Neutral Citation: [2016] NIFam 9

Ref:	**KEE10075**

Judgment: approved by the Court for handing down
*(subject to editorial corrections)**

Delivered:	**14/10/2016**

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

OFFICE OF CARE AND PROTECTION
IN THE MATTER OF NS
(Inherent jurisdiction: patient: liberty: medical treatment)

KEEGAN J

Introduction

[1] This case relates to an elderly lady, NS. She has been represented by the Official Solicitor (OS) throughout these proceedings. At one point in the proceedings I also allowed the Law Centre of Northern Ireland to be present in court as an interested party in NS's case. MS is NS's son and he has appeared throughout the proceedings as a personal litigant.

[2] Mr Michael Potter BL represented the Health and Social Care Trust that brought a number of applications in this case. Ms Martina Connolly BL represented the Official Solicitor. Mr Morgan BL also appeared briefly as a courtesy to the court to clarify the position of the Law Centre. I am grateful to all counsel for their assistance in this case.

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

Chronology of Applications

[4] The first application to come before the court was by way of originating summons for declaratory relief brought by the Trust on a date in June 2016. This was originally dealt with by O'Hara J who on 23 June 2016 appointed the Official Solicitor as guardian and next friend of NS. In the originating summons the plaintiff sought the following relief:

(a) An order that the patient should be discharged from hospital and conveyed to a care facility on the grounds that by reason of her medical condition it is necessary to accommodate the plaintiff at the care facility in a locked unit and that such decision as to her care and supervision is necessary, proportionate and in her best interests.

(b) An order authorising the plaintiff to convey the patient to the residential facility and maintain the patient in residence at the facility and there or elsewhere as may be required to provide such care, supervision and treatment as the patient may need to require.

(c) Such other relief as may be just.

(d) Any appropriate order as to costs as the court may deem just.

[5] I dealt with this application on 8 July 2016 and upon hearing evidence on that date I made an interim order for an 8 week period until 8 September 2016. I made further interim orders as the proceedings were part heard on 8 September 2016 and concluded on 30 September 2016. I made a 2 week interim order on 30 September 2016 pending a judgment. I made my interim orders largely on the same terms as the originating summons that was put before me save I included a specific provision which dealt with the Article 5 point.

[6] I also received an appeal brought by MS from an order of Master Wells of 8 September 2016. This was an order in relation to Master Wells' hearing of applications regarding two enduring powers of attorney (EPA). The first was MS's application to register a handwritten "power of eternity" document of 17 April 2016. That application was refused. The second application was MS's application to register an enduring power of attorney in the prescribed form which was executed by the patient and MS on 23 June 2004. That application was also refused.

[7] The Trust brought a further summons for declaratory relief dated 5 October 2016. This was heard as an emergency on the afternoon of 5 October 2016 as it related to an application on behalf of the applicant trust for declaratory relief to allow NS to have surgery due to a fracture of her left femur. I granted this application to allow for the surgery and the matters as set out in Schedule 1:

(1) The administration of anaesthesia.

(2) The performance of orthopaedic surgery to repair or replace a fracture to the neck of the left femur and any associated injury.

(3) The administration of such post-operative care as will be considered necessary by the practitioners responsible for care of NS including such steps as sedation, nursing, physiotherapy and occupational therapy.

(4) The administration of such treatment as will be considered necessary by the practitioners for the care of NS after the surgery.

[8] As a result of NS's surgery I reconvened the court and I heard further evidence on this issue on 11 October 2016. On that date the Trust also provided a revised draft declaratory order authorising a deprivation of liberty as follows:

(1) By reason of her medical condition the patient requires to be kept in residence in a locked unit and when not in locked accommodation she must be under such supervision as may be necessary to protect her welfare.

(2) The plaintiff trust is authorised to maintain the patient in appropriate accommodation relevant to her needs and to provide such care and treatment as may be relevant to her needs. More specifically the Trust is authorised to take such measures as are required in relation to:

   (a) designating a suitable place of residence;

   (b) carrying out assessments and meeting her assessed needs;

   (c) ensuring access to medical treatment such as may be required;

   (d) facilitating contact with third parties so far as may be reasonable and appropriate taking into account the patient's best interests and relevant human rights considerations; and

   (e) ensuring reasonable and appropriate care and assistance for the patient.

(3) The Trust shall take responsibility for conveying the patient from a hospital where she is currently receiving care to a place of rehabilitation as may be required and/or to a residential care home or such other suitable place of residence or other accommodation as the Trust may deem appropriate.

(4) The Order permits the administration of such post-operative care as will be considered necessary by the practitioners responsible for the care of the patient including such steps as sedation, nursing, physiotherapy and occupational therapy. It also permits the administration of such treatment as may be considered necessary for the care of the patient following her surgery.

(5) For the purposes of and so far as is relevant to this Order the Official Solicitor shall remain the patient's next friend and guardian ad litem to represent the interests of the patient.

[9] During the course of proceedings MS filed numerous papers with the court in hand writing. The court had to elicit what exactly was requested however this was

not an easy task and this led to proceedings taking more than the usual time. Many and various applications were made which I have attempted to deal with in this judgment. In particular, MS required NS to attend at court and to give evidence. I refused that application. MS required all of his mother's medical records to be produced. I refused that application but I asked that the OS allow MS to inspect relevant records at her offices and as NS's representative she agreed. MS also asked that a variety of persons be summonsed to court including Mr Alphy Magennis to deal with his financial claim against the Trust. Also, MS required staff from the Office of Care of Protection who saw NS when MS brought her to court to attend and give evidence. MS also asked that Rosalind Johnston be summonsed as she also met NS.

[10] For the avoidance of any doubt I reject all of these applications save that I did allow MS to view some medical records. Unfortunately, MS refused to sign a standard letter supplied by the OS that he would not breach confidentiality in relation to her report. Again I asked that MS have the facility to view the reports at the OS offices which the OS confirmed would be facilitated. MS did not avail of that. In the context of the EPA appeal MS made various applications to subpoena Tughans Solicitors and Mr James Pringle and to obtain phone records. I deal with these applications in my conclusion section. MS has continued to make applications in a written format to the court, the latest being on 13 October 2016, which is the day before judgment. This asks for Dr English to attend at court and for NS's medical files for the last 16 years. It is not appropriate for MS to make such applications after the case has concluded but in any event I do not consider that they should be granted given the conclusions I have reached.

Background Facts

[11] NS is an 83 year old widow. Her husband died in 2009. She had four children, one of whom is deceased. I note that NS was an independent woman during her life. She was in her local community and she was involved with voluntary organisations and the church. During her married life NS obtained her own apartment while her husband lived at the former matrimonial home. However, in 2008 when her husband became ill, NS moved to the former matrimonial home to look after him. When her husband died NS moved back into her apartment. MS also assisted with his father's care and it appears that he collected some benefits in relation to his father. It is reported that MS had a fractured relationship with his mother. He had little contact with her after his father's death in 2009. It appears that his mother applied for an occupation order in 2009 but that was withdrawn. Contact appears to have been re-established in 2016 and MS now views himself as his mother's primary carer.

[12] NS has a number of longstanding health difficulties including hypothyroidism, chronic obstructive pulmonary disorder, bronchiectasis, osteoarthritis and hypertension. She was also referred by her general practitioner in relation to signs of dementia on 2 June 2012. That led to a diagnosis of probable

dementia. In July 2014 there was an assessment by social services in relation to future care. At this stage NS was being managed at home with the support of family and friends and a neighbour. NS did not want a care package to be put in place. Her daughter was often staying 4-5 nights a week but in July 2014 this daughter suffered a stroke which affected her ability to care for her mother. NS's son in law took over for a time.

[13] On 4 November 2015 there was a referral to social services domiciliary support in relation to NS following a number of hospital admissions. There was a short stay in a residential home around this time and NS was assessed. Between December 2015 and January 2016 NS's daughter and son-in-law and a neighbour helped to look after NS but this could not be maintained indefinitely and there was deterioration at this time in NS's level of independence. There were risks identified to NS's wellbeing and safety if she were not fully supervised. NS was afforded some time in a respite care home on 21 January 2016. This appeared to have gone well however on 12 March 2016 MS took NS out of the home for a day and she was not returned. It appears that after that social services had a difficulty engaging MS. I note that psychiatric appointments were not kept by MS and generally from that point MS's position was that he could look after NS at home himself. The situation at home was not satisfactory and NS had a number of hospital admissions between 19 April and 22 April 2016. She was living at her home address prior to this with MS caring for her during the day and from 14 March 2016 he had been looking after her at night as well. On 3 May 2016 NS was admitted to hospital with a suspected transient ischaemic attack and a delirium.

[14] I note in the papers that MS is supported by the community mental health team on a voluntary basis and that he has a difficult relationship with his siblings. MS was the only relative who took an active part in these proceedings. NS's daughter has kept a constant communication with the social services. She has sent correspondence into court. She does not support a placement of NS at home with MS. It also appears that in 2010 the former matrimonial home was gifted to MS with a right of residence for NS.

[15] The case therefore first came to court when the Trust sought to place NS in a residential facility after the hospital admission in May 2016. This was at a time when a stay in hospital was no longer required. The issue in the case was really whether NS should be discharged to a residential facility or to the care of MS with a care package.

The Evidence

[16] I heard evidence from a wide range of witnesses in this case to determine the various applications from July-October 2016. The first witness I heard from was Dr Catherine Taggart. Dr Taggart is a consultant in liaison psychiatry and she filed two reports in proceedings dated 24 May 2016 and 30 June 2016. Dr Taggart gave

evidence about the capacity of NS to make a decision regarding where she should live. Dr Taggart stated her opinion as follows:

> "My impression is that this lady lacks capacity to make a decision about her care following discharge from hospital. I base this on the fact that her ability to register and recall information is extremely poor and she is unlikely to have the ability to retain information long enough to make a decision. Also her ability to weigh up the relevant factors in coming to a decision is impaired as is her ability to understand the consequences of going home without extra help. This was evident from her inability to engage in any meaningful discussion of the issues, giving replies which were vague and lacking in content, and at times giving no clear reply at all. This is consistent with her diagnosis of delirium and pre-existing dementia."

[17] In her second report Dr Taggart refers to a further meeting with NS and she states as a result of that meeting:

> "Her presentation is consistent of the pre-existing diagnosis of dementia. My impression is that NS continues to lack capacity to decide about her future care, primarily on the basis of very poor short term memory and also that she was unable to weigh up the factors relevant to her decision. Further, I consider her incapable of giving instruction to a solicitor."

[18] On the direction of O'Hara J the Official Solicitor obtained her own report in relation to the issue of capacity. This is a report by Dr Barbara English, consultant psychiatrist, psychiatry of old age. This report was to inform the Official Solicitor in relation to her appointment. The opinion of Dr English states as follows:

> "Considering the balance of probabilities and for the reasons outlined above my opinion is that at the time of assessment NS lacked, by reason of mental disorder, the capacity to decide on her future place of residence. Additionally, it is my opinion, based on the information outlined above and considering the balance of probabilities, that she lacked the capacity to instruct a solicitor regarding the legal proceedings related to the decision making on her future place of residence. NS is documented as having an established diagnosis of dementia, a chronic and progressive condition. I would

therefore not expect her to regain capacity in either of the above areas."

[19] I also heard evidence from a social worker, namely Pam Borland. This social worker gave evidence that she was employed by the Trust as social work lead. She referred to her affidavit of 10 June 2016. Further, this witness referred to an updated report of 24 August 2016. This witness gave evidence on a number of occasions to the court. At the outset she referred to the escalating concerns at home. She referred to the risks to NS as a result of her medical diagnosis and the fact that in her opinion NS required 24 hour residential care. This witness referred to the fact that she considered that NS could not be managed at home due to the risks set out in the papers which included NS's inability to conduct personal care, her potential to fall, risks associated with her short term memory, and risks associated with the abuse of alcohol. It was as a result of these issues that the witness referred to the fact that a residential care home placement was attempted at the start of 2016, first in January 2016 and then in March 2016. Whenever NS was taken out of the home in March 2016 this witness referred to the fact that MS was reluctant to engage with social services or professionals. He was not able to contemplate NS returning to the care of residential staff.

[20] Mr Fred Davidson also gave evidence in July 2016 in relation to the first application. He is a senior social worker with at the relevant hospital where NS was a patient. He gave evidence in relation to the fact that NS was ready to be discharged from hospital. He referred to extreme difficulties in engaging MS about the proposed plan forward and he agreed with the plan for residential care.

[21] I heard evidence from Mr James Pringle who is a solicitor in Tughans Solicitors in Belfast. This was at the September hearing. This witness was called by summons of MS. He gave evidence at the September hearing that his firm were involved in the administration of MS's late father's estate. He referred to two issues. Firstly, he explained that MS wanted to have his mother's right of residence in the former family home released. This was to facilitate MS re-mortgaging the property to raise money. In particular MS wanted to invest in a Guernsey based company which provided some tax relief. Mr Pringle gave evidence about his concern that there was a conflict of interest regarding this issue. In particular there was no agreement in relation to MS taking on the repairs and outgoings of the property if the right of residence was released.

[22] Mr Pringle also gave evidence that the EPA of 17 April 2016 was not valid and no further instructions were given in relation to this. Mr Pringle gave evidence of MS's difficult presentation when dealing with his firm. He referred to an incident late one Friday evening, which he thought was about May or June 2016, where MS was escorted off the premises having gained access to the fourth floor.

[23] At the September hearing I also heard evidence from Dr G McPherson, consultant in psychiatry, old age. Dr McPherson gave the following opinion:

> "I feel NS lacks sufficient mental capacity to make a decision about her care needs and placement. I base this on the fact that her ability to recall information is extremely poor. She was inconsistent and was not able to retain or weigh up information discussed about her needs and risks in order to make a decision. While she talks about going home she is unable to identify where this would be and is easily distracted by the care assistants in the residential facility. This would be in keeping with her diagnosis of probable Alzheimer's disease."

[24] Dr Mc Pherson gave valuable evidence in relation to her involvement with NS since her referral as a patient in 2012. She explained the diagnosis of probable Alzheimer's disease on the basis that it is only upon histological investigations after death that the illness can be definitively diagnosed. Dr McPherson also gave important evidence in relation to three issues raised by MS who disputed that his mother was incapable. She was quite clear that the use of haloperidol medication would not affect her opinion in relation to capacity. She was also quite clear that NS's fluctuating depression would not affect her opinion in relation to capacity. Finally, she was clear that issues of NS's IQ would not affect her opinion in relation to capacity.

[25] In addition to oral evidence I also received comprehensive reports from the Alzheimer's Society who set out a summary of their advocacy involvement with NS. I further considered records in relation to the care of NS including occupational therapy reports and care management reports. I considered a letter which I received from NS's daughter dated July 2016. In this letter her daughter confirms her support of the Trust plan for a move of NS to residential care. This letter also sets out some difficulties that characterise MS's presentation. I have considered the OS reports.

[26] At the hearing on 30 September when the evidence resumed I heard again from Ms Borland. At this hearing I was told that NS had been in the hospital for one week as a result of an infection. I raised my concern that this matter should have been drawn to the attention of the court prior to a hearing given the nature of any application under the inherent jurisdiction of the court. The witness proceeded to state that NS was transferred to hospital as a result of an infection. The witness referred to NS's underlying medical conditions such as chronic obstructive pulmonary disorder, hyperthyroidism and an issue with her back. At this hearing the witness stated that the patient would be ready for discharge from the hospital in the next number of days.

[27] This projection did not come to pass and this case came back to court on 5 October 2016. On this occasion a further summons was presented for declaratory relief in relation to NS. The context of this was that NS had sustained a fracture to her left femur. I was also told that there had been a fall at the residential facility on

23 September. That was information which was not made available at the last hearing date.

[28] On 5 October I heard evidence in relation to the proposed surgery to treat the fracture. I should say at the outset that all parties including MS accepted that NS should have surgery if she was fit for it given that she was in considerable pain having sustained such an injury. I can therefore deal with the evidence in relation to this issue fairly briefly. Dr Gary Heyburn, Consultant in Acute Ortho-medicine, gave evidence. He stated that as soon as the fracture was noted it was decided that an operation was the only real option for this lady. He indicated that his practice is to operate on patients with a hip fracture even though they may have significant comorbidities like NS. The doctor gave evidence in relation to the risks of surgery however he said that there was not any real choice in relation to this. He said that it would be inhumane to allow NS to suffer without this operation. Dr Heyburn referred to the fact that after the operation NS would require a period of approximately 5 days in hospital and thereafter that she would be transferred for a rehabilitative period which might involve up to 6 weeks in a specialist hospital.

[29] Dr Richard Yamin-Ali, a consultant anaesthetist also gave evidence. He referred to the fact that NS had been deemed to be fit for surgery. He said that this would be checked on the morning of the actual operation.

[30] Dr Dearbhail Lewis, consultant psychiatrist, also gave evidence that in her view NS was not capable of giving consent to the proposed surgery. Dr Lewis opined:

> "In summary, NS was unable to recall the very vast majority of the information given to her by Dr Espey. While she clearly expresses a wish to proceed with surgery, her weighing up is affected by extremely limited appreciation of the risks associated with surgery."

This witness also referred to her view that a delirium could develop due to NS's presentation.

[31] In relation to this medical treatment MS asked some appropriate questions of the witnesses. However, he did not raise any substantial objection to the surgery as he too did not want his mother to be in continuing pain.

[32] I reconvened the court and I heard further evidence on 11 October 2016 in relation to the outcome of NS's surgery, her predicted rehabilitation, and any associated issues in relation to her care whilst in the residential home. The Trust called some further witnesses in relation to the matter. Mr Potter also outlined the position in opening to me in relation to the hip fracture. He said that NS fell at the home on 23 September 2016. He said that NS was admitted to hospital with suspected pneumonia on 25 September 2016. He referred to indicators of hip and leg

pain on 26, 27, 28 and 29 September 2016. He said that X-rays were then requested. X-rays were taken on 30 September. Mr Potter said that no fracture was detected until a registrar radiologist viewed the X-rays on 3 October. On that date the fracture to the femur was noted. Prior to that date NS had been in the respiratory unit of the hospital. On 4 October NS was transferred to the fracture unit. I made a declaratory order in relation to NS's care on 5 October. I was told that on 6 October surgery took place in the nature of a partial replacement of the left hip joint. I was told that the surgery was successful and that NS would now undertake a period of rehabilitation.

[33] Ms Borland also gave evidence about the circumstances of the fall. She said that his happened on the afternoon of 23 September. She said that the Trust was notified as there would have to be a care management review. This was referred to what was described as the Quality Monitoring Team on 26 September. Ms Borland described this team as overseeing the care of residents and domiciliary providers. Ms Borland said that the RQIA was notified. Ms Borland referred me to documents which indicated that prior to the fall NS was assessed as a low risk of falls and was mobilising independently. She referred to falls prior to admission to hospital in December 2015/January 2016. Ms Borland stated that after the fall NS was assessed by a staff nurse on site. It was her evidence that there was no reason to believe there was an injury as NS moved independently that afternoon.

[34] Ms Borland referred me to observations of NS in the care home after the fall. There were indicators of pain after this fall but Ms Borland rightly referred to the fact that NS also has a serious back condition. The GP was therefore not contacted. The protocol appears to be that after the first fall the GP will not necessarily be contacted. After a second fall the GP will be contacted but this protocol must depend on the circumstances of the case. NS's daughter was notified via her husband. MS was not notified.

[35] The evidence then continued that NS was admitted to hospital because there was confusion noted in her presentation. The GP was contacted and queried whether or not NS was having a stroke. In terms of the assessments required after the surgery Ms Borland referred to the fact that as the surgery was successful NS was likely to be discharged from hospital in the coming days. It was then anticipated that she would be placed in another hospital for rehabilitative treatment which may take 3-6 weeks but would depend on recovery. After that Ms Borland accepted that there were 3 options, namely a return to the residential care in which NS resided, a placement with MS which the Trust did not support or a different placement which would involve nursing care. In cross-examination Ms Connolly referred this witness to the fact that NS had chronic difficulty with her back including a fracture which has gone back 15 years.

[36] In cross-examination of this witness MS made the valid point that he was not informed about this fall. Ms Borland accepted that that was not correct procedure and he should have been informed and that there was an error in communication.

MS made the case that his mother had been asking for medical assistance and was denied the attendance of the GP. Ms Borland disputed the assertion. MS referred to a bruise which was on his mother's leg on 16 September and suggested that this may be an indicator of lack of care. He also referred to a number of hospital admissions from August to September 2016. MS stated that there was no common sense in that his mother was not taken to hospital immediately after the fall and there was no proper assessment. He referred to the fact that prior to going into the residential home staff in the Office of Care and Protection had seen his mother walking. He suggested that she then deteriorated to the extent that she relied more on a rollator and then she had broken her hip. MS suggested that this showed that the placement at the care home was not the best place for his mother. He said his mother should come home to the flat and he would pay for carers and that this was what she wanted. MS made a case that this witness had effectively been excluding him from decision making and described her as operating in military style.

[37] I asked Ms Borland why I was not informed about the fall when she was giving evidence previously on 30 September. The witness confirmed that she knew about the fall at that time however she accepted that she did not give evidence about it because she was not specifically asked about it. She did say that the first question to her was to describe events from 23 September and she said she intended to go back to the issue of the fall but that did not form part of her evidence.

[38] I then heard from Dr Patterson, consultant geriatrician. Dr Patterson has been working on NS's case for some time. She looked after NS when she was on the respiratory ward. Dr Patterson referred to the fact that there was no obvious and severe pain on the respiratory ward related to NS's leg up to 3 October. On that date she noted deterioration and that NS could not weight bear. Dr Patterson said this was very different from the previous examinations and then it became clear from radiological review that there was a fracture of the hip. Before that she said that there was no clinical suspicion on the basis of the presentation of the patient. MS disputed this case on the basis of the history that he presented. He also put to this witness that whenever his mother was in hospital in January that she was effectively kept in hospital at a time when she should have been released into his care. This witness was clear in saying there was a query about NS's capacity at that time and that is why an application was brought to court for declaratory relief prior to any release from hospital.

[39] I also heard from Mr Mullan, consultant orthopaedic surgeon. He gave helpful evidence to say that in his opinion the fracture could have occurred from 2-3 weeks before it was detected. He said that was because there was no callous reaction on the X-ray. He said that the facture was a displaced fracture. He said that a displaced fracture will cause more pain than an un-displaced fracture. He referred to the possibility that this fracture had previously been un-displaced and then was displaced. He opined that that may explain the progression of pain. Mr Mullan referred to the fact that he saw NS the day before and that she was doing well and that he agreed with Ms Borland that she was ready for release from hospital in the

next few days and that she would then undertake recovery. MS cross-examined this witness about the 16 September bruising which he said was indicative of ill-treatment prior to the fracture occurring. Mr Mullan could not be definitive about that.

Legal Context

[40] The applications are brought to the court under the inherent jurisdiction of the High Court. The Trust sought a declaratory order in June to move NS from a hospital to a care home. This was opposed by MS who said that he could care for NS. However, the Trust and the Official Solicitor acting on behalf of NS felt that she would only receive the appropriate care and treatment befitting her needs in the care home. The test in relation to this has been set out by Mr Potter in a skeleton argument. He articulates this as a two-fold test, namely:

(a) whether or not NS has the capacity to provide a legally valid consent to the proposed care and treatment; and

(b) that the proposed care and treatment is necessary and in her best interests.

[41] The consideration of this case falls within the common law jurisdiction. I was referred in particular to Re F (Medical Sterilisation) [1992] AC 1, Re S (Adult Patient) [2001] Fam 38, Re S (Adult Patient) [2003] 1 FLR 292, Re SA (Vulnerable Adult with capacity: Marriage) [2006] 1 Fam 867. These cases reiterate the two-fold test in the case of RE MB (Medical Treatment) [1997] EWCA Civ 1361 to which I was also referred. In this case the issue of capacity is dealt with by Butler-Sloss LJ as follows:

> "A court should approach the crucial question of competence bearing in mind the following principles – every person is presumed competent to consent to, or to refuse, medical treatment unless and until that presumption is rebutted. A competent woman may choose, even for irrational reasons not to have medical intervention, even though the consequence may be of death of or serious handicap to the child she bears or her own death.
>
> A person lacks capacity if some impairment or disturbance of mental function rendered the person unable to make a decision whether to consent to, or refuse treatment, such an incapacity existed where: a person was unable to comprehend or retain information material to the decision and was unable to use the information and weigh it in the balance as part of the process of making the decision required."

[42] The court will obviously be guided by medical evidence in relation to these questions however they are ultimately matters to be determined on the facts of each case. The reason why the application is brought however is because of the European Convention on Human Rights (ECHR) and in particular Article 5 the right to liberty and Article 8 the right to a private and family life. I was referred to the case of HL v UK [2004] EHRR 40 where the European Court held that a hospital's decision to detain a person without capacity on the basis of common law necessity did not satisfy the requirements of Article 5. It held that there was no adequate procedure in those safeguards. I was also referred to Re Connor [2004] NICA 45 which acknowledged the necessity for a health authority to take proper cognisance of a patient's Article 8 rights.

[43] In England and Wales there is a structure under the Mental Capacity Act of 2005 to deal with these issues and there is a bespoke court of protection. In Northern Ireland the relevant provisions of the Mental Capacity Act have not come into force as yet. Consequently, the court's inherent jurisdiction must be invoked to deal with these issues when Article 5 is engaged. I did enquire whether or not guardianship under the Mental Health (Northern Ireland) Order 1986 would be a sufficient remedy. Mr Potter referred me to a Northern Ireland Court of Appeal decision of JMcA v Belfast Health & Social Care Trust [2014] NICA 37 whereby the court determined that guardianship did not satisfy the requirements of Article 5. In this case the application for a residential placement involves NS being placed in a locked ward and as such it was accepted by all parties that this constitutes a breach of Article 5.

[44] It follows that I am satisfied that I can only deal with the Article 5 case under the auspices of the inherent jurisdiction of the High Court. The Supreme Court in the case of P (By his litigation friend the Official Solicitor) (Appellant) v Cheshire West and Cheshire Council and another (Respondents) [2014] UKSC 19 reiterated the fact that Article 5 is engaged in cases of this nature. The test of whether or not there has been a deprivation of liberty is whether the person in question is under continuous supervision and control and not free to leave the place where he or she lives. The "benevolent" nature of the care arrangements should not be confused with the concept of deprivation of liberty. Human rights have a universal character and what would be a deprivation of liberty for a non-disabled person is also a deprivation of liberty for a disabled person. This remains the case even when the person in question is living contentedly in a domestic environment.

[45] Any deprivation of liberty requires to be authorised pursuant to Article 5(4). There is now a structure for this under the Mental Capacity Act in England and Wales. This follows the decision of R-v-Bournewood Community and Mental Health NHS Trust ex p L (Secretary of State for Health and others Intervening) [1998] 3 All ER 289 and HL v United Kingdom [2004]. A request for authorisation is made by the requisite managing authority. There is usually a short order made at first. There has to be a facility for review. The other direction which I take from the English system is that there should be a provision for liberty to apply whereby there can be recourse

to courts if circumstances change or if there is a need to bring any matter to the attention of the judge. This has been the position within the Northern Ireland courts where these cases are dealt with in the Family Division under the inherent jurisdiction of the court. This is a division which allows for applications to be made with flexibility and at short notice and the courts have applied a built in review mechanism to cases of this nature.

[46] This case therefore involves consideration of a number of questions which I summarise as follows:

(i) Is the patient incapable of making a decision regarding the particular issue put before the court?

(ii) If so is the plan/treatment proposed in the best interests of the patient?

(iii) Is the intervention necessary and proportionate pursuant to Article 8 of the ECHR?

(iv) If the plan involves a deprivation of liberty under Article 5 of the ECHR should that be authorised by the court and if so under what terms regarding duration and review?

Submissions of the Parties

[47] I am very grateful to Mr Potter for his assistance in explaining the legal context for these types of applications. Mr Potter filed a useful written argument and he made oral submissions to the court. Mr Potter argued that the first application should be granted to allow for the transfer of NS from hospital to an appropriate facility. At the hearing in July Mr Potter argued for an order for 6 months. At the hearing in September Mr Potter argued for an order for 1 year. However, I allowed Mr Potter some time to consider the position upon NS's surgery.

[48] I reconvened the court after 30 September to hear further submissions in relation to this. After that hearing Mr Potter made further submissions which I summarise as follows:

(i) That the residential care home had provided appropriate care, they had hospitalised NS when necessary. The hip pain had increased in hospital consistent with the fracture becoming displaced. He referred to Dr Patterson stating that the severe pain was on 3 October and surgery was 3 days later.

(ii) Mr Potter stated that NS was well that she would be discharged soon into rehabilitation. He opined that it was reasonably likely that it would only be at the end of November that a decision would be taken as to whether or not NS should be returned to the care home or a nursing care placement.

(iii) Mr Potter referred me back to the authorities.

(iv) Mr Potter referred to a revised draft order which he said would now cover the issues in relation to the intervening event.

[49] Throughout the case MS made a number of submissions to me. Many of these were incoherent, repetitive and rambling. At times MS was disrespectful and antagonistic in his presentation towards professionals. However, MS could also be engaging with the court and at times he asked appropriate questions. I understand that this type of case stirs human emotions. I take into account MS's own personality. It was clear to me at every stage in these proceedings that MS has objected to his mother being placed in residential care. He stated that his mother does not want this as she wants to go home and to live with him. In addition he made a number of points to me as follows:

(i) MS made the case that he had worked with the Trust before in particular when his father was ill and that he was a carer for his father. He made a case that the Trust was in some way responsible for his father's death on the Liverpool bypass.

(ii) He made a case that being at home was not harming his mother.

(iii) He made a case that NS was being harmed in residential care. He also said that he was the person having to point out NS's need for medical assistance in hospital. He also made the case that he had to attend at the hospital on many occasions including into the early hours of the morning.

(iv) MS made the case that both the EPAs should stand. He produced some documentary evidence from a Minister in America in relation to this. He suggested that Mr Pringle had not been truthful under oath. He presented a letter from Nigel Dodds dated 25 August 2015 and a letter from Alban McGuinness of 8 September 2015. He also referred to various letters of 8 September 2015 and a letter from the court of 23 September 2015. In relation to these he stated that NS clearly has capacity and that the people dealing with NS have noted this in the correspondence.

(v) MS consistently throughout the hearing asked that his mother attend at the court to express her own views. He also said that the capacity reports were not independent. He indicated at various stages that he wanted to obtain an independent report and also get a human rights barrister in London for this case.

(vi) MS indicated that there was a financial issue in this case and that the Trust was financially liable as a result of keeping NS in residential care. He asked that a cheque be paid for that money immediately.

(vii) MS said that his mother was not being properly represented and he objected to the appointment of the Official Solicitor. He said that Dr English was not independent. He said that Dr McPherson also was not independent and he referred to Dr Taggart and that her conclusion could be wrong.

(viii) MS indicated that he had brought his mother to the Official Solicitors office and the Office of Care and Protection and that she had requested to go home to various staff. Overall MS made a clear case that he thought his mother had capacity, also that he could care for her and that the Trust had acted unlawfully in placing his mother in residential care and also that various solicitors had acted improperly.

[50] MS made further submissions after the reconvened hearing as follows:

(i) He opposed the paragraph 6 provision of the Trust revised draft order whereby the Official Solicitor would remain involved.

(ii) He referred to the EPA which he said was still subject to appeal. In relation to the EPA he referred to the fact that there should be a subpoena for the phone records of Mr Pringle, a transcript of telephone calls between himself and Mr Pringle and telephone records from Tughans Solicitors over a one year period.

(iii) MS stated that he required that Mr Maginness, from the Directorate of Legal Services to attend at court immediately to pay £2.7million to him which is a figure that he calculated as compensation for his mother's detention. He said that the figure continued to rise each day.

(iv) MS required that 5 members of the Office of Care and Protection should attend at court and give evidence that they saw his mother when he brought her down to the court office and that they could assist the court. He also said that Ms Rosalind Johnston should be required to give evidence in relation to her observations of his mother.

(v) MS said that he was very happy that the operation had taken place and was successful. He was also very happy that his mother should undertake rehabilitation at a hospital. It was the next part of the plan he was not happy with, he said his mother should come home after that. He also said that the Trust were negligent in their care of NS in the residential home.

[51] Ms Connolly who conducted the case in a tactful manner on behalf of the Official Solicitor made the following submissions throughout the case:

(i) Throughout the proceedings Ms Connolly rejected any suggestion that NS should come to court. She referred to the diagnosis and the medical condition

which NS has and she said that it was not appropriate for her to come to court.

(ii) Ms Connolly said that the OS had been properly appointed and that she was both a solicitor for NS and her guardian ad litem. Ms Connolly stated that there were now a number of opinions that indicated that this lady did not have capacity and that was also the view of the Official Solicitor.

(iii) Ms Connolly stated that in relation to best interests that the Official Solicitor had never had a closed mind in this case. The Official Solicitor had asked for a short order at the outset to properly check on the position in relation to residential care. At the hearing the Official Solicitor kept the matter under review.

(iv) The OS was satisfied with how NS had been looked after within the home. If the court were to make a declaratory order in relation to her ongoing placement in residential care the OS made a case that there should be a specific addition to the declaration in relation to the regulation of contact and conduct of third parties during contact with the patient. The OS indicated that a 12 month order would be appropriate.

(v) After the reconvened hearing Ms Connolly made submissions in relation to NS. She indicated that the Official Solicitor had visited NS that day. The OS reported that NS had little comprehension as to why she was in hospital but she was in good form and was positive about her previous care placement. Ms Connolly rightly referred to some uncertainty about her future placement. She referred me to paragraph 6 of the revised declaration which would retain the Official Solicitor's involvement and she indicated that the OS had no difficulty with that.

[52] I also heard submissions about the EPA appeal. I indicated that as I had heard from Mr Pringle I was also willing to hear this appeal as part of the ongoing declaratory proceedings. However, MS indicated that he did not want to pursue the EPA appeal without the presence of an independent report. I suggested that the appeal could be adjourned generally until MS was in a position to litigate upon it and that was agreed by all parties. The applications by MS for Mr Pringle's phone records and phone records from Tughan's Solicitors can be dealt with when MS applies to have the appeal re-entered for hearing.

Conclusions

[53] Having heard all of the evidence and considered the papers in this case and having heard the submissions of the legally represented parties and the submissions of MS throughout this case my conclusions are as follows.

[54] I am of the view that NS lacks capacity. I take this view on the basis of the evidence I have heard from Dr Taggart and Dr McPherson. Their opinions are confirmed by the report from Dr English and I consider that all doctors have applied the appropriate legal test and that NS simply does not have the capacity to either make a decision about where she should live or a decision in relation to her medical treatment. In relation to that latter issue I also heard from Dr Lewis. I accept the diagnosis of probable dementia. This is a chronic and progressive condition.

[55] I consider that it is and has been appropriate for the Official Solicitor to represent NS as her solicitor and guardian. She has been appointed to conduct litigation on behalf of NS and she has done so with conspicuous care. The OS has also been there to safeguard the best interests of NS although ultimately a decision in relation to best interests is for the court. However, I consider that the OS was correct to object to NS coming to court at any stage given her diagnosis and that is why I did not accede to that application made by MS.

[56] Having decided upon capacity I have to determine what is in the best interests of NS in terms of her care. In this case I only made a short interim order on the first occasion in July because I wanted to see how the residential care placement would progress. At that stage I decided that residential care was clearly what was necessary for NS. I made this assessment on the basis of a number of factors. It seemed clear to me that NS needed 24 hour support by dedicated carers in a residential home. Secondly, without reiterating all of the difficulties it had not been a happy time at home prior to the move to residential care.

[57] I also find that MS was not able to provide for the needs of NS at home. I do not accept MS's case that this plan was agreed and then reneged upon by social services. I do not accept that because care services issued an apology at one stage to MS that he is an appropriate carer. I accept that MS is named on a letter regarding receipt of benefits for his late father but that does not mean he was his primary carer. NS also looked after her husband. Even if the letter MS relies upon means that he was a primary carer for his father that does not translate into an ability to care for NS given her particular needs. MS does not accept the medical diagnosis and as such I cannot see that he could properly attend to NS's care including provision of medication and socialisation. Finally, and critically, having observed MS over a number of months during this court process, I consider that MS is not able to cooperate with medical professionals or social services to the extent that he could care for NS at home in any respect even with an extensive care package. I do not consider that this is likely to change.

[58] There were no issues raised by the Trust when I heard this case in September regarding the residential placement. However, I queried the issue of NS being in hospital for an extended period in September. That was a significant change and it ultimately led to the case coming back to me in early October. The fracture issue is important and it will obviously have to be investigated. I heard some evidence about the aetiology of the fracture however I am sure that this matter will be the

subject of further investigation and that may include independent investigation. As such I do not consider that it is appropriate for me to make evidential findings on this issue at this stage. I do not accede to MS's application that I should make a finding of negligence against the Trust. I explained to him that such a course was outside the remit of this case.

[59] However, I will say that I have concerns about how this issue was dealt with during this litigation. Firstly, the issue of NS being in hospital was only explained at the 30 September hearing on my instigation. Secondly, the fall was not mentioned in evidence on 30 September even though the Trust knew about it. I am not satisfied with Ms Borland's explanation regarding this. Thirdly, the fall was not communicated to MS which Ms Borland said was an error. There may be nothing at all improper about this but in my view the communication about this important matter was substandard. This gave the court the impression that the Trust was not entirely forthcoming about a significant aspect of NS's care. This is in the context of a case where her son has asserted that the Trust is not looking after her properly. In my view, the fact that NS sustained a fracture during her tenure in the residential home and the way it was handled changes the complexion of the case.

[60] It follows that a hearing will be required in this case to assess the placement options for NS in the future following her rehabilitation. That could be done by way of making a full order as requested for one year with a review when the time arises that NS is discharged from rehabilitation. Or I could decline to make any further declaratory order on the first summons, given that my order of 5 October covers the rehabilitation period. In that instance the health authority would have to bring a further application if a deprivation of liberty is contemplated. That would have to be properly vouched with evidence. I have considered both options and I am of the view that as this issue will require court adjudication in any event that I should not make any further order on the first summons. There is no necessity for me to make the order. It is a wide permissive order which deals with a deprivation of liberty. I consider that the court should scrutinise such an application rather than grant a pre-authorisation to the Trust. In this case I am unsure whether it would constitute a deprivation of liberty if MS were to be placed in a specialist nursing care facility. The original application was only mounted because of the locked ward in the care home. A fresh application can be made as and when the need arises. It seems to me that the declaratory order I made in relation to medical treatment of 5 October 2016 covers the position until that time. If any amendment is needed to that order I will allow the parties liberty to apply.

[61] I consider that the temporary residence of NS at the residential facility pursuant to the order of 8 July 2016 and subsequent interim orders was proportionate under Article 8 ECHR. The placement was also authorised in accordance with Article 5 of the ECHR.

[62] Given MS's request I will adjourn the appeal from Master Wells' decision regarding the enduring powers of attorney. This will be adjourned generally and

MS can re-enter the appeal when he has obtained the information that he needs to do that.

[63] I do encourage MS to obtain legal representation in relation to the outstanding appeal and for any future case in relation to declaratory relief. During my involvement in the case MS has had the benefit of assistance from the Law Centre who had an interest in his mother's case. He also indicated that at one point another Solicitor was willing to take his case on. Most recently MS has said he is obtaining assistance from a human rights barrister in London. I hope that some legal assistance will be obtained by MS otherwise the court will have to actively regulate future hearings.

[64] MS has also lost a number of files of papers during the currency of proceedings which has made the sharing of information difficult. This has prolonged the court process as extensive oral evidence has had to be called to allow MS to hear and deal with the issues. MS has been offered the opportunity to view some relevant health records at the Trust and the Official Solicitor's offices which he declined. I hope that in the future MS will be able to conduct the litigation in a more purposive way as that will hopefully lead to a more efficient use of court time in dealing with the important and sensitive issues in this case.

[65] I finish this judgment by saying that I hope that NS can now obtain some comfort and settlement as she recovers from her operation. I have already said that MS needs to try to show respect for the medical professionals and social services who are trying their best to provide for NS. I understand that he wants NS to return home to him however I cannot see that that is a feasible option.

[66] Accordingly, I will make no further interim declaratory order. I will adjourn the original summons generally and the Trust can re-enter the case at an appropriate time if necessary and depending upon the circumstances that evolve from NS's rehabilitation. This means that the OS remains appointed. My order of 5 October 2016 governs the care of NS pending any further adjudication by the court. I am receptive to the point raised by the OS about further definition being brought to the declaratory relief however I do not consider that is necessary at this stage. There is liberty to apply if the need arises but I am hoping that MS will not cause any difficulties whilst his mother is recuperating.