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Judgment: approved by the court for handing down (subject to editorial corrections)*	*Delivered:* **07/08/2023**

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

_____

FAMILY DIVISION

OFFICE OF CARE AND PROTECTION

_____

Between:

A HEALTH AND SOCIAL CARE TRUST

Plaintiff

v

JU

Defendant

_____

Mr M Potter (instructed by the Directorate of Legal Services) for the Trust
Ms S Kyle (instructed by Luke Curran solicitors) for the defendant
Ms Anyadike-Danes KC (instructed by the Commissioner for Older People for Northern Ireland) for the Notice Party made a written submission

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McFARLAND J

Introduction

[1] This judgment has been anonymised to protect the identity of an elderly lady. I have used the cipher JU. These are not her initials. Nothing can be published that will identify JU.

[2] The Trust seeks an order under the inherent jurisdiction of the High Court to deprive the defendant of her liberty.

[3] The defendant is a lady in her early seventies and resides under a guardianship order in a private residential nursing home ("the nursing home") in a rural setting. She is married but estranged from her husband. She has two children and would have contact with them on an occasional basis. She has suffered from long-standing mental health problems and has diagnoses of persistent delusional disorder, emotionally unstable personality traits and recurrent depressive disorder.

She contests these diagnoses, but for the purposes of this judgment it is not necessary to make any ruling on this specific issue.

[4] Over the years she has had a number of hospital admissions, the last of which was under the hospital order provisions of the Mental Health (NI) Order 1986 ("the MHO") in October 2019. References in this judgment to 'hospital' orders and 'guardianship' orders refer to Part II MHO orders and not Part III Orders which relate to criminal cases. She remained under the hospital order but was then transferred to the nursing home in July 2021. In March 2022 she became the subject of a guardianship order under the MHO.

[5] The Trust is seeking an order to deprive her of her liberty because it considers that it may require powers to ensure her safe management should her condition deteriorate. The extent of the powers are set out in a draft order placed before the court:

(a) [The Trust] or its servants or agents may take such measures as are deemed proportionate and necessary and in [JU's] best interest that may include:

    (i) Placing her under significant or constant monitoring and supervision as may be appropriate;

    (ii) Preventing her from leaving the place of residence;

    (iii) Returning her to her place of residence;

    (iv) Taking such other measures to restrict her liberty or deprive her of her liberty as may be reasonably necessary and appropriate in the circumstances.

(b) And in exercising these powers the [Trust] shall respect [JU's] human rights and seek to abide by the least restrictive alternative principle.

[6] The order sought by the Trust is under the inherent jurisdiction of the court and would be on an anticipatory and contingent basis. Given the fact that social work and medical employees of the Trust are unlikely to be present on a regular basis at the nursing home, the measures being sought by the Trust are to enable the nursing home staff, acting as the Trust's agents, to exercise these powers. I will abbreviate deprivation of liberty by using the acronym "DOL."

[7] JU opposes the Trust's application.

Does JU lack capacity?

[8] It is agreed evidence that the Trust cannot show that JU lacks capacity. At its height the evidence is that she has borderline capacity, but with a presumption of

capacity the court will proceed on the basis that she has capacity. The DOL provisions of the Mental Capacity Act (NI) 2016 ("MCA") (the only provisions of the MCA that have been commenced and are operational), cannot apply because of her current capacitous state of mind.

Medical issues and relevant history

[9] JU's mental health began to deteriorate in the mid-1990s. She was diagnosed with a depressive reaction with anxiety largely relating to where she was living and unhappiness within her marriage. She took over-doses of medication in September and December 2007. After a further over-dose in 2008 she was admitted to hospital and received electroconvulsive therapy treatment. Following another over-dose in 2017 she was admitted to an acute mental health inpatient care facility at a local hospital. She had a period of leave from the hospital and was travelling with her husband. At a motorway service station she said she was going to the lavatory but proceeded to a bridge and sustained serious injuries when she attempted to commit suicide by jumping onto the carriageway below. After three months recovering from her physical injuries, she was discharged home in March 2018.

[10] She was re-admitted to the facility in November 2018 due to low mood and later discharged home after six weeks. In 2019 she and her husband separated when he left the family home and following a further deterioration in her mental health, on 22 September 2019 evidence emerged that JU had set fire to the family home using multiple fire sites with accelerant. A helicopter search followed, and she was later found unconscious in a nearby field suffering from hypothermia. Following treatment in an intensive care unit, on 2 October 2019 JU was detained under an assessment order under the MHO back to the facility. Her detention then continued under a hospital order for treatment which included further electroconvulsive therapy treatment and use of anti-psychotic medication.

[11] Using leave of absence provisions in the MHO, JU was moved to the nursing home, where she currently resides, on 19 July 2021. This is a private facility. It is not specifically a home for occupants with mental health problems, but its management and staff have an element of training, expertise and experience when dealing with residents with such a condition. She was then discharged from the hospital order and made the subject of a guardianship order under the MHO from March 2022. She remains under the provisions of that order. The order requires JU to reside at the nursing home.

[12] A senior mental health social worker is designated as JU's guardian. She visits her every two to three months and a key worker sees her more regularly. Whilst there is a gated protective area, JU has the code for access and is able to use it. JU leaves the nursing home about four times a week and there is no particular cause for concern when she leaves. Although she has expressed a view that she does not wish to continue living there and wants to return to her home, there has never been an issue about her not returning to the nursing home. These are unaccompanied

visits and include trips to local villages and towns.

[13] On occasions JU may become stressed and the trigger points would appear to be family related, discontent concerning these proceedings and her general concern about her life and wellbeing. A 'traffic light' system has been developed which appears to be working well. This allows staff and JU to identify periods of concerning behaviour which may require intervention, verbal assistance and de-escalation techniques. Three levels of intensity are identified – red, amber and green. JU is aware of these 'traffic lights.' In the 14 months of guardianship there have been two red 'traffic light' events (both in April 2022 when she had just entered guardianship). There have been about four 'high' amber events. The guardian described that dealing with JU was similar to 'walking on eggshells', but that she is currently settled within the nursing home and is well managed by the staff.

[14] The major concern of the Trust is that should there be a deterioration in JU's condition it believes it lacks the powers to deprive her of her liberty and in particular it would be unable to intervene at a suitable level to prevent her causing harm to herself.

[15] Medical evidence has been provided to the court in written form from various medical practitioners and from oral evidence by Dr Southwell, a consultant old age psychiatrist.

[16] The Trust's application was primarily based on the report of Dr O'Muirithe, a locum consultant psychiatrist. It is dated 31 May 2022 and is described by Dr O'Muirithe as a draft report. No explanation was offered concerning why this is being submitted to the court in a draft form or why the Trust has been seeking to deprive JU of her liberty based on a draft report. On this basis the court can only assume that any opinions expressed in the report are provisional and not final. He does states that "[JU]'s capacity fluctuates and that in times of mental distress she has an impaired ability to take in information and weigh it in the balance"

[17] The report referred to an earlier report of Dr Kane, consultant psychiatrist, of 25 August 2020 prepared for a Mental Health Review Tribunal. That report set out the relevant medical history which included the drug over-doses in 2017 and the significant suicide attempt by the jumping off the bridge in November 2017. The diagnosis in 2017 was that she was displaying emotionally unstable personality traits. Dr Kane reports that another psychiatrist Dr Kelly provided a second opinion in October 2018. Dr Kelly felt that given that JU's sister was describing her personality as being reasonably stable with no indication of eating disorders, drug or alcohol mis-use or self-harm until the age of 57, the diagnosis of emotionally unstable personality disorder was a problem. Dr Kelly did not offer an alternative diagnosis. Dr Kane reported that Dr Salisbury, consultant clinical psychologist, reported in December 2018 that there was no evidence of a significant deterioration in cognitive functioning nor any evidence of a progressive neurological condition.

[18] Dr Kane reported that Dr O'Muirithe diagnosed JU in November 2019 as suffering from a persistent delusional disorder, emotionally unstable personality disorder and a recurrent depressive disorder (then in remission).

[19] Dr Kane's conclusion in August 2020 was that JU continued to suffer from a persistent delusional disorder and continued to experience persecutory delusions and lacked insight. In light of the impulsive suicide attempts there remained a substantial risk of self-inflicted serious harm and therefore required ongoing treatment as an in-patient.

[20] Dr O'Muirithe provided a further report on 15 June 2022. Again, this is described as a draft report so any opinion expressed must be considered as provisional. It was based primarily on an interview with JU and concluded that the criteria for the hospital order were no longer met because suitable alternative accommodation in a non-hospital environment was available, and that the lesser restrictions within a guardianship order were appropriate. Her condition was described as being "subject to some fluctuation."

[21] Dr O'Muirithe stated that guardianship within the nursing home provided "just as much protection to [JU] as would admission under the MHO." This was based on his expressed opinion that "the purpose of guardianship under the MHO and the use of additional measures as outlined above would be to protect [JU] from suicidal behaviour." The additional powers referred to by Dr O'Muirithe were monitoring and supervision, refusing permission to leave the home when appropriate, and power to return her home.

[22] A further report was prepared by Dr Megahey on 20 January 2023. She described JU's mental health as being reasonably stable. In relation to additional powers over and above those powers under the guardianship order, Dr Megahey stated that in the event of a deterioration, additional supervision may be appropriate as would return to the nursing home. Further hospital treatment may be required if the condition deteriorated so significantly that the staff at the nursing home could not provide appropriate care.

[23] The final report considered by the court was from Dr Southwell and is dated 11 May 2023. This was supplemented by his oral evidence. His opinion was that JU's condition was chronic in nature, it had varying degrees of intensity, and the likelihood of relapse was high with a resulting deterioration in her mental state and a consequent increase in risk and self-harming behaviour. She did not warrant hospital detention but further powers over and above guardianship powers were required to manage any deterioration. Dr Southwell opined that "further powers to manage deterioration and relapse in [JU's] mental health to maintain her safety over and above that afforded through guardianship are required. These powers would be in conjunction with increased input from the community mental health team or home treatment team as deemed appropriate by her clinical team."

[24] In oral evidence, he stated that JU did satisfy the "failure to detain" second limb of the test for an assessment order and a hospital order, in that there was currently a substantial likelihood of significant physical harm to her, but that the first, or diagnostic, test for either was not satisfied. This opinion was not supported by any other medical opinion, and I assess this evidence below.

[25] Dr Southwell examined JU on 10 May 2023 (the most recent psychiatric assessment) and he agreed that she did not lack capacity.

Existing and potential powers under the MHO and the MCA

[26] The existing statutory framework is comprised in the provisions of the MHO relating to assessment, hospital and guardianship orders and the operational parts of the MCA relating to DOL.

[27] The relevant articles of the MHO are as follows

> "**Article 4.**—(1) A patient may be admitted to a hospital for assessment and there detained … in pursuance of an application for admission for assessment …
>
> (2) An application for assessment may be made in respect of a patient on the grounds that—
>
> (a) he is suffering from mental disorder of a nature or degree which warrants his detention in a hospital for assessment (or for assessment followed by medical treatment); and
>
> (b) failure to so detain him would create a substantial likelihood of serious physical harm to himself or to other persons.
>
> **Article 7A.**—(1) This Article applies to a hospital managed by an HSC trust other than an authorised HSC trust.
>
> (2) If, where a patient is an in-patient in a hospital to which this Article applies, it appears to a medical practitioner on the staff of the hospital that an application for assessment ought to be made in respect of the patient, he may furnish to the HSC trust managing the hospital a report in the prescribed form to that effect; and where he does so, the patient may be detained in the hospital for a period not exceeding 48 hours from the time when the report is so furnished.

(3) A patient who has been detained in a hospital under paragraph (2) shall not be further detained under that paragraph immediately after the expiry of that period of detention.

Article 8.—(1) An application for assessment duly completed in accordance with this Part shall be sufficient authority for—

(a) the applicant or a person authorised by the applicant; or

(b) the responsible authority, if the applicant so requests in a case of difficulty,

to take the patient and convey him to the hospital specified in the application at any time within the period of—

(i) two days beginning with the date on which the medical recommendation was signed; or

(ii) such longer period (not exceeding 14 days) as a medical practitioner appointed for the purposes of this Part by RQIA may certify in the prescribed form to be necessary in exceptional circumstances.

(2) Where a patient is admitted within that period to the hospital specified in any such application …—

(a) the application shall be sufficient authority for the responsible authority to detain the patient in the hospital …

(3) Where a patient who is subject under this Order to the guardianship of a person other than an authorised HSC trust is admitted to hospital for assessment, it shall be the duty of the responsible authority to inform the guardian of the patient to that effect as soon as may be practicable.

Article 12.—(1) Where, during the period for which a patient is detained for assessment … he is examined by a medical practitioner appointed for the purposes of this

Part by RQIA and that medical practitioner furnishes to the responsible authority in the prescribed form a report of the examination stating—

(a) that, in his opinion, the patient is suffering from mental illness or severe mental impairment of a nature or degree which warrants his detention in hospital for medical treatment; and

(b) that, in his opinion, failure to so detain the patient would create a substantial likelihood of serious physical harm to himself or to other persons; …

that report shall be sufficient authority for the responsible authority to detain the patient in the hospital for medical treatment and the patient may, subject to the provisions of this Order, be so detained for a period not exceeding 6 months beginning with the date of admission, but shall not be so detained for any longer period unless the authority for his detention is renewed under Article 13 …

Article 13.—(1) Authority for the detention of a patient for treatment may, unless the patient has previously been discharged, be renewed under this Article …

Article 15.—(1) The responsible medical officer may grant to any patient who is for the time being liable to be detained in a hospital under this Part leave to be absent from the hospital subject to such conditions, if any, as that officer considers necessary in the interests of the patient or for the protection of other persons.

Article 18.—(1) A patient who has attained the age of 16 years may be received into guardianship, for the period allowed by the following provisions of this Part, in pursuance of an application (in this Order referred to as "a guardianship application") made in accordance with this Article.

(2) A guardianship application may be made in respect of a patient on the grounds that—

(a) he is suffering from mental illness or severe mental handicap of a nature or degree which warrants his reception into guardianship under this Article; and

(b) it is necessary in the interests of the welfare of the patient that he should be so received. …

Article 22.—(1) Where a guardianship application … is accepted by that authority, the application shall, subject to regulations, confer on the authorised HSC trust or person named in the application as guardian, to the exclusion of any other person—

(a) the power to require the patient to reside at a place specified by the authorised or person named as guardian;

(b) the power to require the patient to attend at places and times so specified for the purpose of medical treatment, occupation, education or training;

(c) the power to require access to the patient to be given at any place where the patient is residing to any medical practitioner, approved social worker or other person so specified.

Article 29.—(1) Where a patient who is for the time being liable to be detained under this Part in a hospital—

(a) absents himself from the hospital without leave granted under Article 15; or

(b) fails to return to the hospital on any occasion on which, or at the expiration of any period for which, leave of absence was granted to him under that Article, or upon being recalled thereunder; or

(c) absents himself without permission from any place where he is required to reside in accordance with conditions imposed on the grant of leave of absence under that Article;

he may, subject to paragraphs (3) and (4), be taken into custody and returned to the hospital or place by any officer on the staff of the hospital, by any constable or approved social worker or by any person authorised in writing by the responsible authority.

(2) Where a patient who is for the time being subject to guardianship under this Part absents himself without

the leave of his guardian from the place at which he is required by the guardian to reside, he may, subject to paragraph (3), be taken into custody and returned to that place by any constable or approved social worker or by any person authorised in writing by the guardian or by the responsible authority.

…

(5) In this Order "absent without leave" means absent from any hospital or other place and liable to be taken into custody and returned under this Article."

[28] The relevant sections of the MCA are as follows:

"**Section 1**.—…

(2) The person is not to be treated as lacking that capacity unless it is established that the person lacks capacity in relation to the matter within the meaning given by section 3.

Section 3.—(1) For the purposes of this Act, a person who is 16 or over lacks capacity in relation to a matter if, at the material time, the person is unable to make a decision for himself or herself about the matter (within the meaning given by section 4) because of an impairment of, or a disturbance in the functioning of, the mind or brain.

(2) It does not matter—

(a) whether the impairment or disturbance is permanent or temporary;

(b) what the cause of the impairment or disturbance is.

(3) In particular, it does not matter whether the impairment or disturbance is caused by a disorder or disability or otherwise than by a disorder or disability.

Section 4.—(1) For the purposes of this Part a person is "unable to make a decision" for himself or herself about a matter if the person—

(a) is not able to understand the information relevant to the decision;

(b) is not able to retain that information for the time required to make the decision;

(c) is not able to appreciate the relevance of that information and to use and weigh that information as part of the process of making the decision; or

(d) is not able to communicate his or her decision (whether by talking, using sign language or any other means);

and references to enabling or helping a person to make a decision about a matter are to be read accordingly.

(2) In subsection (1) "the information relevant to the decision" includes information about the reasonably foreseeable consequences of—

(a) deciding one way or another; or

(b) failing to make the decision.

Section 24.—(1) This section applies where the act mentioned in section 9(1) amounts to, or is one of a number of acts that together amount to, a deprivation of P's liberty.

(2) Section 9(2) (protection from liability) applies to the act only if—

(a) the deprivation of P's liberty consists of—

(i) the detention of P, in circumstances amounting to a deprivation of liberty, in a place in which care or treatment is available for P; or

(ii) related detention;

(b) the detention in question is authorised; and

(c) the prevention of serious harm condition (as well as the conditions of section 9(1)(c) and (d), and any other conditions that apply under this Part) is met.

(3) Subsection (2)(b) does not apply where the situation is an emergency (see section 65).

Section 65.—(1) This section applies in relation to sections 13, 15, 16, 17, 19, 20, 24, 26, 28 and 35 (provisions which contain additional safeguards, and which require a determination of whether the situation is an "emergency").

(2) For the purposes of any one of those sections, the situation is an "emergency" if at the relevant time—

(a) D knows that the safeguard in that section is not met, but reasonably believes that to delay until that safeguard is met would create an unacceptable risk of harm to P; or

(b) D does not know whether that safeguard is met, but reasonably believes that to delay even until it is established whether it is met would create an unacceptable risk of harm to P.

(3) But the situation is not an "emergency" by virtue of falling within subsection (2) if the fact that the safeguard in question is not met by the relevant time is to any extent due to an unreasonable failure by D to take a step that it would have been practicable to take for the purposes of ensuring that the safeguard is met by the relevant time.

(4) Subsections (2) and (3) are to be read in accordance with section 66.

(5) For the purposes of any section mentioned in subsection (1), the situation is also an "emergency" if, at the time when the act mentioned in that section is done, D—

(a) does not know of the effect of that section;

(b) is not a person with expertise such that he or she could reasonably be expected to know of its effect; and

(c) reasonably believes that it is necessary to do the act without delay to prevent harm to P."

[29] JU's situation, and the legislative framework relating to it, can be summarised as follows. She is subject to a guardianship order because it has been determined that she is suffering from a mental illness or severe mental handicap of a nature and degree which warrants her reception into guardianship. It has also been determined as being necessary in the interests of her welfare (Art. 12(2)).

[30] Under the terms of the guardianship order JU is required to reside at the nursing home. Should she absent herself from the nursing home without the leave of her guardian, a police officer, a social worker or any other person duly authorised by the guardian, or the Trust has the power, without warrant, to detain JU and to return her to the nursing home (Art. 29(2)).

[31] JU does not at present satisfy the detention provisions for either an assessment order or a hospital order (see Art. 4 and Art. 12) which require evidence of a substantial likelihood of serious physical harm either to her or to another person. The diagnostic test for an assessment order is that she is suffering from a mental disorder of a nature or degree which warrants her detention in a hospital for assessment. The diagnostic test for a hospital order is that the patient is suffering from a mental illness or severe mental impairment of a nature or degree which warrants her detention in hospital for medical treatment.

[32] Should JU's condition deteriorate, and it is considered that she does satisfy the conditions for the making of an assessment order, on the making of an application, the Trust has the power to take and convey JU to a hospital (Art. 8(1)) and to detain her in the hospital (Art. 8(2)(a)). If she was already an in-patient at a hospital, any application gives the Trust the power to detain her (Art. 7A).

[33] The DOL provisions in the MCA can not apply to her because she is capacitous, however should JU lose her capacity, power is vested in the Trust to take emergency steps to apply DOL provisions (section 65).

Issues for consideration

[34] The Trust's case is that should JU's condition deteriorate then it is powerless to act to protect the well-being of JU and to fulfil the Trust's operational Article 2 ECHR duty of care that it owes to her. It therefore requires powers to deprive her of her liberty so that it can fulfil its duty.

[35] The key questions before the court are therefore:

(a) Does the Trust owe an operational Article 2 ECHR duty of care to JU?;

(b) If so, is that duty currently engaged?;

(c) If not currently engaged, in the event of deterioration in JU's mental health

and the duty becomes engaged, are the existing statutory powers sufficient for the Trust to take lawful steps to fulfil its duty?;

(d) If the existing statutory powers are insufficient, is the inherent jurisdiction of the court available to permit the deprivation of the liberty of JU?;

(e) If they are available, should the court exercise its discretion and grant the Trust, and others, the powers the Trust seeks, and on what terms?

The operational Article 2 ECHR duty

[36] It should be noted from the outset that consideration of this first question does expose a fundamental, if not fatal, flaw in the Trust's argument. Its case is that the operational Article 2 ECHR duty applies and as it cannot lawfully exercise control over JU, it needs extra-statutory powers from the court. The case-law however suggests that the state's operational Article 2 ECHR duty only arises to citizens over whom the state exercises control.

[37] Article 2 of the ECHR provides:

> "1. Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.
>
> 2. Deprivation of life shall not be regarded as inflicted in contravention of this article when it results from the use of force which is no more than absolutely necessary:
>
> (a) in defence of any person from unlawful violence;
>
> (b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;
>
> (c) in action lawfully taken for the purpose of quelling a riot or insurrection."

[38] The Trust seeks to rely on the decision of *Rabone v Pennine Care* [2012] UKSC 2. Its case is that the Trust has an operational Article 2 ECHR duty towards JU. *Rabone* interpreted this right to include an obligation on the state to take steps to protect people under its control who were in immediate danger from a real and immediate risk of suicide.

[39] The patient in *Rabone* was a 'voluntary' patient who had the freedom to leave the hospital at which she was being treated. The medical opinion was that should she seek to leave the Trust should use its power to detain her for assessment under

the English equivalent of Art 4 MHO. Contrary to that opinion she was allowed to leave the hospital without being detained. She committed suicide a short time later. Lord Dyson at [34] expressed the firmest of opinions that the circumstances of the patient were such that she was a person under the Trust's control:

> "She had been admitted to hospital because she was a real suicide risk. By reason of her mental state, she was extremely vulnerable. The trust assumed responsibility for her. **She was under its control. Although she was not a detained patient, it is clear that, if she had insisted on leaving the hospital, the authorities could and should have exercised their powers under the [Mental Health Act] to prevent her from doing so**. In fact, however, the judge found that, if the trust had refused to allow her to leave, she would not have insisted on leaving. This demonstrates the control that the trust was exercising over [her]. In reality, the difference between her position and that of a hypothetical detained psychiatric patient, who (apart from the fact of being detained) was in circumstances similar to those of [her], would have been one of form, not substance." (my emphasis)

[40] The operational duty therefore flowed from the control exercised over the patient. If there was no control there was no duty, as Lord Dyson had observed in earlier comments at [33]:

> "As I have said, the ECtHR has not considered whether an operational duty exists to protect against the risk of suicide by informal psychiatric patients. **But the Strasbourg jurisprudence shows that there is such a duty to protect persons from a real and immediate risk of suicide at least where they are under the control of the state.** By contrast, the ECtHR has stated that in the generality of cases involving medical negligence, there is no operational duty under article 2." [my emphasis]

[41] The Trust argues it has no control over JU and will continue to have no control in the event of deterioration of her mental state. That is why it seeks these further powers to restrict JU's liberty. For reasons I will deal with below, that is a questionable assertion, but should it be correct, the extension to the argument is that the Trust has no operational Article 2 ECHR duty towards her.

[42] I have also considered two important decisions delivered subsequent to *Rabone*, *Oliveira v Portugal* [2019] 69 EHRR 8 and the very recent case of *Maguire* [2023] UKSC 20. In the latter case, Lord Sales carried out an extensive review of the existing case law relating to the Article 2 ECHR duty. The case itself related to the

conduct of an inquest into the death of a vulnerable adult with Down's Syndrome who had been living in a care home and subject to certain DOL provisions. She became unwell and following a delayed admission into hospital she subsequently died in hospital. The issues involved consideration of the care provided at the care home and the decision making concerning the transfer to hospital, and was therefore more focussed on what could be described as the interface between the operational Article 2 ECHR duty and medical negligence issues.

[43] The ECtHR decision in *Oliveria* is of more relevance to JU's situation. A 35 year old (described in the judgment as 'J.A.') with chronic alcoholism and a significant mental health history had been admitted to a psychiatric hospital following a drug over-dose. He was a voluntary patient but under a restrictive regime being confined to a unit. The day after his admission he left the unit without permission and was returned by a family member. Over the next few weeks the regime was relaxed permitting the patient to leave the unit but not the hospital grounds. He was allowed to spend weekends at home. On the second weekend a family member brought the patient back because he had consumed a large amount of alcohol. He was given emergency medication and appears to have left the hospital sometime in the afternoon and later in the early evening, still dressed in his pyjamas he committed suicide by throwing himself in front of a train.

[44] A civil action based on a failure to monitor J.A. was dismissed by the Portuguese Supreme Court.

[45] Given the relevance of this decision, I propose to quote extensively from the judgment of the Grand Chamber of the court. In summarising the application of the positive duty under Article 2 ECHR, the Grand Chamber stated as follows:

> "110. In a series of cases where the risk derived … from self-harm by a detained person, the Court found that a positive obligation arose where the authorities knew or ought to have known that the person posed a real and immediate risk of suicide.
>
> …
>
> 112. …[T]he Court reiterates that the very essence of the Convention is respect for human dignity and human freedom. In this regard, the authorities must discharge their duties in a manner compatible with the rights and freedoms of the individual concerned and in such a way as to diminish the opportunities for self-harm, without infringing personal autonomy … The Court has acknowledged that excessively restrictive measures may give rise to issues under Articles 3, 5 and 8 of the Convention (see *Hiller* … § 55).

> 113. As regards mentally ill persons, the Court has considered them to be particularly vulnerable … Where the authorities decide to place and keep in detention a person suffering from a mental illness, they should demonstrate special care in guaranteeing such conditions as correspond to the person's special needs resulting from his or her disability. The same applies to persons who are placed involuntarily in psychiatric institutions (see *Hiller* … § 48 …).
>
> 114. … The Court in *Reynolds* [*v UK no 2694/08*] did not explicitly find that the positive obligation to take preventive operational measures extended to voluntary psychiatric inpatients. However, it clearly did not exclude such a finding either. The Court is now called upon to decide that question in the present case.
>
> 115. Concerning suicide risks in particular, the Court has previously had regard to a variety of factors where a person is detained by the authorities (mostly in police custody or detention), in order to establish whether the authorities knew or ought to have known that the life of a particular individual was subject to a real and immediate risk, triggering the duty to take appropriate preventive measures. These factors commonly include:
>
> (i) a history of mental health problems …
>
> (ii) the gravity of the mental condition …
>
> (iii) previous attempts to commit suicide or self-harm …
>
> (iv) suicidal thoughts or threats …
>
> (v) signs of physical or mental distress … "

[46] The Grand Chamber then proceeded to apply these principles to the specific facts in J.A.'s case at [124]–[126]:

> "124. … the Court considers that the authorities do have a general operational duty with respect to a voluntary psychiatric patient to take reasonable measures to protect him or her from a real and immediate risk of suicide. The specific measures required will depend on the particular

> circumstances of the case, and those specific circumstances will often differ depending on whether the patient is voluntarily or involuntarily hospitalised. Therefore, this duty, namely to take reasonable measures to prevent a person from self-harm, exists with respect to both categories of patient. However, the Court considers that in the case of patients who are hospitalised following a judicial order, and therefore involuntarily, the Court, in its own assessment, may apply a stricter standard of scrutiny.
>
> 125. Accordingly, the Court must examine whether the authorities knew or ought to have known that A.J. posed a real and immediate risk of suicide and, if so, whether they did all that could reasonably have been expected of them to prevent that risk by putting into place the restrictive measures available … The Court will bear in mind the operational choices which must be made in terms of priorities and resources in providing public healthcare and certain other public services in the same way as it bears in mind the difficulties involved in policing modern societies ...
>
> 126. … [T]he Court has established a list of relevant criteria concerning the assessment of suicide risks. It will look at these factors in the specific circumstances of the present case in order to establish whether the authorities knew or ought to have known that the life of the applicant's son was subject to both a real and an immediate risk, triggering the duty to take appropriate preventive measures."

[47] The Grand Chamber's reference and approval of the judgment in the earlier case of *Hiller v Austria* (22 February 2017 1967/14) is instructive. The patient in that case was 19 years old and was admitted to hospital suffering from an acute episode of paranoid schizophrenia. The placement was authorised by court order. About a month into his detention he failed to return from an authorised walk in the hospital grounds and died after jumping in front of a train. At para [49] the Grand Chamber set out the limits of the obligations placed on a state in respect of its operational Article 2 ECHR duty:

> "[49] The Court further reiterates that Article 2 may imply in certain well-defined circumstances a positive obligation on the authorities to take preventive operational measures to protect an individual from another individual or, in particular circumstances, from

> himself … However, in the particular circumstances of the danger of self-harm, the Court has held that for a positive obligation to arise, it must be established that the authorities knew or ought to have known at the relevant time that the person concerned was under a real and immediate risk to his life and that they had not taken measures which could reasonably have been expected of them ... Such an obligation must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities."

[48] The final case relating to the Article 2 operational duty I wish to refer to is the judgment of Popplewell LJ in *Morahan* [2021] EWHC 1603. The cousin of the deceased brought a judicial review application concerning the coroner's decision not to conduct an enhanced investigation into the death. The deceased had been detained under section 2 of the Mental Health Act 1983 for assessment, but this was then rescinded, and she remained a voluntary inpatient. She left the unit by agreement and was found several days later dead from a drug overdose. Popplewell LJ carried out an extensive review of the national and Strasbourg jurisprudence and at [67] summarised his conclusion relating to vulnerable people cared for by an institution which exercises some control over them:

> "[T]he question whether an operational duty is owed to protect them from a foreseeable risk of a particular type of harm is informed by whether the nature of the control is linked to the nature of the harm. A prison's control over its inmates gives rise to an obligation to protect its detainees against suicide risks because, as Baroness Hale observed in *Rabone*, the very fact of incarceration increases such a risk. The control is linked to the risk. So too in the case of detained mental patients, where the detention gives rise to the increased risk of suicide whatever the nature of the mental condition being treated. The same is true of voluntary mental patients in relation to the risk of suicide where their residence at the institution is not truly voluntary if and because the mental condition for which they are being treated itself enhances the suicide risk. It does so not only as the potential result of incarceration, if not truly voluntary, but often also because, as was identified in both *Rabone* and *Fernandes de Oliveira*, the mental condition which the institution assumes control for treating impairs the patient's capacity to make a rational decision whether to take their own life. The nature of the control is again linked to the risk of harm. Where, however, there is no link between the control and the type of harm, to impose an operational duty to protect

> against the risk would be to divorce the duty from its underlying justification as one linked to state responsibility. It would also undermine the requirement identified in *Osman* that the positive obligations inherent in article 2 should not be interpreted so as to impose a disproportionate burden on a state's authorities. The control by the state could not justify the imposition of the duty by reference to state responsibility if the risk were of a type of harm which is unconnected to the control which the state has assumed over the individual. A psychiatric hospital owes no duty to protect a patient, whether voluntary or detained, from the risk of accidental death from a road traffic accident whilst on unescorted leave."

[49] The reference in *Oliveria* to a 'stricter standard of scrutiny' at para [124] can also be inferred in the JU's case. Although she is not an inpatient (or even an outpatient) in a hospital, she is the subject of an order made under the MHO, albeit not the severest of the orders that are available. That order does not require hospitalisation, but it does require a degree of supervision as provided by the guardianship order. Her place of residence is dictated to her, and she can be compelled to attend for medical treatment under the provisions of the guardianship order. Therefore, her status has to be considered as being an involuntary one.

[50] *Oliveria* refers to the operational duty placed on the authorities as being determined on the particular circumstances of the case, and in particular they are likely to differ between voluntary and involuntary patients. Although JU could be described as falling into the 'involuntary' category because of the residence requirement, it must be taken into account that she is not receiving any form of hospital treatment, she is complying with her prescribed medication intake, and by virtue of the care being provided to her she is leading a largely normal existence being permitted to come and go from the nursing home without issue. Occasional deterioration in presentation has been noted but they have not been recent and could not be described as being a concern. The main issue relates to her medical history and the suicide attempt (similar in nature to the patients in *Oliveria* and in *Hiller*) in 2017. The fire-setting in 2018 would not fall to be categorised as a self-harming incident but was the result of reckless conduct putting at risk her own life and the life of others. Although significant and relevant these events did occur some time ago now, she has been successfully treated in the aftermath of both incidents, and there is no evidence placed before the court that JU's current state of mind could suggest any repeat of that conduct.

[51] In any event, and for the reasons given, I consider that the Trust, and the guardian under the guardianship order, do exercise control over JU and as such they do owe an operational Article 2 ECHR duty to her. That duty, must however, be seen in light of JU's current presentation and specifically the risk of harm that she is currently presenting to herself and others.

Is the operational Article 2 ECHR duty engaged because of a risk to JU's life?

[52] To determine whether the operational Article 2 ECHR duty is currently engaged, it is necessary to look at a variety of factors set out in *Oliveria* at [115]. There is clearly a history of mental health problems. At times these problems have presented as being grave, but currently they are under control. There have been previous attempts at self-harm including drug over-doses and a significant incident of attempted suicide in 2017. There is no evidence of any current suicidal thoughts or threats. Occasionally JU presents in a heightened state of distress but there is no evidence to suggest that this cannot be managed within the nursing home and by its staff. The only significant factor is the suicide attempt, however because of the vintage of that event, the fact that it has not been repeated, the successful response by JU to medical intervention to date, and her current presentation within the setting of the nursing home where she now resides, the level of the duty has to be regarded as being at a relatively modest level. To use the popular phase, there are no current 'red flags' in this case.

[53] In the circumstances the evidence suggests that the operational Article 2 ECHR duty is not currently engaged.

[54] JU's mood and condition may fluctuate from time to time, as will often be the case with people with mental health problems, but there is nothing to suggest any particular problem at this moment. All the evidence suggests that the staff within the nursing home are well able to identify and cope with any heightened displays of anxiety by JU and, again, there is nothing to suggest that the nursing home staff are not able to cope with any peaks and troughs in JU's presentation based on the history of her period of residence in the nursing home.

[55] There being no evidence to suggest that the operational Article 2 ECHR duty is engaged at present, the only issue is whether it may become engaged in the future with a deterioration in her condition over and above what is being experienced to date.

Are the existing statutory powers available to the Trust and the guardian sufficient for the Trust to fulfil its operational Article 2 ECHR duty should it become engaged with a deterioration in her condition?

[56] It is important to note that the powers the Trust seeks are contingent on a deterioration in the mental health of JU. It does not seek to exercise the powers now, but only if her condition should deteriorate. In other words, they are anticipatory and contingent on a deterioration.

[57] Leaving aside the problem of the vesting of such decision making powers as to the diagnosis of a deterioration in JU's mental condition to non-medically qualified staff and then vesting the exercise of powers of DOL in the hands of

non-state actors, ie the nursing home staff, I do consider that the Trust do currently have adequate powers to fulfil its operational Article 2 ECHR duty should JU's condition deteriorate.

[58] The main concern is that JU would leave the nursing home in a state of heightened anxiety raising fears of an immediate suicide attempt. The Trust seeks powers to permit significant and constant monitoring of JU. I do not believe that these powers are required at all, given the history of her presentation within the nursing home. There will be normal social interaction between JU and the nursing home staff, and any issues about JU's presentation should become obvious to staff members. That may require the staff member to take urgent action should it be required, or to refer the matter to management and/or the Trust for further consideration. Additional powers are not required or justified.

[59] Should JU seek to leave the residential home in such a state of heightened anxiety, under the statutory provisions of the guardianship order the staff would not be able to prevent her from doing so. However, if it was considered by the staff that she was leaving the residential home without the leave of the guardian, then there are ample statutory powers under the MHO to have JU detained once she has crossed the threshold of the nursing home and then returned to the nursing home. There would be no need for an arrest warrant to be issued. The guardian can give explicit instructions to JU about when and in what condition she has the permission of the guardian to leave the nursing home. The guardian or the Trust can designate members of the nursing home staff who can exercise the statutory power of detention and return. Any police officer can exercise that power, as can any authorised social worker.

[60] Mr Potter sought to argue that absenting oneself implied some form of permanence, in other words the legislation referred to living permanently elsewhere, but I can find no support for such a proposition, nor could he refer me to one. Art 29(5) specifically defines absent without leave as "absent from any hospital or other place and liable to be taken into custody and returned under this Article." It would be bizarre if a patient subject to detention or guardianship under the MHO could not be detained and returned to their permitted residence or hospital until such time as they took up permanent residence elsewhere. This would leave the police or Trust powerless should a patient be sleeping rough or just wandering the streets. There is no temporal straitjacket applying to the meaning of absenting.

[61] As a consequence whilst there would be no power to actually prevent JU from leaving the nursing home, once she stepped over the threshold of the premises and did so without leave, she would be subject to detention and return.

[62] There was some discussion with Dr Southwell as to the powers to detain her for assessment under art. 4 of MHO. He was of the view that the diagnostic test (she was suffering from a mental disorder warranting detention) was not satisfied and would not be satisfied even if there was an escalation in the condition of JU. I have

difficulty in accepting that assessment. For a start one could never be definitive about any diagnosis until the patient presents with the escalated condition. The statutory diagnostic test for an assessment order is that the patient is suffering from mental disorder of a nature or degree which warrants his detention in a hospital for assessment. Dr Southwell was unclear as to whether this test failed on the first or second limb. JU is clearly suffering from a mental disorder or a series of mental disorders. Dr Southwell therefore must be of the view that in a heightened and escalated presentation which gives rise to a substantial likelihood of serious physical harm to JU through suicide, that the mental disorder, or disorders, would not warrant detention for assessment or hospitalisation. No explanation was forthcoming for that opinion. That may be the case because no assessment is required and the patient can go straight under a hospital order, the diagnostic test for which is that the patient is suffering from mental illness or severe mental impairment of a nature or degree which warrants his detention in hospital for medical treatment.

[63] Dr Southwell considered that even now JU does actually satisfy the evaluation test that a failure to detain her would create a substantial likelihood of serious physical harm to herself or to others. I am not sure if this is an opinion shared with his colleagues but if it is correct then given his asserted opinion of the substantial likelihood of harm, and the already confirmed diagnoses of her mental health conditions, it is difficult to come to a conclusion that she could not be subject at the very least to an assessment order, if not a hospital order, even at this time and without any deterioration.

[64] The DOL provisions in the MCA would also be available in any emergency (see sections 24 and 65). Section 65 (5) would allow a person without expertise (ie a nursing home employee) to act in an emergency based on their reasonable belief that it was necessary to deprive JU of her liberty without delay, on the basis that she lacked capacity and to prevent harm to JU.

[65] The statutory provisions in the MHO and the MCA are clearly adequate to deal with any deterioration in JU's condition or presentation and are available to Trust employees and to the nursing home employees.

[66] I therefore consider that the Trust does not require these additional powers. I will however, briefly, deal with the remaining questions that were posed above, namely whether the inherent jurisdiction of the court is available, and if it is available, whether it should be exercised.

Is the inherent jurisdiction of the court available to permit the DOL of JU, and if so, should the powers be granted?

[67] The key to the exercise of the inherent jurisdiction is to consider whether there are any gaps in the legislation, and then whether the court, in the role of *parens patriae*, is required to fill the gap to protect the well-being of the citizen.

Lord Dunedin in *AG v De Keyser's Royal Hotel* [1920] AC 508 at 526 described the use of the jurisdiction in the following terms:

> "[I]f the whole ground of something which could be done by the prerogative is covered by the statute, it is the statute that rules."

[68] Lord Wilberforce in *A v Liverpool City Council* [1982] AC 363 was dealing with the inherent jurisdiction and the provisions of the statutory scheme of the Children Act 1989. At 373(c) he summarised the position in the following terms:

> "… the inherent jurisdiction of the High Court is not taken away. Any child, whether under care or not, may be made a ward of court… But in some instances there may be an area of concern to which the powers of the local authority, limited as they are by statute, do not extend…. **The court's general inherent power is always available to fill gaps or to supplement the powers of the local authority.**"
> [my emphasis]

[70] It is therefore necessary to show that there is a gap in any legislative scheme before the court can invoke its inherent jurisdiction.

[71] The legislative scheme is provided by the MHO and the MCA. Obviously, the failure to commence in full the MCA means that certain legislative provisions are not available, but it is difficult to actually itemise any gaps in the legislation when it comes to imposing DOL on capacitous adults.

[72] Article 5(1) ECHR which states as follows:

> "1. Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:
>
> …
>
> (e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants."

[73] In *Petschulies v Germany* (2 September 2016 App no 6281/13) the ECtHR reiterated that the term "persons of unsound mind" in sub-paragraph (e) does not lend itself to precise definition, since its meaning continually evolves as research in psychiatry progresses. It did however state at [59] that:

> "An individual cannot be deprived of his liberty on the basis of being of "unsound mind" unless the following three minimum conditions are fulfilled: firstly, he must reliably be shown to be of unsound mind, that is, a true mental disorder must be established before a competent authority on the basis of objective medical expertise; secondly, the mental disorder must be of a kind or degree warranting compulsory confinement; thirdly, the validity of continued confinement depends upon the persistence of such a disorder."

[74] More recently the Grand Chamber in *Ilnseher v Germany* (4 December 2018 App Nos. 10211/12 and 27505/14) reaffirmed the three minimum conditions set out in *Petschulies* and added at [129] that:

> "[T]he permissible grounds for deprivation of liberty listed in Article 5 § 1 are to be interpreted narrowly. A mental condition has to be of a certain severity in order to be considered as a "true" mental disorder for the purposes of sub-paragraph (e) of Article 5 § 1 as it has to be so serious as to necessitate treatment in an institution for mental health patients."

[74] With the necessity for the strict interpretation of Article 5(1)(e) ECHR and the narrow interpretation of "person of unsound mind", I would conclude that the legislative provisions in the MHO and the MCA are adequate and do not have any gaps that need to be filled by the inherent power. There are powers to detain, assess and treat within the MHO. The provisions are compliant with Article 5(1)(e). The MHO powers allow for an immediate response in the event of a sudden deterioration. Similarly, although a capacitous person cannot be subject to a DOL, should they lose their capacity, then there are powers available under the MCA to put in place appropriate DOL orders. Both the MHO and the MCA provide for permissible steps to be taken in an emergency.

[75] I therefore conclude that the inherent jurisdiction of the court is not available in cases of making DOL orders for vulnerable, yet capacitous, adults.

[76] Before concluding this judgment, I also wish to mention briefly several recent cases decided in England not so much on the issue of whether the inherent jurisdiction is available, but rather whether, if available, it should be used to restrict the liberty of a capacitous adult.

[77] Lieven J in *Cumbria Northumberland and Tyne & Wear NHS Foundation Trust v EG* [2021] EWHC 2990 held that the inherent jurisdiction could not extend to deprive the liberty of a person with capacity. She did so for two reasons. The first was the

Strasbourg jurisprudence which I have mentioned above, and the second was:

> "[T]he use of the inherent jurisdiction in respect of vulnerable adults is a facilitative rather than a dictatorial one. It is to be used to allow the vulnerable person to have the space, away from the factor which is overbearing their capacitous will, to make a fully free decision. An order which deprives that person of their liberty is a dictatorial order which severely constrains their freedom, however well meant, rather than allowing them the space to reach a freely made decision."

[78] This echoes comments made by Keegan J in *O & R* [2020] NIFam 23 when she noted that the inherent jurisdiction was a safety net and not a springboard, and further that the inherent jurisdiction should not be used to reverse an outcome under a statutory scheme which deals with the actual issue.

[79] In a very recent decision of Mostyn J in *A Local Authority v LD and RD* [2023] EWHC 1258 was dealing with a case relating to a vulnerable but capacitous adult with DOL powers being sought to protect him from others who may be exploiting him. Mostyn J referred to a speech by the former President of the Family Division, Sir James Munby, to the Court of Protection Bar Association on 10 December 2020 entitled - *Whither the inherent jurisdiction? How did we get here? Where are we now? Where are we going?*[1] In that wide ranging speech, Sir James Munby argued that there was no power to make an order which had the effect of depriving a vulnerable, but capacitous, adult of their liberty.

[80] At page 30 of the published speech, Sir James Munby quoted from Davis LJ *Re L* [2012] EWCA Civ 253 at [76]:

> "It is, of course, of the essence of humanity that adults are entitled to be eccentric, entitled to be unorthodox, entitled to be obstinate, entitled to be irrational. Many are. But the decided authorities show that there can be no power of public intervention simply because an adult proposes to make a decision, or to tolerate a state of affairs, which most would consider neither wise nor sensible. There has to be much more than simply that for any intervention to be justified."

and then went on to state:

> "I agree. It is fundamental that a capacitous adult has the right to decide what is to happen to him, whether his

[1] This speech is available at – www.cpba.org.uk/wp-content/uploads/2020/12/2020copba.pdf

> reasons are good or bad or, indeed, for no reason at all. There is no scope for judicial paternalism, no scope for a judge to prevent an autonomous adult doing (or not doing) what he wants."

[81] In *LD & RD* at [41] and [42] Mostyn J stated:

> "[41] … I cannot see that there could ever be room for a class or type of unsoundness of mind for the purposes of Article 5 which does not amount to mental incapacity under the Mental Capacity Act 2005 or a mental disorder under the Mental Health Act 1983.
>
> [42] I accept that this may leave a gap in the law in that there may be out there fully capacitous, yet extremely vulnerable, adults being ruthlessly victimised and exploited by members of their family, or their carers, who the state cannot protect by forcibly removing them from their homes. That is a gap which, in my opinion, should be filled not by judicial legislation but by parliamentary legislation."

[82] Hayden J in *Local Authority v H* [2023] EWCOP 4 at [19] cautioned against the corruption of the process when there is an instinctive need to protect a vulnerable adult. In the context of that case, his concern was about the integrity of the objective assessment of capacity, but his warning is also relevant, if not more so, in the case of a capacitous adult:

> "Paternalism has no place; protection of individual autonomy is the magnetic north of this court."

[83] The theme emerging from this recent line of authority is not a new one but reflects a caution which the courts have always held against any form of interference in the liberty of a citizen. If the citizen lacks capacity either because of their age or their medical condition, then the court will act, as required, to protect their well-being. If, however, they do not lack capacity, it is not the role of the court to interfere with the liberty of a citizen, albeit for the best of motives. The deprivation of the liberty of a capacitous adult is a matter for the legislature subject to the compatibility provisions of the Human Rights Act 1998.

Article 8 ECHR

[84] I have not had to decide this case by considering where the application of Article 8 ECHR lies in relation to the Trust's application. Article 8 refers to respect for private and family life, which can only be interfered with when it is "necessary in a democratic society in the interests of national security, public safety or the

economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others."

[85] This case does raise important issues, not least for JU but also the guardian and for the Trust, but the starting point must be that JU does not lack capacity. The concern in this case is that JU may, at some time in the future, take steps to end her life. The law in this country recognises that people who have capacity can exercise that capacity by making decisions to end their own life. They can do so by refusing medical treatment or they can do so by taking active steps to bring about their death. This has been recognised by the ECtHR in *Haas v Switzerland* [2011] ECHR 2422 in the following terms:

> "An individual's right to decide by what means and at what point his or her life will end, provided he or she is capable of freely reaching a decision on this question and acting in consequence, is one of the aspects of the right to respect for private life within the meaning of Article 8 of the Convention."

[86] In *Hiller* the ECtHR made specific reference to The Council of Europe's Recommendation (Rec (2004) 10) concerning the human rights and dignity of persons with mental disorder, Principle 9.1 of the UN General Assembly's resolution (17 December 1991) – "Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others", and the UN's convention on the rights of persons with disabilities (13 December 2006).

[87] The ECtHR at [54] and [55] concluded that there had been no disregard by Austria of its Article 2 ECHR obligations because it was necessary to scale back any DOL without delay when the patient's medication started to work, and he was compliant with the hospital rules because the advantages of an open hospitalisation clearly outweighed the disadvantages of a closed option. Ultimately it was decided that had the patient's liberty been restricted more than it had been, then this would have raised issues not only under Articles 3 (prohibition of torture and inhuman treatment), Article 5 and Article 8 ECHR.

[88] There is a strong argument to suggest that granting these powers to the Trust when JU is not only capacitous, but also receiving and taking appropriate medication, and is both settled and compliant within the nursing home and capable of carrying on her life with appropriate social interaction with staff, fellow residents and the wider community, would be hard to justify under Article 8 ECHR as a proportionate response.

Conclusion

[89] The ultimate conclusion in relation to the situation in respect of JU is that although the Trust do owe her an operational Article 2 ECHR duty, her current presentation does not engage that duty. Should there be a deterioration in her condition (whether temporary or permanent) then the duty may become engaged, however the combined statutory scheme of the MHO and the MCA is available and proper application of the powers vested by the legislation would be sufficient to fulfil any duty. There being no gaps in the legislation there is no scope for the court to exercise its inherent jurisdiction, and even if it could, the court could not restrict the liberty of JU as long as she retained her capacity.

[90] The application of the Trust is therefore refused.

[91] JU is a legally assisted party and there will be a taxation order in respect of her costs. Should she wish to seek an order for her costs against the Trust there is liberty of apply to the court.