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For Action by: NHS Trust and Local Health Board Chief Executives

**Action required:
Cascade as appropriate**

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Advice on the decision of the European Court of Human Rights in the case of HL v UK (The "Bournewood" Case")

Purpose

1. This note is to provide further information for NHS bodies and local authorities about the implications of the judgement of European Court of Human Rights in the case of HL v UK (the "Bournewood" case). Similar guidance has been issued by the Department of Health for NHS Bodies and Local Authorities in England and it covers:
 - a summary of the case and the key points of the judgement (paragraphs 2 – 29)
 - steps to be taken by the UK Government to develop proposals for new procedural safeguards (paragraphs 29 – 30)
 - steps that might be taken in the interim by NHS bodies and local authorities pending the development of those new safeguards (paragraphs 32 – 38)

Please note that the Welsh Assembly Government cannot provide legal advice to individual NHS bodies, local authorities, or independent providers. They must continue to take their own legal advice in these matters.

The Case

2. The case concerned a man (Mr L) in his 40s with autism and learning disabilities. He is unable to speak and his level of understanding is limited. He is frequently agitated and has a history of self-harming behaviour. He lacks the capacity to consent or object to medical treatment.
3. For over 30 years Mr L was cared for in Bournewood Hospital ("the hospital"), a National Health Service trust hospital. In March 1994 he was discharged on a trial basis to paid carers with whom he successfully resided until July 1997.
4. In July 1997 Mr L was readmitted to Bournewood Hospital after an incident at a day-care centre when he became particularly agitated, hitting himself on the head with his fists and banging his head against the wall.
5. His consultant at the hospital considered detaining him under the Mental Health Act 1983 ("the 1983 Act") but concluded that that was not necessary as he was compliant and did not resist admission. Mr L was therefore admitted as an "informal patient", in his own best interests under the common law doctrine of necessity. This was in line with standard practice. The consultant confirmed (in her submissions in the judicial review proceedings referred to below) that if the applicant had resisted admission, she would have detained him compulsorily under the 1983 Act as she was firmly of the view that he required in-patient treatment for his mental disorder. For clinical reasons, the

consultant advised Mr L's carers against visiting him initially, it appears on the basis that Mr L would think each time that he could go home with them.

6. Around September 1997, legal action was begun on Mr L's behalf to secure (amongst other things) his discharge from hospital. The action was unsuccessful in the High Court, but in December 1997 the Court of Appeal held that Mr L had been unlawfully detained. It also found that because of the Mental Health Act 1983 the common law doctrine of necessity could not be used to detain someone for treatment for mental disorder. Following this Mr L was formally detained under the Mental Health Act 1983, but was then discharged about six weeks later.
7. The Court of Appeal's judgement was subsequently overturned on 25th June 1998 by the House of Lords who found that Mr L had not been detained. The case was then taken to the European Court of Human Rights ("the European Court"). A hearing took place on 27 May 2003, and the Court's judgement was published on 5 October 2004. The Court found that there had been a violation of Articles 5(1) and 5(4) ("Right to liberty and security") of the European Convention on Human Rights. It held that these findings of violation themselves constituted "just satisfaction" and therefore rejected Mr L's claim for damages. Mr L was awarded costs against the UK Government of around €27,000.
8. The full text of the judgement can be found on the European Court's website at <http://www.echr.coe.int/Eng/Judgments.htm> (Application number 45508/99)

The judgement and its implications

9. The case has important implications for NHS bodies, local authorities and other bodies involved in providing or arranging the care and treatment of people who lack capacity to consent to treatment in hospital and possibly in other residential settings as well. (For convenience such people are referred to in this note as "incapacitated.")
 10. Public authorities, NHS bodies and local authorities are required by the Human Rights Act 1998 to act in a way which is compatible with Convention rights (except to the extent that they are prevented from doing so by primary legislation which cannot be read in a way which is compatible with the Convention).
- (a) *Deprivation of liberty***
11. The European Court found that Mr L had been deprived of his liberty within the meaning of Article 5(1) of the Convention which, in so far as is relevant, reads as follows:

"1. Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law: ...

(e) the lawful detention ... of persons of unsound mind, ...;

12. It is important to note that this judgement does not concern the treatment of incapacitated patients generally. It was concerned only with the question of deprivation of liberty of an incapacitated person.

13. The European Court made clear that the question of whether someone has, in fact, been deprived of liberty depends on the particular circumstances of the case. Specifically the Court said that:

“It is not disputed that in order to determine whether there has been a deprivation of liberty, the starting-point must be the specific situation of the individual concerned and account must be taken of a whole range of factors arising in a particular case such as the type, duration, effects and manner of implementation of the measure in question. The distinction between a deprivation of, and restriction upon, liberty is merely one of degree or intensity and not one of nature or substance.” [Paragraph 89 of the judgement]

14. The European Court’s judgement does not, therefore, mean that incapacitated patients admitted to hospital or to care homes are automatically deprived of their liberty, even if staff would prevent them leaving unescorted for their own safety.

15. There must be particular factors which provide the “degree” and “intensity” to render the situation one of deprivation of liberty. The factors might relate, for example, to the type of care being provided, its duration, its effects and the way in which the admission came about.

16. In this case, the European Court said that

“the key factor in the present case [is] that the health care professionals treating and managing the applicant exercised complete and effective control over his care and movements”

and, noting that Mr L had been resident with his carers for over three years, the Court went on to say that

“the clear intention of Dr M and the other relevant health care professionals to exercise strict control over his assessment, treatment, contacts and, notably, movement and residence: the applicant would only be released from the hospital to the care of Mr and Mrs E as and when those professionals considered it appropriate.” [Paragraph 91]

17. Accordingly, the Court found that “the concrete situation was that the applicant was under continuous supervision and control and was not free to leave.” [Paragraph 91]

18. The Court attached particular importance to the fact that Mr L had a settled home with his paid carers to which he was prevented from returning and that his contact with those carers was (to some extent) restricted by the staff of the hospital. The Court did not consider the issue of whether the ward was “locked” or “lockable” to be determinative.

(b) *Lack of procedural safeguards*

19. Unlike the Court of Appeal, the European Court did not find that Mr L's rights had been breached simply because he was admitted to hospital on the basis of the common law doctrine of necessity (i.e. in his "best interests"), rather than under specific statutory provisions (e.g. the Mental Health Act 1983).
20. However, the Court did find that the absence of procedural safeguards surrounding his admission failed to protect him against "arbitrary deprivations of liberty on grounds of necessity and, consequently, [failed] to comply with the essential purpose of Article 5(1) of the Convention."
21. In this latter respect, the European Court was clearly influenced by the "lack of any fixed procedural rules by which the admission and detention of compliant incapacitated persons is conducted" when contrasted with "the extensive network of safeguards applicable to psychiatric committals covered by the [Mental Health Act] 1983". The Court said,

"In particular and most obviously, the Court notes the lack of any formalised admission procedures which indicate who can propose admission, for what reasons and on the basis of what kind of medical and other assessments and conclusions. There is no requirement to fix the exact purpose of admission (for example, for assessment or for treatment) and, consistently, no limits in terms of time, treatment or care attached to that admission. Nor is there any specific provision requiring a continuing clinical assessment of the persistence of a disorder warranting detention." [Paragraph 120]

22. The European Court also said,

"The nomination of a representative of a patient who could make certain objections and applications on his or her behalf is a procedural protection accorded to those committed involuntarily under the 1983 Act and which would be of equal importance for patients who are legally incapacitated and have, as in the present case, extremely limited communication abilities." [Paragraph 120]

by which it presumably had in mind the role of the nearest relative under the Mental Health Act 1983.

23. Above all, although it did not question their good faith, the Court seems to have been concerned that the hospital's health care professionals were able to assume

"full control of the liberty and treatment of a vulnerable incapacitated individual solely on the basis of their own clinical assessments completed as and when they considered fit" [paragraph 121]

24. The Court did not say that Mr L should have been formally detained under the Mental Health Act 1983. Nor, in the UK Government's view, does the judgement mean that procedural safeguards for people in Mr L's position must be identical to those for patients detained under the Mental Health Act 1983. Indeed, the Court noted the "Government's understandable concern ... to avoid the full, formal and inflexible impact of the 1983 Act."

25. However, the UK Government has accepted that to avoid further violations of Article 5(1) new procedural safeguards are required for patients who are not formally detained, but who are, in effect, deprived of their liberty in their best interests under the common law of necessity.

(c) Breach of Article 5(4)

26. The European Court also found a violation of Mr L's rights under Article 5(4) of the Convention, which reads as follows:

“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.”

27. The European Court said that Article 5(4) gives:

“The right to an individual deprived of his liberty to have the lawfulness of that detention reviewed by a court in the light, not only of domestic law requirements, but also of the text of the Convention, the general principles embodied therein and the aim of the restrictions permitted by paragraph 1: the scheme of Article 5 implies that the notion of “lawfulness” should have the same significance in paragraphs 1 (e) and 4 [of Article 5] in relation to the same deprivation of liberty. This does not guarantee a right to review of such scope as to empower the court on all aspects of the case or to substitute its own discretion for that of the decision-making authority. The review should, however, be wide enough to bear on those conditions which are essential for the lawful detention of a person, in this case, on the ground of unsoundness of mind”

28. The European Court also found that, at the time (in 1997 and 1998), neither judicial review nor any other legal remedy was sufficient to guarantee a review of this nature.

29. The UK Government's view is that action has already been taken to prevent further violations of Article 5(4)¹.

Next Steps

(a) Proposals for new procedural safeguards

30. As set out above, the UK Government accepts that to avoid further violations of Article 5(1) additional procedural safeguards are required for incapacitated patients who are not formally detained, but who are, in effect, deprived of their liberty.

31. They therefore intend to bring forward proposals for appropriate new safeguards as soon as possible. Before doing so, the UK Government has stated that it will consult with interested parties, including representative groups, the NHS and local authorities. Its aim is to ensure that there are procedural safeguards, which are effective, proportionate and deliverable in practice.

(b) Steps that might be taken in the interim by NHS bodies and local authorities

¹ The UK Government is considering whether any further action is needed in light of the Court of Appeal's judgement of 3rd of December in the case of R (MH) v Secretary of State for Health, which concerned the Mental Health Act.

32. Until these safeguards are established in law, the effect of the judgement is that it would be unlawful for an NHS body or a local authority (without the prior authorisation of the High Court) to arrange or provide care or treatment for an incapacitated patient in a way that amounted to deprivation of liberty within the meaning of article 5 of the Convention, unless the patient were detained under the Mental Health Act 1983.
33. Nonetheless, the NHS and local authorities will need to continue to provide care and treatment for incapacitated patients, and it is important that neither the safety of those patients nor the quality of the care they receive is jeopardised during the interim period.
34. Pending the development of new safeguards described above, NHS bodies and local authorities will want to consider what steps they can take in the short-term to protect incapacitated people against the risk of arbitrary deprivation of liberty and minimise the risk of further successful legal challenges.
35. It is suggested that NHS bodies and local authorities consider putting in place procedures when making arrangements to provide care to incapacitated persons. The body concerned should ensure that when determining the care to be provided, that consideration is also given to whether this would involve depriving the patient's liberty within the meaning of article 5 of the Convention, taking into account the factors identified by the Court as described in paragraphs 12 to 19 above. The same question will need to be asked when reviewing the circumstances of those people who they have already placed who may, in practice, be deprived of their liberty.
36. If patients are considered to be deprived of their liberty (or at risk of it), consideration should always be given to alternatives to ensure that they get adequate care but which falls short of deprivation of liberty. In particular, authorities will want wherever possible to avoid situations in which professionals may be said to take "full and effective control" over patients' care and liberty.
37. Elements of good practice which are likely to assist in this, and in avoiding the risk of legal challenge, may include:
 - ensuring that decisions are taken (and reviewed) in a structured way, which includes safeguards against arbitrary deprivation of liberty. There should, for example, be a proper assessment of whether the patient lacks capacity to decide whether or not to accept the care proposed and that decision should be taken on the basis of proper medical advice by a person properly equipped to make the judgement
 - effective, documented care planning (including the Care Programme Approach where relevant) for such patients, including appropriate and documented involvement of family, friends, carers (both paid and unpaid) and others interested in their welfare
 - ensuring that alternatives to admission to hospital or residential care should be considered and that any restrictions placed on the patient while in hospital or residential care should be kept to the minimum necessary in all the circumstances of their case

- ensuring appropriate information should be given to patients themselves and to family, friends and carers. This would include information about the purpose and reasons for the patient's admission, proposals to review the care plan and the outcome of such reviews, and the way in which they can challenge decisions (e.g. through the relevant complaints procedure). The involvement of local advocacy services where these are available could be encouraged to support patients and their families, friends and carers
- taking steps to help patients retain contact with family, friends, carers, with proper consideration given to the views of those people. If, exceptionally, there are good clinical reasons why that is not in the patient's best interests, those reasons should be properly documented and explained to the people they affect
- ensuring both the assessment of capacity and the care plan are kept under review. It may well be helpful to include an independent element in the review. Depending on the circumstances, this might be achieved by involvement of social work or community health staff, or by seeking a second medical (or other appropriate clinical) opinion either from within the organisation or elsewhere. Such a second opinion will be particularly important where family members, carers or friends do not agree with the authority's decisions. But even where there is no dispute an authority must ensure its decision making stands up to scrutiny;

38. If it is concluded that there is no way of providing appropriate care which does not amount to deprivation of liberty, then consideration will have to be given to using the formal powers of detention in the Mental Health Act 1983. However, it is important to remember that:

- nothing in the judgement changes the requirements in the Mental Health Act which must be met before patients can be detained. It should not therefore be assumed that all patients who are to be subject to restrictions that may amount to deprivation of liberty can be detained under the Act. (For example, it would be unlawful to detain patients under the Act if their mental disorder does not warrant detention in hospital, although reception into guardianship under the Act might be appropriate in some cases.)
- there are dangers in using the Act simply to be "on the safe side". Although it provides procedural safeguards, the use of the Mental Health Act will not necessarily be welcomed by patients themselves or by their family, friends or carers, given the "stigma" that is often (wrongly) perceived to attach to it. Moreover, a significant increase in the use of the Mental Health Act will inevitably put considerable further pressure on local authority approved social workers, the availability of second opinion appointed doctors (SOADs) and on the operation of Mental Health Review Tribunals (MHRT).

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