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*(subject to editorial corrections)**

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

OFFICE OF CARE AND PROTECTION

IN THE MATTER OF PT

BETWEEN:

BELFAST HEALTH AND SOCIAL CARE TRUST

Plaintiff;

and

PT

First Respondent;

and

THE OFFICIAL SOLICITOR TO THE COURT OF JUDICATURE NORTHERN IRELAND

Second Respondent.

McBRIDE J

Application

[1] This is an application by Belfast Health and Social Care Trust ("the Trust"), seeking the following relief, under the inherent jurisdiction of the court:-

(a) A declaration that the first-named respondent ("PT") lacks capacity to consent to the care, treatment and ancillary arrangements proposed for him as set out in the care plan ("care plan").

(b) A declaration that the care plan can lawfully be carried out in respect of PT as it is in his best interests.

(c) A declaration, that in so far as the care plan deprives PT of his liberty, same can be lawfully carried out.

[2] The Trust was represented by Ms M Connolly. The Official Solicitor, who acts as guardian ad litem to represent the interests of PT, was represented by Ms Murphy. I am grateful to both counsel for their well-researched and marshalled skeleton arguments.

[3] These proceedings have been anonymised to protect the interests of PT. Nothing should be published which would identify PT or any of the adults in this case.

Background

[4] PT was born in 1993. He has a diagnosis of Di George's Syndrome, Fallot's Tetralogy, Bilateral Vesicoureteric Reflux, Asthma, gastro-oestphageal reflux and Scoliosis. He therefore has had significant physical health problems since birth and has severe impairment of intelligence and social functioning.

[5] Due to his parents' inability to care for him, PT was made a Ward of Court at birth, later a Deemed Care Order. Since birth he has resided at a number of short-term placements and statutory residential homes. Since 5 April 2002, PT has lived with JB and her family, on a full-time fostering placement.

[6] When PT was aged 18 years it was decided that JB should continue to care for him. She was assessed and trained as a carer with the Adult Family Placement Scheme and approved as a carer for adults with a learning disability, in 2011.

[7] PT was made the subject of guardianship in May 2011.

Evidence in Respect of Capacity

[8] There were two reports presented to the court by Dr M.I. Mulholland, Consultant Psychiatrist dated 2 April 2016 and 8 December 2016.

[9] Dr Mulholland noted that PT had Global Developmental Delay since early childhood, resulting in severe impairment of intelligence and social functioning, which comes within the definition of severe mental handicap within the Mental Health (Northern Ireland) Order 1986.

[10] PT is unable to read or write. He can communicate using modified Makaton signs and single utterances. He cannot recognise problems, use previous experience to inform decision making and cannot grasp complex or abstract ideas.

[11] Dr Mulholland carried out a capacity assessment in respect of the following questions:

(a) Does PT have the capacity to litigate?

(b) Does PT have the capacity to make decisions about his care and residence and specifically whether he should be accommodated with JB?

(c) Does PT have the capacity to decide whether to leave the home unescorted?

[12] After analysing his ability to understand, retain and weigh up the information and then to communicate his decision, Dr Mulholland concluded that PT had limited ability to understand complex issues, had poor retention of information, was unable to balance benefits and risks and was unable to communicate his decisions. Dr Mulholland therefore concluded that he lacked capacity to litigate, to make decisions about his care and residence and to decide whether to leave his home unescorted.

Evidence of Care Plan

[13] Ms Wilson, Social Worker provided a report dated 7 April 2016. In this report she set out the background to the case together with details of PT's care plan.

[14] The care plan stipulates, inter alia, that PT will reside with JB, who will provide supervision of PT both in the home and outside the home. It also stipulates that the front and back doors of the home will be locked whilst PT is in the home. Car doors are also to be locked whilst PT is in the car and it is in motion, as PT in the past tried to open the car door whilst JB was driving the car. The care plan is subject to an annual review by a multidisciplinary team.

[15] Dr Mulholland highlights in her reports that PT has no awareness of dangers or risks, including dangers presented by traffic or strangers and therefore requires constant supervision to protect him from slips, falls, dangers in the home and on the road, and from strangers at all times. She also considered that it was necessary to lock front and back doors to the home to prevent PT wandering off out of the home. Ms Wilson recognised in her report that the care plan involves a deprivation of PT's liberty but submits that the deprivation is necessary to keep PT safe.

[16] It is the view of the multidisciplinary team that JB is a highly skilled carer who provides PT with a long-term placement which is safe, homely and stimulating. PT is well settled in the placement and appears to be happy.

Evidence of the Official Solicitor

[17] The Official Solicitor met with PT and his carer JB on 16 September 2016. In a written report dated 28 September 2016 the Official Solicitor noted that PT had limited vocabulary and was only able to understand very basic instructions. JB reported to her that PT functions at the level of a 2-3 year old. She advised that PT had no concept of "stranger danger" and as a result she has to lock the front and back doors to prevent him wandering off. She further reported that she had to lock the car doors when PT was present as he had previously attempted to open the

doors whilst the car was in motion. The Official Solicitor reports; "PT is in an excellent and supportive placement" and she noted "a very special bond" between PT and JB. She concludes that there is "a justifiable requirement to lock doors in the home and the car" to avoid PT being placed in danger.

Submissions of the Trust and Official Solicitor

[18] The Trust submitted that PT lacked capacity on the basis of Dr Mulholland's reports. It was the Trust's opinion that the care plan involved a deprivation of liberty and therefore it requested that the court exercise its inherent jurisdiction to approve the aspects of the plan which involved this deprivation. The Trust submitted that the Court had an inherent jurisdiction to approve the care plan as PT lacked capacity and the care plan was in his best interests.

[19] The Official Solicitor agreed with the Trust that the care plan involved a deprivation of liberty. The Official Solicitor submitted that the court had an inherent jurisdiction to sanction the deprivation of liberty and should do so in this case, as the Trust's actions were necessary and in PT's best interests.

LEGAL FRAMEWORK

Inherent Jurisdiction – Its History and Ambit

[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".

Basis on which Inherent Jurisdiction is exercised - Best Interests

[22] Munby J stated in Re SA at paragraph 84:

> "Just as there are, in theory, no limits to the court's power when exercising a wardship jurisdiction I suspect that there are in theory, few if any limits to the court's powers when exercising the inherent jurisdiction in relation to adults"

Although the ambit of the inherent jurisdiction of the High Court is very wide, there are limits on it exercise. It must be exercised in accordance with law and in particular it must comply with the requirements of the Human Rights Act and the European Convention on Human Rights.

[23] As was noted in Re SA at paragraph 37:

> "It is now clear…that the court exercises what is, in substance and reality a jurisdiction in relation to incompetent adults which is for all practical purposes indistinguishable from its well-known *parens patriae* or wardship jurisdiction in relation to children. The court

> exercises a protective jurisdiction in relation to vulnerable adults just as it does in relation to wards of court."

As has been noted in a number of cases the court has power to grant whatever relief in declaratory form as is necessary to safeguard and promote the incompetent adult's welfare and interests. As Munby J went on to observe in Re SA at paragraphs [96-97]:

> "It is elementary that the Court exercises its powers by reference to the incompetent adult's best interests."

'Best interests' depends on the particular circumstances of each case. It goes beyond medical interests and it takes into account ethical, social, moral and welfare considerations including the recognition of emotions and human relations. In Re GM [2011] EWHC 2778 Hedley J at paragraph 21 set out the broad scope of best interests, when she said:

> "If one asks what has to be taken into account in considering the best interests of any human being … the answer is a very wide-ranging one: his health, his care needs, his needs for physical care and his needs for consistency. There is of course, more to human life than that, there is fundamentally the emotional dimension, the importance of relationships, the importance of a sense of belonging in the place in which you are living, and the sense of belonging to a specific group in respect of which you are a particularly important person."

Similarly in A Local Authority v PB & P [2011] EWHC 502 at paragraph 7 Charles J held:

> "It is always important to recognise the commitment and love of a family to caring for a member of the family who lacks capacity and the significant part that that inevitably plays in decisions that fall to be made by the court."

In Re A [2000] 1 FLR 389, Thorpe LJ introduced a more formalised approach to assessing best interests by recommending that a judge should draw up a balance sheet indicating on each side the advantages and disadvantages associated with those courses of conduct together with potential gains and losses and with the probabilities that the gain or loss might accrue.

[24] In England and Wales the Mental Capacity Act 2005 now provides a statutory framework for the application of the 'best interests' standard. This Act does not apply in Northern Ireland and in the absence of legislation, decisions made under

the common law will continue to provide guidance for the meaning of the 'best interests' test.

Applicable Legal Principles

[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").

CONSIDERATION

The court considers that 4 questions need to be addressed in this case:

a. Does PT lack capacity?

b. Is there a gap in the existing legislation, thereby permitting the exercise of the inherent jurisdiction?

c. Is the care plan in PT's 'best interests'?

d. Is the care plan compliant with the ECHR?

Question 1 - Does PT lack capacity?

Relevant Legal Principles regarding capacity

[26] A person is presumed to have capacity until the contrary is established. Capacity is "issue specific" in that a person may have capacity for one purpose but

lack capacity for another purpose. The test for capacity was set out in Re C (Adult: Refusal of Treatment) [1994] 1 WLR 290 by Thorpe J at page 27-295 as follows:

> "I consider helpful, Dr Eastman's analysis of the decision-making process into three stages: first, comprehending and retaining treatment information, secondly believing it and thirdly, weighing it in the balance to arrive at choice".

[27] Similarly Re MB (Medical Treatment) [1997] 2 FLR 426 Butler-Sloss LJ at page 437 explains the test as follows:

> "A person lacks capacity if some impairment or disturbance of mental functioning renders the person unable to make a decision whether to consent or to refuse treatment. That inability to make a decision will occur when:
>
> (a) The patient is unable to comprehend and retain information which is material to the decision …
>
> (b) The patient is unable to use the information and weigh it in the balance as part of the process of arriving at the decision".

[28] Although these cases involve the question of capacity to consent to medical treatment, Munby J in X v MM [2007] EWHC [2003] at paragraphs 72 and 73 stated that this test could be applied to other welfare decisions. He concluded that there was no relevant distinction between the test formulated in Re MB and the test set out in Section 3 (1) of the Mental Capacity Act 2005. He said as follows:-

> "Each of these formulations is simply a statement of the general theory of what is meant by 'understanding' a problem and having the capacity to decide what to do about it … The same theory or principle is now to be found in the statutory test of capacity as set out in Section 3(1) of the Mental Capacity Act 2005:
>
> > '… A person is unable to make a decision for himself if he is unable –
> >
> > (a) to understand the information relevant to the decision,
> >
> > (b) to retain that information,

(c) to use or weigh that information as part of the process of making the decision, or

(d) to communicate his decision …'

[29] There is therefore no difference between the statutory test and the existing common law tests. Hence, in determining the capacity of PT in respect of welfare matters, the court can apply the test set out in the Mental Capacity Act 2005, even though that legislation does not apply in Northern Ireland, as it is in line with the existing common law tests.

Findings regarding capacity

[30] In her report dated 7 April 2006, Dr Mulholland applied the test set out in Section 3 Mental Capacity Act 2005 and concluded that PT lacked capacity to litigate, to make decisions about his care and residence, and to decide whether to leave the home unescorted. The Official Solicitor did not challenge these conclusions.

[31] I find that Dr Mulholland, was entitled to apply this legal test in respect of assessing PT's capacity. In light of the uncontroverted evidence of Dr Mulholland, I find that PT lacks capacity to litigate, to make decisions about his care and residence and about whether to leave the home unescorted. This conclusion is further supported by: the comments of his foster mother JB that PT functions as a 2-3 year old; the Official Solicitor's observation that PT was only able to carry out simple tasks and the fact PT suffers from a severe mental handicap as defined by the Mental Health (Northern Ireland) Order 1986 in that he has a "state of arrest or incomplete development of mind which includes severe impairment of intelligence and of social functioning".

Question 2 – Is there a 'gap' in existing legislation?

[32] PT is subject to guardianship. In accordance with Article 22 of the Mental Health (Northern Ireland) Order 1986, the Trust has power to require PT to reside at a place specified by the Trust or person named as guardian. Therefore, the inherent jurisdiction of the court cannot be invoked in respect of where PT resides as this is governed by legislation. The Trust submits however, that as its care plan involves a deprivation of liberty, a court order is required to be made under the inherent jurisdiction, as the Mental Health (NI) Order 1986 does not provide any legislative basis to sanction deprivation of liberty.

[33] In JMcA v RH&SCT [2014] NICA 37 the Court was concerned with the extent to which a trust could impose a supervision plan involving a deprivation of liberty on foot of a Guardianship Order under the 1986 Mental Health (NI) Order. The Court accepted that in England and Wales there is deprivation of liberty legislation in the form of the Mental Capacity Act 2005 which provides a mechanism for lawful

restriction on or deprivation of liberty of a person such as PT. The court accepted there is no such legislative provision in Northern Ireland and for this reason the court stated that urgent consideration should be given to the implementation of similar legislation in this jurisdiction. Therefore, it is clear there is a lacuna or 'gap' in the 1986 Mental Health (NI) Order and as a result, a care plan which involves a deprivation of the liberty of a person subject to guardianship, cannot be sanctioned under the Mental Health (NI) Order 1986. Such deprivation of liberty can only be sanctioned by the High Court acting under its inherent jurisdiction.

Question 3 – Is PT's care plan in his best interests?

[34] Before exercising its inherent jurisdiction to approve the Trust's proposed actions the court must be satisfied that these actions are in PT's best interests.

[35] As set out in paragraph [23] above, an assessment of 'best interests' involves having regard to all the circumstances of the case.

[36] The only aspect of the care plan which requires the court to exercise its inherent jurisdiction are those parts which may involve a deprivation of his liberty.

[37] As appears from paragraph [23] a determination about 'best interests' involves not just a consideration of the medical evidence which relates to the incapacitated adult's physical and mental health and care needs, but also involves, consideration of the evidence given by other professionals, in particular social workers in relation to broader considerations which relate to the incapacitated adult's emotional needs, including his relationships and family circumstances. All the professional and expert witnesses agree that due to PT's poor physical mobility and lack of awareness of dangers and risks including dangers presented by traffic and strangers, he requires constant supervision to protect him from slips, falls and dangers in the home and on the road. Further, to keep him safe from wandering off, PT requires the front and back doors of the home to be locked. In addition he requires car doors to be locked when it is in motion. The purpose of locking the doors and the continuous supervision is to ensure that PT is kept safe. The Official Solicitor agrees that there is a "justifiable requirement" to lock the doors in the home and in the car and in the day centre to avoid placing PT in danger.

[38] In light of the uncontroverted evidence of the professional and expert witnesses, I find that continuous supervision by his foster mother JB and the locking of the external doors of the home and car doors whilst it is in motion are in his best interests as they protect his health and physical safety. The provisions also ensure he can continue to live with JB, with whom he has a special bond. For this reason I find that it is in his emotional best interests to remain in this placement. This can only happen if the proposed deprivation of liberty is permitted.

Question 4 – Is the care plan compliant with the provisions of the European Convention on Human Rights?

[39] Since the court is a public authority, any exercise of its inherent jurisdiction must be exercised in a manner which complies with the European Convention on Human Rights.

Relevant Provisions of the ECHR

[40] The relevant provision of the Convention is Article 5. Article 5(1) provides:

> "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 …"

Paragraph 5(4) provides:

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

[41] In HL v UK [2004] 40 EHRR 761 at paragraph 123 the court held:

> "Article 5(1) regulates the circumstances in which one's liberty can be taken away and Article 5(4) requires a review of its legality thereafter".

[42] As appears from the Strasbourg jurisprudence and in particular HL v UK, in order to comply with the Convention, a judge exercising the inherent jurisdiction of the court, must:-

(a) First, determine whether Article 5 is engaged, that is, decide whether the proposed actions, in this case the arrangements set out in the care plan, amount to a deprivation of liberty.

(b) If so, the court must then determine whether the provisions of Article 5(1)(e) are met. In this case the court must determine whether PT is a person of

'unsound mind'. 'Unsound mind' is not defined in the Convention but the Guide to Article 5 states at paragraph 88 – 90 and paragraph 94 as follows:

> "88. An individual cannot be deprived of his liberty as being of 'unsound mind' unless the following 3 minimum conditions are satisfied...:-
>
> (i) the individual must be reliably shown, by objective medical expertise to be of unsound mind, unless emergency detention is required,
>
> (ii) the individual's mental disorder must be of a kind to warrant compulsory confinement. The deprivation of liberty must be shown to have been necessary in the circumstances.
>
> (iii) the mental disorder, verified by objective medical evidence, must persist throughout the period of detention.
>
> 89. No deprivation of liberty of a person considered to be of unsound mind may be deemed in conformity with Article 5(i)(e) of the Convention if it has been ordered without seeking the opinion of a medical expert.
>
> 90. As to the second of the above conditions, the detention of a mentally disordered person may be necessary not only where the person needs therapy, medication or other clinical treatment to cure or alleviate his condition, but also where the person needs control and supervision to prevent him, for example, causing harm to himself or other persons.
>
> 94. The detention of persons of unsound mind must be effected in a hospital, clinic, or other appropriate institution authorised for the detention of such persons."

These paragraphs make it clear that the court must be provided with expert, objective medical evidence in respect of the questions whether the person is of 'unsound mind, whether his mental disorder is of a kind to warrant compulsory confinement and whether the mental disorder will persist throughout the period of detention.

(c) The court must then determine whether the detention is in conformity with the essential objective of Article 5(1), that is, to prevent individuals being deprived of their liberty in an arbitrary fashion. This objective and the

broader condition that the detention must be "in accordance with a procedure prescribed by law" requires that domestic law provides adequate legal protections and "fair and proper procedures". As appears from the jurisprudence, a Trust seeking to deprive an incapacitated individual of his liberty, must apply to the court for an order before the detention commences and the individual must be afforded the necessary legal safeguards including legal representation and access to the court.

(d) The court must then determine whether the provisions of Article 5(4) are met. In accordance with Article 5(4) a person deprived of his liberty has the right to have the lawfulness of his detention reviewed speedily by a court. Thus, any order authorising detention must contain provisions for adequate review at "reasonable intervals". This is usually achieved by the Order authorising deprivation of liberty, containing a liberty to apply on short notice, provision. The review provided must also be wide enough to ensure that the conditions which are essential for the lawful detention of a person still persist. In this case, any review must ensure that unsoundness of mind of a kind or degree warranting compulsory confinement still persists – see HL v UK paragraph 135.

[43] Therefore, before the court exercises its inherent jurisdiction it must fully address the following questions, in order to be satisfied that any order it makes complies with the ECHR.

(a) Is Article 5 is engaged? Does the care plan contain provisions which amount to a deprivation of liberty?

(b) If so, are the provisions of Article 5 (1) (e) met?

(c) If so, is the detention in accordance with the objective of Article 5 and is it in accordance with a procedure prescribed by law?

(d) Is the proposed Order compliant with the provisions of Article 5 (4)?

Is Article 5 engaged? Is PT deprived of his liberty?

[44] The leading case on the meaning of deprivation of liberty is P v Cheshire West and Cheshire Council [2014] UKSC 19. The Supreme Court had to consider whether the living arrangements of three mentally incapacitated persons amounted to a deprivation of liberty. One of the appeals involved two sisters MIG and MEG. MIG had a learning disability. She lived happily with a foster mother and never attempted to leave home by herself, but if she did the foster mother would restrain her. Her sister MEG also had a learning disability. Her care needs were met in a residential home on the basis of continuous supervision and control. She was always accompanied by staff when she left the home. The court held that these cases

involved deprivation of liberty within Article 5 of the European Convention on Human Rights. Lady Hale said at paragraph 46:

> "What it means to be deprived of liberty must be the same for everyone, whether or not they have physical or mental disabilities. If it would be a deprivation of my liberty to be obliged to live in a particular place, subject to constant monitoring and control, only allowed out with close supervision, and unable to move away without permission even if such an opportunity became available, then it must also be a deprivation of the liberty of a disabled person. The fact that my living arrangements are comfortable, and indeed make my life as enjoyable it can possibly be, should make no difference. A gilded cage is still a cage."

[45] The Trust and the Official Solicitor all agree that the care plan involves a deprivation of PT's liberty. It is clear from the reports of the social worker, Dr Mulholland and the Official Solicitor that the care plan requires PT to be placed under continuous supervision and monitoring by his foster mother both in and outside the home. In addition PT is not free to leave the home as the external doors are locked. Further whilst the car is in motion the car door is also locked.

[46] The Guide to the ECHR on Article 5 at paragraph 94 sets out that the detention of persons of unsound mind can be affected in a hospital, clinic or other appropriate institution authorised for the detention of such persons. In Cheshire West the Court had to consider whether a deprivation of liberty could also take place in a foster placement which is a domestic setting. The majority of the Court accepted it could. PT is in such a placement and therefore I find that a deprivation of liberty can occur in a foster placement even though it is not a hospital, clinic or institution. I also find that although this is a benign regime, in accordance with the definition set out in Cheshire West, PT's care plan involves a deprivation of liberty because there is constant supervision and he is not free to leave the home as the external doors are locked and car doors are locked whilst he is present.

Are the provisions of Article 5 (1) (e) met - Is PT of 'unsound mind'?

[47] The court has the benefit of 2 reports from Dr Mulholland who is a consultant psychiatrist. This evidence fulfils the requirements of the European jurisprudence which requires expert, objective medical evidence, in respect of the questions:

(a) Is PT a person of unsound mind?

(b) Is his mental disorder of a kind to warrant his compulsory detention and

(c) Will his mental disorder persist throughout the period of detention?

The uncontroverted medical evidence of Dr Mulholland is that PT suffers from a severe impairment of intelligence and social functioning which amounts to severe mental handicap as defined by the Mental Health (Northern Ireland) Order 1986. This is a lifelong condition. Dr Mulholland concludes that the restrictions placed upon PT are "necessary and proportionate" to prevent him suffering serious harm.

[48] Having considered Dr Mulholland's reports together with the report of the Official Solicitor I find that the provisions of Article 5 (1) (e) are met. There is objective medical evidence before the court indicating that PT is of unsound mind, this condition is persisting and is of a kind to warrant his compulsory confinement as PT needs supervision to prevent him causing harm to himself.

Is the detention in accordance with the essential objective of Article 5 and in accordance with a procedure prescribed by law?

[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.

[50] Further, in accordance with the aim of Article 5(1) the court should only authorise the minimum deprivation of liberty consistent with the welfare principle. Ms Wilson, in her report dated 7 April 2016 notes that the locking the external doors in the home, affords PT an element of freedom to move around the home environment. This indicates that consideration has been given to the minimum deprivation that is necessary to keep PT safe. Having regard to all the professional expert reports I find that the care plan represents the minimum deprivation necessary to achieve the aim of Article 5, namely to ensure that PT does not cause harm to himself.

[51] A Trust seeking to deprive a person of his liberty must apply to the court for an order before the detention commences. That was not done in this case as the Trust submits the need for such an order only became clear due to recent jurisprudence. I have not been asked to retrospectively sanction the deprivation of liberty and I therefore do not rule on that question. Any order this court makes is limited to sanctioning any deprivation of liberty which may arise from the date of the order.

Does the proposed order comply with provisions of Article 5 (4)?

[52] In accordance with the requirements of Article 5 (4) the Court order must provide for adequate review at reasonable intervals. The Trust seeks an order of 12 months duration. I find that this is a reasonable interval to review the order as the Care Plan and Guardianship are reviewed annually. To accord with the requirements of Article 5(4) the Order should also a include liberty to apply at short notice provision. The review provisions must also ensure that there is sufficient medical evidence before the court to enable it to review whether there still persists an unsoundness of mind of a degree or kind to warrant PT's compulsory confinement. In addition it is necessary to build other safeguards into the Order including PT's right to legal representation.

Terms of Court Order

[52] Accordingly, I order as follows:-

> "(i) The court declares PT lacks capacity to consent to the arrangements set out in the Schedule.
>
> (ii) The court declares that the arrangements set out in Schedule 1 hereto can lawfully be carried out in respect of PT, as they are in his best interests.
>
> (iii) The court declares that insofar as any of the arrangements set out in Schedule 1 deprive PT of his liberty same can lawfully be carried out.
>
> (iv) This order is made for a period of 12 months from the date thereof.
>
> (v) This case shall be listed for further hearing on 11 December 2017.
>
> (vi) On or before 13 November 2017 the Trust shall file a report, including an updated care plan with the court, and the Official Solicitor, which shall provide an update in respect of PT's circumstances and in particular provide medical evidence which shall confirm whether there still persists unsoundness of mind of a degree or kind to warranting his compulsory confinement.
>
> (vii) The Official Solicitor shall be appointed to act as Guardian ad Litem to represent the interests of PT pending any further order and on or before

27 November 2017 the Official Solicitor is at liberty to file a report with the Court.

(viii) Service on PT shall be effected by sending any court summonses and accompanying documentation to the Official Solicitor.

(ix) Liberty to apply."

Schedule 1

Whilst PT resides in the care of JB she may be permitted, when it is considered necessary, to:

a. Lock the external doors of the home; and

b. Lock the car doors whilst it is in motion; and

c. Exercise such supervision and monitoring as she considers necessary to ensure PT's safety both inside and outside the home."

[53] I make no order as to costs inter parties.