancery Courts. This jurisdiction was believed to have been rendered obsolete with the coming into force of Mental Health legislation. It soon became clear however that there were gaps in the legislation in relation to many welfare decisions. In *Re F (A Mental Patient: Sterilisation)* [1990] 2 AC 1 the House of Lords invoked the inherent declaratory jurisdiction of the High Court to make a declaration with regard to the sterilisation of a mentally handicapped woman. Since that time, the inherent jurisdiction of the court has been invoked to meet an increasing number of cases involving non-medical issues. As Dame Elizabeth Butler-Sloss P noted in *Re A (Local Authority)* [2004] 1 FLR 541 paragraph 96:

> 'Until there is legislation passed which will protect and oversee the welfare of those under a permanent disability the courts have a duty to continue, as Lord Donaldson of Lymington MR said in *Re F (Medication: Sterilisation)*:
>
> > 'To use the common law as the great safety net to fill gaps where it is clearly necessary to do so.'

Thus, the inherent jurisdiction of the High Court exists where there are gaps in the legislation.

[21] The inherent jurisdiction of the court has, as appears from *Re SA (Vulnerable Adult with Capacity: Marriage)* [2005] EWHC 2942 and *Local Authority X v MM* [2007] EWHC 2003 and *Re PS (An Adult)* [2007] EWHC 623, been invoked in relation to a wide range of welfare issues. In *Re SA,* Munby J observed at paragraph 45:

> 'The court can regulate everything that conduces to the incompetent adult's welfare and happiness.'

Specifically, in *Re PS (An Adult)* Munby J at paragraph 16 held that a Judge exercising the inherent jurisdiction of the Court, had power to detain. He said:

> 'A judge exercising the inherent jurisdiction of the court has power to direct that the child or

> adult in question should be placed at and remain in a specified institution such as, for example, hospital, residential unit, care home or secure unit. It is equally clear that the court's power extends to authorising the person's detention in such a place and the use of reasonable force (if necessary) to detain him and ensure he remains there.'"

[77] Further, at para [25], McBride J summarised the relevant legal principles in respect of the use of inherent jurisdiction for vulnerable adults:

> "[25] The following principles can therefore be distilled from the existing jurisprudence relating to the High Court's inherent jurisdiction:
>
> (a) The inherent jurisdiction can be invoked in respect of adults who lack capacity. As noted in *Re SA* [2005] EWHC 2902 it can also be invoked in respect of vulnerable adults who do not lack capacity.
>
> (b) The jurisdiction can only be exercised where 'gaps' exist in the legislation. If the matter is covered by legislation then the inherent jurisdiction cannot be invoked. In England and Wales the Mental Capacity Act 2005 now regulates the jurisdiction over persons who lack mental capacity. Similar legislation has not yet been implemented in Northern Ireland. Therefore, the inherent jurisdiction of the court continues to be exercised in relation to welfare decisions, in respect of incapacitated adults.
>
> (c) The test governing the operation of the inherent jurisdiction is "best interests."
>
> (d) The inherent jurisdiction must be exercised in accordance with law and in particular must be compatible with the Human Rights Act and the European Convention on Human Rights ("ECHR")."

[78] The background circumstances in *BHSCT v PT* concerned an application by the Trust for declaratory orders (a) that PT lacked capacity to consent to care, treatment and ancillary arrangements as set out in a care plan; (b) that the care plan could be lawfully carried out in respect of PT's best interests and (c) that, insofar as

the care plan deprived PT of his liberty, such provision was lawful in the circumstances. Having considered Article 5 ECHR, the court granted the said declaratory orders, stating at para [49]:

> "[49] The court can authorise a deprivation of liberty under its inherent jurisdiction if it is in PT's best interests. Therefore, if the Trust obtains a court order depriving PT of his liberty, this would be in accordance with a procedure prescribed by law. When such an order is sought the incapacitated individual should be afforded legal representation and, in this case, the Official Solicitor was appointed to act to represent his interests. I further find that the deprivation in this case is not arbitrary. The Convention allows certain individuals to be deprived of their liberty on the basis that "their own interests may necessitate their detention" - ECHR guide on Article 5, paragraph 85 and *Guzzardi v Italy*."

[79] It is observed that McBride J's detailed analysis of the relevant principles relating to the High Court's inherent declaratory jurisdiction was applied in circumstances when the DoL provisions in the MCA 2016 were not in force.

[80] The MCA 2016 was partially implemented in December 2019. Pursuant to section 9, sections 24-27 and Schedule 1 MCA 2016, a statutory framework has now been established which permits a relevant authority to obtain a DoL authorisation in respect of an incapacious individual. It is clear that these provisions were enacted for the purpose of promoting compliance with Article 5 ECHR in respect of DoL (see also The Mental Capacity (2016 Act) (Commencement No.1) (Amendment) Order (NI) 2019 and The Mental Capacity (Deprivation of Liberty) (No.2) Regulations (NI) 2019.

[81] Mr Potter, in a recent article dealing with an overview of the declaratory jurisdiction of the High Court in Northern Ireland[1], states that when the MCA 2016 is fully implemented, the legislation will put the declaratory jurisdiction onto a statutory footing for persons who fall within the definition of incapacity under the MCA 2016. It is claimed that this will considerably reduce the need for the court to exercise its inherent jurisdiction in the field of health and social care, and that the court's intervention will be confined to cases where neither mental health nor mental capacity legislation is applicable. Such examples would include vulnerable persons who require protection but who do not fall within the statutory definition of incapacity. In his article, Mr Potter states that the partial implementation of the MCA has created a somewhat anomalous legal position in respect of people whose care plan involves the DoL, as well as other significant interferences with the autonomy

[1] 'The use of declaratory jurisdiction of the High Court in the field of health and social care in Northern Ireland', Journal of Elder Law Incapacity 2024, 35-66

(eg invasive medical treatment). Accordingly, the inherent jurisdiction continues to be used as a flexible instrument to provide adequate safeguards and to ensure the lawfulness of various forms of health and social care intervention, with the common law principle of necessity premising such other interventions.

[82] In this context, it seems to me that if, in the exercise of its declaratory jurisdiction, the court is empowered to consider an application for DoL authorisation under the MCA 2016, it should do so.

The interim declaratory order of the court

[83] The decision of the Review Tribunal to revoke the DoL authorisation pursuant to section 51 of the MCA 2016 was given on 5 April 2023.

[84] On 7 April 2023, the applicant Trust lodged an emergency application to the Family Division Office of Care and Protection to obtain a Declaratory Order to authorise the patient's DoL and to continue with his care and treatment, pending consideration of the Review Tribunal's decision for revoking P's DoL authorisation.

[85] On 14 April 2023, following the hearing of the said application, Huddelston J granted an interim declaratory order in the following terms:

> "The plaintiff Trust has the permission of the court to deprive the said P (the patient) of his liberty at [a named residential care facility] notwithstanding the decision of the Review Tribunal dated 5 April in proceedings under Chapter 7 of the Mental Capacity Act (NI) 2016, but at all times in accordance with the Mental Capacity Act (NI) 2016, and pending further Order of this court, a full application by the Trust under the Act."

[86] For the reasons considered above, the applicant Trust were correct to take immediate steps to obtain a declaratory order. Furthermore, Huddleston J was correct to refuse any application by the Trust Panel for a fresh DoL authorisation under the MCA 2016, pending a judicial review of the Review Tribunal's decision.

[87] The leading authority in support of this finding is *R(On the application of Majera (formerly SM (Rowanda)) v Secretary of State for the Home Department* [2021] UKSC 46 in which Lord Reed said at para [44]:

> "44. It is a well-established principle of our constitutional law that a court order must be obeyed unless and until it has been set aside or varied by the court (or, conceivably, overruled by legislation). The principle was authoritatively stated in *Chuck v Cremer*

> (1846) 1 Coop temp Cott 338; 47 ER 884, in terms which have been repeated time and again in later authorities...
> 45. Three important points can be taken from this passage. First, there is a legal duty to obey a court order which has not been set aside: "it must not be disobeyed." As the mandatory language makes clear, this is a rule of law, not merely a matter of good practice. Secondly, the rationale of according such authority to court orders, as explained in the second and third sentences, is what would now be described as the rule of law. As was said in *R (Evans) v Attorney General (Campaign for Freedom of Information intervening)* [2015] UKSC 21; [2015] AC 1787, para 52, "subject to being overruled by a higher court or (given Parliamentary supremacy) a statute, it is a basic principle that a decision of a court is binding as between the parties, and cannot be ignored or set aside by anyone, including (indeed it may fairly be said, least of all) the executive." This principle was described (ibid) as "fundamental to the rule of law." Thirdly, as the Lord Chancellor made clear in *Chuck v Cremer*, the rule applies to orders which are "null", as well as to orders which are merely irregular. Notwithstanding the paradox involved in this use of language, a court order which is "null" must be obeyed unless and until it is set aside."

[88] The said principle was applied by the Court of Appeal in *Re Brian McGee for Judicial Review* [2007] NICA 38, albeit in the context of a health professional's failure to abide by the decision of a Mental Health Tribunal, in which Girvan LJ stated as follows at para [9]:

> "[9] In *R (Von Brandenburg) v East London and City Mental Health NHS Trust* (2004) 2 AC 280 the House of Lords gave guidance as to how a relevant mental health authority should deal with the consequences of a Mental Health Tribunal's decision that a patient is no longer liable to be detained where there is a change in the condition of the patient following the Tribunal's decision. Lord Bingham stressed that proper effect must be given to a Tribunal decision and it is not open to the nearest relative of a patient or an approved social worker to apply for admission of the patient simply because they disagree with the Tribunal's decision to discharge. This is, however, subject to the proviso that if the approved social worker has formed the reasonable and bona fide opinion that he has information not known to the Tribunal which puts a significantly different complexion on the case as

> compared with that which was before the Tribunal it may be permissible to detain the patient. Lord Bingham pointed out that it is an approved social worker who makes the application not the doctors. A recommending doctor is not required to do more than express his or her best professional opinion."

[89] Another example of the principle, which is relevant to the facts of this case, is as stated by Lord Reed in *Majera* at para [51]:

> "[51] Another recent example, which also illustrates the point that the rule set out in *Chuck v Cremer* is not confined to orders made by courts possessing unlimited jurisdiction, is the decision of the Court of Appeal (Simon Brown, Mummery and Dyson LJJ) in *R (H) v Ashworth Special Hospital Authority* [2002] EWCA Civ 923; [2003] 1 WLR 127. The case arose out of the decision of a hospital authority to re-detain a patient after a mental health tribunal had ordered his discharge from detention. The hospital authority then applied for judicial review of the tribunal's order, on the ground that it was unreasonable and unsupported by adequate reasons, and the patient applied for judicial review of the authority's decision, on the basis that it was incompatible with the tribunal's order. Both applications succeeded: the tribunal's order was held to be unlawful and was quashed, but the authority was also held to have acted unlawfully in making a decision which was inconsistent with the tribunal's order at a time when that order had not been set aside. The mental health tribunal was, of course, a body exercising a limited jurisdiction.
>
> [52] Dyson LJ based his reasoning upon article 5(4) of the European Convention on Human Rights, but it was entirely consistent with the common law. He stated at para 56:
>
> > 'In the absence of material circumstances of which the tribunal is not aware when it orders discharge, in my judgment it is not open to the professionals, at any rate until and unless the tribunal's decision has been quashed by a court, to resection a patient…To countenance such a course as lawful would be to permit the professionals and their legal advisers to determine whether a decision by a court to

> discharge a detained person should have effect.'
>
> Simon Brown LJ based his reasoning on the rule of law, stating at para 102:
>
> > '…the tribunal's view must prevail; the authority cannot simply overrule the discharge order. Court orders must be respected - the rule of law is the imperative here.'
>
> The authority's decision was therefore unlawful, notwithstanding the Court of Appeal's conclusion that the tribunal's order was also unlawful and had rightly been quashed by the court below."

[90] For the reasons given above, it is my decision that the Review Tribunal lawfully revoked the DoL authorisation. After such revocation, there is no provision within the MCA 2016 which permits the Trust to make a fresh application for a DoL authorisation in respect of P. Moreover, a court order must be obeyed unless and until it has been set aside or varied on appeal or pursuant to judicial review proceedings. Therefore, the focus on whether the patient's DoL is lawful, to include whether the care and treatment in the best interests of the patient, inevitably falls on the court's powers to grant declaratory relief.

The way forward

[91] The background circumstances of this case demonstrate the importance of the court's inherent jurisdiction to provide protection for persons who lack capacity, particularly when Article 5 ECHR is engaged. In *MS (Inherent Jurisdiction: Patient: Liberty: Medical Treatment)* [2016] NIFam 9, Keegan J, having considered the relevant authorities, articulated a two-fold test was applicable in declaratory cases, namely:

(a) Whether the patient has the capacity to provide a legally valid consent to the proposed care and treatment; and

(b) Whether the proposed care and treatment is necessary in the patient's best interests.

[92] In this case, there is no dispute between the parties that P lacks the mental capacity to provide a legally valid consent to his care and treatment. He has life-long profound intellectual disability and has no formal speech. He has a comorbid diagnosis of Autism Spectrum Disorder, Bipolar Affective Disorder and a diagnosis of epilepsy and hypothyroidism. The critical question for this court is whether, in light of the decision of the Review Tribunal to revoke the DoL authorisation due to the Trust's mismanagement of medication, the continued care

and treatment provided to P by the Trust in the said placement is both necessary and in P's best interests.

[93] The declaratory order of the High Court dated 7 April 2023 must be reviewed at a hearing to be arranged as soon as possible. In advance of this hearing, the Trust must submit a report which addresses the issues and concerns raised by the Review Tribunal in its decision. The Tribunal found that the evidence provided by the Trust, comprising the SEA, SAI, adult safeguarding and reporting to RQIA lacked clarity and did not offer sufficient evidential support to the contention that the medication errors had been adequately managed. In light of the deficiencies articulated by the Tribunal and highlighted in this judgment, it is imperative that the report indicates the changes that have been put in place to ensure P's appropriate care and treatment from the date of the interim declaratory order to the date of the scheduled hearing. The report must also put forward proposals for the appropriate care and treatment for P in the suggested placement, to include the provision for the safe management of medication.

[94] This hearing will involve consideration of the following issues:

(i) Does P have the capacity to provide a legally valid consent to the proposed care and treatment?

(ii) If so, what precisely is the care and treatment proposed by the Trust in the best interests of the patient?

(iii) Is the proposed care and treatment plan in P's best interests? Does it take into consideration the issues raised by the Review Tribunal and the failings relating to management of medication?

(iv) Since the Trust plan involves a DoL under Article 5 of the ECHR, should a further declaratory be made authorising P's DoL and, if so, under what terms including duration and review?

(v) If the court is satisfied that a further declaratory order should be made, can the court include a term that the Trust is permitted to make a DoL authorisation in respect of P pursuant to the relevant provisions of the MCA 2016, particularly in view of the statutory safeguards in the legislation for P as a vulnerable person?

[95] These proceedings have raised interesting issues. I would like to extend my appreciation to counsel for their thought-provoking and comprehensive written and oral submissions.

[96] I will hear the parties on the matter of costs if not agreed.