Neutral Citation Number: [2020] EWCOP12

Case No: 13398706

IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 11/03/2020

Before :

THE HONOURABLE MR JUSTICE HAYDEN
VICE PRESIDENT OF THE COURT OF PROTECTION

- -

Between :

THE HEALTH SERVICE EXECUTIVE OF IRELAND	**Applicant**
- and -	
ELLERN MEDE MOORGATE	**Respondent**

- -
- -

Mr Henry Setright QC, Alexander Ruck Keene and Katherine Barnes (instructed by **Bindmans LLP**) for the **Applicant**

Hearing dates: 12th February 2020

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Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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THE HONOURABLE MR JUSTICE HAYDEN

This judgment was delivered in public. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of SM and members of SM's family must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

Mr Justice Hayden :

1. This case requires consideration of whether the necessary criteria are met for the recognition and enforcement of protective measures contained in an order made by the Irish High Court on 4th February 2020. The order was made by the President of the Irish High Court on the application of the Health Service Executive of Ireland ("HSE"). The order authorised the transfer for treatment of SM, a 19-year-old Irish girl, to Ellern Mede Moorgate ("Ellern Mede"), a specialist hospital with a high dependency unit in the North-East of England. The consensus before the Irish Court was that SM requires a placement which can stabilise her general mental health before treating her underlying condition.

2. In this application, the HSE seek the recognition and enforcement of the protective measures contained in the Irish Order of 4th February 2020 to transfer SM to Ellern Mede for what is said to be "*extremely urgent treatment*", pursuant to the provisions of Schedule 3 to the Mental Capacity Act 2005 ("MCA"). Neither the question of SM's capacity, nor the urgency of treatment, is contentious. However, Mr Setright QC, Mr Ruck Keene and Ms Katherine Barnes, who appear on behalf of the HSE, have invited me to consider and approve the legal framework, both in relation to the transfer and in the context of a proposed 'detailed and structured review' by the Irish High Court.

3. There are plainly important issues concerning the liberty of SM and how they can most effectively be safeguarded across the jurisdictions. Whilst Ireland has many centres of medical excellence, specialist units, such as the one contemplated here, and more generally concerning the treatment of serious eating disorders, are in short supply. This is one of a number of cases in which similar arrangements have been made.

FACTUAL BACKGROUND

4. SM has a diagnosis of anorexia nervosa and a previous history of moderate and major depressive episodes. She is presently an in-patient at Springfield University Hospital ("Springfield") in London, having been transferred there from St James' Hospital in Dublin on 13th March 2019. SM has been assessed as lacking capacity to consent to or refuse medical treatment. The most recent evidence in this regard is set out in the affidavit of Dr John O'Mahoney, Executive Clinical Director of the HSE and a specialist psychiatrist, dated 3rd February 2020. Dr O'Mahoney reports that SM's capacity is *"significantly compromised by her disordered thinking so that she is not capable of capacitously agreeing to treatment"*. There is an earlier and similarly detailed assessment, dated 28th January 2019, undertaken by a Dr Kingston, a consultant psychiatrist at St James' Hospital.

5. Having concluded that SM lacked capacity relating to her medical treatment, the President of the Irish High Court made SM a ward of court and appointed Ms Patricia Hickey, the General Solicitor, as her 'committee in wardship', acting independently of the HSE. The objective was to ensure that SM's rights and best interests are protected in the Irish proceedings. Ms Hickey's role is, as I understand it, similar to that of the Official Solicitor in this jurisdiction.

6. On 27th February 2019, the Irish High Court made an order authorising SM's admission and treatment, until further order, at Springfield. It is important to note that the Order of 27th February 2019 records that, having considered "*the suite of evidence before it*", the High Court was satisfied: SM's diagnoses and condition prevented her from having mental capacity to consent to care and treatment; protective measures were required to safeguard SM's health and safety in her best interests; and, as the kind of specialist treatment required was not available in Ireland, treatment at Springfield in England was in SM's best interests.

7. On 5th March 2019, the HSE made an application for recognition and enforcement to the High Court (Family Division) in London. This was approved by Mr Justice Newton on 8th March, facilitating the transfer on 13th March.

8. SM's condition has deteriorated significantly since moving to Springfield. As set out in the report of Dr Giovanni Galavotti, the Lead Clinician and consultant psychiatrist, dated 17th January 2020. SM's initial weight gain at Springfield was accompanied by a deterioration in her mental condition. SM is said to experience regular flashbacks and dissociative states. She has attempted suicide on a regular basis:

> "*[SM] is attempting to strangle herself every day with anything she can use as a ligature, including her clothes which have to be cut to free her from the ligature. This has now caused the added problem that SM sometimes runs out of clothes and needs to wear disposable hospital gowns.*"

9. It has been necessary for SM to be fed nasogastrically as she has lost motivation to seek to restore her weight. I am told that although SM does not need to be restrained, it is necessary for several staff members to keep her in position whilst feeding. The reasons for SM's deterioration are unclear. It seems the clinicians working with her have speculated that it may be linked to allegations she has made since arriving at Springfield concerning sexual abuse which she asserts that she suffered as a child. Dr Galavotti's explains that, over Christmas 2019, SM told her parents that she had been the victim of sustained abuse by an adult when she was a child. Dr O'Mahoney's affidavit also refers to SM having made allegations of a similar complexion during the period of her placement at Springfield.

10. Dr Galavotti's report ends with a request that SM be moved to another specialist placement as a matter of urgency as the treating team at Springfield no longer feels able to meet the expectations of SM and her family in terms of progression and on-going care. He also considers there would be no value to extending SM's placement at Springfield as she is too unwell to engage with any of the therapies on offer.

11. As a result, on 3rd February 2020, the HSE filed a notice of motion with the High Court in Ireland seeking an order permitting the transfer of SM from Springfield to a new placement at Ellern Mede, also in England, for further detention and treatment. The motion was supported, in particular, by a detailed affidavit from Dr O'Mahoney.

12. Dr O'Mahoney's evidence confirms the view of SM's treating clinician that Springfield is no longer able to meet her needs and that SM is extremely distressed. For example, and in addition to SM's sustained, repeated attempts to commit suicide, Dr O'Mahoney refers to SM having to spend extensive periods in a padded room, being unable to tolerate having even a bed (SM's father having given evidence that SM had formed a

view that she did not deserve one), engaging in extreme self-harming behaviours and being selectively mute. Consequently, Dr O'Mahoney explains that he has been urgently investigating an alternative placement for SM and has found what he considers to be a suitable placement for her at Ellern Mede. In summary, this placement is considered appropriate because it offers a high dependency unit akin to psychiatric intensive care. Dr Hind Al-Khairfulla, the Medical Director at Ellern Mede, has assessed SM and agreed to accept her as of 17th February 2020. Springfield has agreed to retain care of SM until that date on the strict understanding that SM will be transferred on 17th February 2020 without delay.

13. The President of the Irish High Court considered the HSE's application at a hearing on 4th February 2020 at which the HSE, SM's parents and SM were all represented. SM was represented by Ms Hickey, who continued (and continues) to act as her committee on the basis that SM *"lacks the capacity to litigate*". As recorded in the transcript of that hearing, SM's parents were fully supportive of the application, as was Ms Hickey. As for SM's expressed views, communicated to the court on her behalf by her committee, although she had previously supported a move to Ellern Mede, at the time of the hearing her expressed preference was for an alternative placement in England known as the Schoen Clinic. This was because SM expressed that she felt that the trauma underlying her other difficulties could be effectively treated there.

14. Mr Justice Kelly, the President of the Irish High Court, granted the HSE's application and made an order, dated 4th February 2020, authorising SM's transfer to and treatment at Ellern Mede, with the matter to come back before the Irish High Court for an "*intensive review*" on 24th March 2020. In so doing, he took express account of SM's preference for the Schoen Clinic. However, he found that, unlike Ellern Mede, which was the clinical recommendation of Dr Galavotti and Dr O'Mahoney, a placement at the Schoen Clinic would not be in her best interests. In a detailed judgment Mr Justice Kelly observes:

> "*although it [the Schoen Clinic] can provide psychiatric and psychological attention and care, in the event of her needing nasogastric feed tubing, which is highly likely because the pattern in the past has been that that has to be resorted to on a regular basis, that cannot be provided in the Schoen Clinic and, instead, she would have to moved from that to an NHS hospital in Leeds. That seems to me to not be to her benefit; that she would be involved in more travelling to and fro [sic] one place over another.*"

15. It is this Irish Order of 4th February 2020 that the Applicant now seeks to have recognised and enforced in this jurisdiction. The application is uncontested. In particular, Ms Hickey, as SM's committee, supports the application on SM's behalf, and also understands that, in terms of her expressed views, SM "*is acquiescing to the transfer*".

THE APPLICATION

16. The HSE submits that it is necessary to ensure that there is a proper legal framework for SM's proposed placement and treatment at Ellern Mede. In light of the matters set out above, the HSE has by this application taken urgent steps to seek recognition and

enforcement of the protective measures of the Irish Order of 4th February 2020 so as to secure:

i) Authority for the placement and treatment of SM at Ellern Mede;

ii) Protection for the rights of SM under the European Convention on Human Rights ("ECHR") whilst admitted to and treated there; and

iii) Recognition of the continued jurisdiction of the Irish High Court over the person of SM whilst she is physically present in England.

17. In pursuance of this, the Irish Order of 4th February 2020 directed at paragraph 22:

> "*the Applicant shall make application forthwith to the Courts of England and Wales including if necessary for urgent interim provision for the enforcement and recognition of the Orders of this Honourable Court with permission to disclose the papers from these proceedings before the relevant Court.*"

URGENCY

18. This application is urgent because, as summarised above, SM is an extremely vulnerable individual whose current placement can no longer continue. Those responsible for it no longer consider that they can adequately cope[1] with her complex needs. SM requires the assistance of an even more highly specialist placement to stabilise her mental state before going on to treat her underlying conditions. Given the seriousness and frequency of SM's attempts at suicide and her self-harm, it is manifest that SM's life will be put at risk by any delay to the proposed transfer to Ellern Mede.

19. Further, given that Springfield's agreement to continue looking after SM is conditional on her being transferred elsewhere by 17th February 2020, the treating team at Springfield may find that they are unable safely to care for SM after this date. This could result in SM having to be moved at very short notice to a placement which is significantly less suitable than Ellern Mede (and, indeed, Springfield, which has recognised that it is no longer able to meet SM's needs).

20. Following the Irish Order of 4th February 2020, the HSE intends to transfer SM to Ellern Mede on 17th February 2020, which is the earliest date upon which it has a space available for SM. Building on the proposal that Dr O'Mahoney outlines in his affidavit, dated 3rd February 2020, the HSE has planned for Allied Admissions, the provider of the 'Assisted Admissions Service' in Ireland, to provide a secure vehicle with a driver and two attendants to undertake the physical transfer. The attendants are trained in mental healthcare and, if necessary, they can provide care, impose restraints and administer oral PRN medication.

[1] No criticism is made in this regard by the HSE of the Springfield placement or those operating it – it is accepted that the firm indication that the placement must end urgently is made in the light of the sharp deterioration in SM's condition, and from the best informed clinical motives, and the clinicians, whilst unequivocally stressing that SM must very soon move, are entirely co-operative in the current process.

21. The HSE are understandably concerned that a sound legal framework is identified in order to secure SM's placement and treatment at Ellern Mede.

THE PROCEDURE

22. It is necessary to identify the procedural route by which the HSE submit that the Court can best bring about the speedy determination of this application, which is made under the provisions of paragraphs 20(1) and 22(1) of Schedule 3 MCA. To the extent that the proposals require a departure from the procedure set out in the Court of Protection Rules 2017 and Practice Direction 23A ("PD 23A"), the HSE invite the Court to authorise such departure in light of the urgency of the matter.

23. In their written and oral submissions, the HSE emphasise paragraph 10 of PD 23A, which provides that an applicant should *"**identify whether any person other than the adult has an interest in the application such that they should be named as a respondent to it**."*

24. When these proceedings were originally issued to recognise and enforce the Irish Order of 27th February 2019, the South West London and St George's Health NHS Trust, as the public body responsible for Springfield, was named as the Respondent to the application. This was considered necessary so as to enable this Court to be satisfied that it could take appropriate steps to ensure implementation of the Irish Order. However, given that the current application proposes moving SM away from Springfield, it is no longer thought necessary or appropriate for them to remain as a party. In contrast, the new provider, Ellern Mede, has an obvious interest in the application and thus becomes the Respondent. As such, the Applicant applies to discharge the South West London and St George's Health NHS Trust as a party and to join Ellern Mede as a party. I grant both applications.

25. The HSE submit that, consistent with the reasoning in **HSE v PD [2015] EWCOP 48** ("**Re PD**"), SM need not be joined as a party. In that case, Baker J concluded that "*[i]n some cases, joinder of the adult as a party will be considered necessary, but I anticipate that in the majority of cases it will not*." I respectfully agree. It is not necessary or indeed desirable here, in circumstances where: the application is plainly urgent; SM's committee, Ms Hickey, has confirmed to the HSE, by email dated 7th February 2020, that she is in agreement with the order being sought; and, SM was represented by her committee in the Irish proceedings and, as is plain from the judgment I have referred to above, was able to have her wishes and feelings considered by the Court. Ms Hickey has also reported that SM's response to the transfer can properly be described now as acquiescent. Finally, and for completeness, it requires to be stated that there will be general liberty to apply to the Court in circumstances where SM or her committee wish to draw any matters to the Court's attention.

26. Paragraph 12 of PD 23A provides that "***A Schedule 3 application should be accompanied by a COP 24 witness statement by or on behalf of the applicant***." A witness statement has been duly filed by Katherine Kelleher on behalf of the HSE. For completeness, the HSE invite the Court to make a transparency order in the standard terms with appropriate reporting restrictions at the outset of the urgent hearing sought to protect the identity of SM and her family.

THE LEGAL FRAMEWORK

27. A great deal of the legal framework applicable to this application has been the subject of detailed analysis by Baker J in **HSE v PA, PB and PC [2015] EWCOP 38** ("**Re PA and Others**"). It is unnecessary for me to reprise the characteristically thorough exegesis of the law set out in that judgment. In considering the ambit of s.63 MCA, headed "International Protection of Adults", Baker J reached the following conclusion:

> "39. … *I accept, however, the submission made by Mr Setright QC, Mr Ruck Keene and Ms Butler-Cole that Schedule 3 implements, as a matter of domestic law, obligations in respect of the recognition, enforcement and implementation of 'protective measures' imposed by a foreign Court regardless of whether that Court is located in a Convention country, and that it would not be permissible to apply one rule for 2000 Convention states and another for non-Convention states. I do not accept that the Courts of England and Wales should automatically adopt a more cautious approach when asked to recognise and enforce an order of a non-Convention state. Each case will turn on its own facts, to which this Court must apply the provisions of the Schedule, in particular the provisions as to recognition in paragraph 19 including the grounds on which recognition may be refused. … Given the close similarities between the legal systems of England and Wales and the Republic of Ireland, however, I anticipate that the circumstances in which the Court will find cause to exercise its discretion to refuse to recognise protective measures in orders of the Irish Courts will be rare, notwithstanding the fact that Ireland (like England and Wales) has yet to ratify the Convention*."

28. I respectfully agree. Moreover, I cannot see that anything stated there could be regarded as being in any way controversial. Section 63 MCA requires to be set out:

> "*Schedule 3 (a) gives effect in England and Wales to the Convention on the International Protection of Adults signed at The Hague on 13th January 2000 (insofar as this Act does not otherwise do so) and (b) makes related provision as to the private international law of England and Wales*."

Definitions

29. It is not necessary for me to burden this judgment with the extensive definitions which apply within Schedule 3, other than to highlight the following:

    i) Paragraph 2(4) provides that "[a]*n expression which appears in this Schedule and in the Convention is to be construed in accordance with the Convention*.";

    ii) Paragraph 4 provides that, in respect of a person over 18, an "*adult*" is a person who "*as a result of impairment or insufficiency of his personal faculties, cannot protect his interests.*";

    iii) Paragraph 5 defines a "*protective measure*" as "*a measure directed to the protection of the person or property*" and sets out a non-exhaustive list of

examples, which includes "*the institution of a protective regime*" (paragraph 5(a)); "*placing the adult in a place where protection can be provided* (paragraph 5(e)); and "*authorising a specific intervention for the protection of the person or property of the adult*" (paragraph 5(g)).

30. It is clear that a 'protective measure' can include a placement of the nature in contemplation here. In **Re PA and Others** (Supra), the St Andrew's healthcare provision involved a unit with similar facilities to those at Ellern Mede:

> "*46. On this point, there is no issue in this case. In each case, the effect of the Irish order was to place the person concerned in St Andrew's, being a place where protection could be provided. The order directing the placement at St Andrew's and the ancillary provisions facilitating the placement, are therefore "protective measures" within the meaning of Schedule 3 paragraph 5(1)(e).*
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> *47. As set out above, Schedule 3 paragraph 19(1) provides that 'a protective measure taken in relation to an adult under the law of a country other than England and Wales is to be recognised in England and Wales if it was taken on the ground that the adult is habitually resident in the other country.' On behalf of the Official Solicitor, Mr Rees submitted in his written argument in respect of this provision that it appears to direct the attention of the Court of Protection, not to an objective view of the habitual residence of the person in question, but to the subjective basis upon which the foreign Court acted and that, if this is the correct test, this Court will be bound by the Irish Court's declaration in each case that the individual is habitually resident in Ireland.*"

Recognition and enforcement

31. It is important to consider how and to what degree protective measures taken outside England and Wales are to be recognised:

    i) By paragraph 20(1), an interested person may apply to the Court of Protection for a declaration as to whether a protective measure taken under the law of a country other than England and Wales is to be recognised in England and Wales;

    ii) Paragraph 19(1) establishes the general rule that "*a protective measure taken in relation to an adult under the law of a country other than England and Wales is to be recognised in England and Wales if it was taken on the ground that the adult is habitually resident in the other country*.";

    iii) Paragraph 22(1) then provides that an interested person can apply to the Court for a declaration that a protective measure taken in a foreign country is to be enforced in England and Wales. The same principles then apply as regards recognition (paragraph 22(2)). In the event that the order is declared to be enforceable, it is "*enforceable in England and Wales as if it were a measure of like effect taken by the Court*" (paragraph 22(3)).

32. Paragraphs 19(3) and 19(4) of Schedule 3 set out the only circumstances in which the general rules set out in paragraphs 19(1) and 22(1) may be disapplied:

i) Paragraph 19(3) provides that the court may decline to recognise (or, in turn, declare to be unenforceable) the measure on essentially procedural grounds, if it thinks that: (a) the case in which the measure was taken was not urgent; (b) the adult was not given an opportunity to be heard; and (c) that omission amounted to a breach of natural justice;

ii) Paragraph 19(4) provides that a court may decline to recognise (or, in turn, declare to be unenforceable) a measure if it thinks that: (a) recognition of the measure would be manifestly contrary to public policy; (b) the measure would be inconsistent with a mandatory provision of the law of England and Wales, or; (c) the measure is inconsistent with one subsequently taken, or recognised, in England and Wales in relation to the adult.

33. In **Re PA and Others** (Supra), Baker J was provided with a letter from the Ministry of Justice, "Strategy and Specialist Policy: Mental Capacity", dated 2nd December 2014. He considered that to be "*an insightful contribution*" from which he drew a number of general points of specific relevance to these cases. In identifying these propositions, Baker J also and explicitly had in mind: **LAB v KB (Abduction: Brussels II Revised) [2010] 2 FLR 1664**, per Roderic Wood J; **Re L (A Child) (Recognition of Foreign Order) [2012] EWCA Civ 1157**, per Munby LJ:

> "*93. First, by including Schedule 3 in the MCA, Parliament authorised a system of recognition and enforcement of foreign orders notwithstanding the fact that the approach of the foreign courts and laws to these issues may be different to that of the domestic court. These differences may extend not only to the way in which the individual is treated but also to questions of jurisprudence and capacity. Thus the fact that there are provisions within the Act that appear to conflict with the laws and procedures of the foreign state should not by itself lead to a refusal to recognise or enforce the foreign order. Given that Parliament has included section 63 and Schedule 3 within the MCA, clearly intending to facilitate recognition and enforcement in such circumstances, it cannot be the case that those other provisions within the Act that seemingly conflict with the laws and procedures of the foreign state are mandatory provisions of the laws of England and Wales so as to justify the English Court refusing to recognise the foreign order on grounds of such inconsistency. In such circumstances, it is only where the Court concludes that recognition of the foreign measure would be manifestly contrary to public policy that the discretionary ground to refuse recognition will arise. Furthermore, in conducting the public policy review, the Court must always bear in mind, in the words of Munby LJ that 'the test is stringent, the bar is set high'.*"

34. As Baker J properly recognised, there may be a range of decisions made under the laws of different jurisdictions that are advanced for recognition under Schedule 3. Although an extensive review as to the merits of the foreign measure will be neither necessary nor indeed appropriate, a limited review will always be required, the objective of which will be to identify any cases where the content or form of the foreign measure is inappropriate, disproportionate or clearly discordant with sound welfare-focused practice in the UK. This, in my judgement, is to add nothing more to the reasoning of the European Court in **Pellegrini v Italy (2002) 35 EHRR 2**, which emphasises the obligation upon this Court to satisfy itself that the relevant proceedings are consistent with the guarantees protected by Articles 5, 6 and 8 ECHR. The consideration of

obligations under different international instruments was characterised by the European Court in **X v Latvia [2014] 1 FLR 1135** in these terms:

> "*94. This approach involves a combined and harmonious application of the international instruments, and in particular in the instant case of the Convention and the Hague Convention, regard being had to its purpose and its impact on the protection of the rights of children and parents. Such consideration of international provisions should not result in conflict or opposition between the different treaties, provided that the Court is able to perform its task in full, namely "to ensure the observance of the engagements undertaken by the High Contracting Parties" to the Convention (see, among other authorities, Loizidou v. Turkey (preliminary objections), 23 March 1995, § 93, Series A no. 310), by interpreting and applying the Convention's provisions in a manner that renders its guarantees practical and effective (see, in particular, Artico v. Italy, 13 May 1980, § 33, Series A no. 37, and Nada, cited above, § 182).*"

35. Given the significant restrictions integral to the measures in question in this case, and the draconian nature of any compulsory psychiatric placement and treatment of an individual, there is an obligation on the Court of Protection to be clear that the criteria in **Winterwerp v Netherlands (1979) 2 EHRR 387** are met. This is to emphasise the importance of recognising that when depriving the liberty of someone of unsound mind, the Court can only act lawfully where it has satisfied itself that the safeguards guaranteed by Article 5(1)(e) and 5(4) are in place:

> "*39. The next issue to be examined is the 'lawfulness' of the detention for the purposes of Article 5 para. 1 (e) (art. 5-1-e). Such 'lawfulness' presupposes conformity with the domestic law in the first place and also, as confirmed by Article 18 (art. 18), conformity with the purpose of the restrictions permitted by Article 5 para. 1 (e) (art. 5-1-e); it is required in respect of both the ordering and the execution of the measures involving deprivation of liberty (see the above-mentioned Engel and others judgment, p. 28, para. 68 in fine).*
>
> *As regards the conformity with the domestic law, the Court points out that the term 'lawful' covers procedural as well as substantive rules. There thus exists a certain overlapping between this term and the general requirement stated at the beginning of Article 5 para. 1 (art. 5-1), namely observance of "a procedure prescribed by law" (see paragraph 45 below).*
>
> *Indeed, these two expressions reflect the importance of the aim underlying Article 5 para. 1 (art. 5-1) (see paragraph 37 above): in a democratic society subscribing to the rule of law (see the Golder judgment of 21 February 1975, Series A no. 18, pp. 16-17, para. 34, and the above-mentioned Klass and others judgment, p. 25, para. 55), no detention that is arbitrary can ever be regarded as 'lawful'.*
>
> *The Commission likewise stresses that there must be no element of arbitrariness; the conclusion it draws is that no one may be confined as "a person of unsound mind" in the absence of medical evidence establishing that his mental state is such as to justify his compulsory hospitalisation (see paragraph 76 of the report). The applicant and the Government both express similar opinions.*
>
> *The Court fully agrees with this line of reasoning. In the Court's opinion, except in emergency cases, the individual concerned should not be deprived of his liberty unless he has been reliably shown to be of 'unsound mind'. The very nature of what has to be established before the competent national authority - that is, a*

> *true mental disorder - calls for objective medical expertise. Further, the mental disorder must be of a kind or degree warranting compulsory confinement. What is more, the validity of continued confinement depends upon the persistence of such a disorder (see, mutatis mutandis, the Stögmüller judgment of 10 November 1969, Series A no. 9, pp. 39-40, para. 4, and the above-mentioned De Wilde, Ooms and Versyp judgment, p. 43, para. 82).*"

36. Finally, counsel drew to my attention the decision of Mostyn J in **Re M [2011] EWHC 3590**, which was also concerned with the compulsory placement of an Irish national in an English psychiatric hospital. There Mostyn J concluded that an order recognising and enforcing a foreign measure under Schedule 3 is not a "*welfare order*", as defined by s.16A(4)(b) MCA. I respectfully agree, as I note did Baker J in **Re PA and Others**. One of the consequences of this is that the rules relating to "*ineligibility*" in s.16A and Schedule 1A do not apply. Mr Setright properly points out that the consequence of this is that a court may find itself in the position of recognising and enforcing orders of a foreign court which have the consequence of depriving P of his or her liberty in circumstances where this would not be possible under the domestic jurisdiction, under the aegis of the MCA. This might arise, for example, where the Court of Protection is required to recognise and enforce an order where an individual is being treated or is treatable under the Mental Health Act 1983 ("MHA"), as defined in Schedule 1A MCA. The check on this, however, is provided, in my view, by the discretion the court has, in its review, to refuse recognition and enforcement where the order would be manifestly contrary to public policy.

37. As I have indicated above, at the hearing on 12th February 2020, Mr Setright and Ms Barnes were concerned that I should conduct a review of the applicable framework of the law in this area beyond the issues specific to the case in order to provide more general guidance in what counsel describe as "*this distinctive and relatively unusual jurisdiction*". As I have made clear, the circumstances of SM were both parlous and requiring of an urgent decision. I felt able to make the substantive order sought by the HSE on 12th February, but I also indicated that there were a number of matters on which I would require further assistance before handing down judgment. These were identified, in my order, in these terms:

> "*On the assumption that the Court of Protection considers that the reciprocal regime set out in the skeleton argument is consistent with SM's emotional and medical treatment needs:*
>
> *1) Whether that would continue to be the most effective regime if it was required to endure long term (perhaps for several years);*
>
> *2) Whether, in that event, the options pursuant to the MHA and MCA in the Court of Protection in England and Wales might at that point prove to offer a more effective alternative;*
>
> *3) What is the locus (scope and ambit) of the MCA if during the period of SM's detention and treatment her habitual residence does not change?*"

38. The HSE is keen to press upon me that SM's case and others like it, which involve the mandatory transfer of placement of a highly vulnerable individual to a different country

in order to obtain crucial specialist treatment, is regarded by the Irish High Court as of the utmost seriousness. They emphasise that each case requires and receives close scrutiny by a High Court judge in Ireland, and recognise that the Court of Protection in England and Wales also approaches the recognition and enforcement of these orders with care. The strength of this submission is, in my judgement, established by the detail and extent of the Irish High Court's scrutiny of the case summarised in the earlier passages of this judgment.

39. I am told that the HSE are reasonably confident that they have been a party to all Schedule 3 cases involving Ireland since the first application in 2011 (see **Re M [2011] EWHC 3590 (COP)**). Equally, each of the applications has been considered by a Tier 3 Court of Protection judge.

40. In counsel's supplemental written submissions, in response to my enquiries (above), it is stated:

> "*… Nonetheless, as we have said, given the distinctive character and importance of the Schedule 3 regime, the HSE welcomes the opportunity for review by the Vice-President that the listing of this hearing has allowed. The HSE, and its English team, are anxious to do what they can to ensure that the Schedule 3 regime operates as effectively and fairly as possible and, if there are further points of finetuning required, that they can speedily be achieved.*
>
> *[SM]'s case, as with the others of a similar nature that have been put before the Court of Protection since 2011, plainly involves placement in circumstances amounting to a deprivation of liberty, and authority to provide medical treatment (in extremis) on a non-consensual basis. The order of the President of the Irish High Court of 4th February 2020, as recognised and enforced by the order of this court on 12th February 2020, provides the legal framework for both (see paragraphs (4) and (5)), and, by operation of Schedule 3, these paragraphs are effective in England & Wales as if it they were a domestic order of the English courts.*"

41. It is this cooperative arrangement, at senior court level, characterised by what is described as "*an extremely active approach*" by the Irish High Court to its wardship jurisdiction, that is identified as the primary safeguard in the protection of the fundamental rights and liberties at stake. I consider that the HSE are both entirely correct and accurate when they identify the very close relationship between all those involved in the care and treatment of Irish adults placed in England and those involved at all levels in the Irish system as fundamental both to the fairness and proportionality of the process.

42. Many of the cases, particularly those concerned with anorexia nervosa, involve circumstances when the professionals are 'firefighting'. By this I mean they are dealing with an urgent and potentially life threatening situation. Frequently, the contemplated treatment is of relatively limited duration, though 18 months is not uncommon. Additionally, long-term deprivation of liberty and compulsory medical treatment is inherently undesirable.

43. Experience in the Court of Protection makes it easy to contemplate circumstances in which deprivation of liberty and/or medical treatment of some kind might be required

on a much longer term basis. In exchanges with Mr Setright, I posited the very real challenges faced by severely autistic adults and their families often requiring long-term intervention. My concern was that there was a risk, with the effluxion of time, that the careful scrutiny afforded by the regime that I have outlined above might become diluted and take on a more routine administrative complexion. Were that to happen it is not difficult to contemplate circumstances developing in ways which might be contrary to an individual's welfare and human rights.

44. It is self-evident that these cases engage Article 2 ECHR (right to life); Article 5(4) (right to challenge deprivation of liberty); and Articles 6 and 8 ECHR (rights to "*an effective procedural possibility, judicial or otherwise, of influencing the course of [non-consensual] treatment or having it reviewed by an independent authority*" (see **LM v Slovenia [2014] ECHR 608** at 185)). Mr Setright, Mr Ruck Keene (who I understand to have joined this team specifically to address the issues that I raised with Mr Setright during the course of the hearing) and Ms Barnes have provided a comprehensive outline of the various domestic regimes available to SM and those in similar circumstances. It is, if I may say so, such a thorough and useful document that I propose to append it to this judgment in order that it may provide a convenient and easily accessible checklist for practitioners generally. This document is, I suspect, largely the work of Mr Ruck Keene and Ms Barnes, and I pay fulsome tribute to their industry. This document was prepared to contrast the potential approaches if, for whatever reason, a particular individual required to be considered solely by reference to English domestic law. The submission on behalf of the HSE is that the regime provided for by recognition and enforcement under Schedule 3 offers, "*at a minimum*", materially equivalent protections to those provided in the MHA and, in certain respects, "*better protection.*"

45. It is contended that the provisions of Schedule 3, the Irish Orders and the regime of recognition and enforcement by the English courts mean that, in practice, any issues or difficulties encountered either by or on behalf of the Applicant, or indeed their treating clinicians, will be resolved expeditiously before the Irish High Court without the cumbersome requirement for applications in English law. Mr Setright buttresses that proposition by pointing to nearly a decade of jurisprudence in which these arrangements have demonstrably provided exceptionally flexible and effective access to appropriate relief in law.

46. Key to understanding why this regime has been effective is that it provides for continuity of personnel. Responsibility for supervising the arrangements has been assumed by the President of the Irish High Court and thus provides not merely judicial continuity, as I have stated, but consistent overview at the very highest level. Additionally, P's committee and advocate remain a constant point of contact, not least for the family concerned. It is also apparent that the cases have been allocated regular and, to use the words selected by the Irish High Court in this case, "*intense*" reviews. It is impossible not to recognise strong resonances with the wardship jurisdiction for children that operated in the High Court (Family Division) in England and Wales prior to the introduction of the Children Act 1989 ("CA"). The use of wardship and the inherent jurisdiction in that period was referred to by the Law Commission as a Rolls Royce service, many of the principles of which were incorporated into the CA to afford wider access for children and families to a range of options which had hitherto been confined to cases heard in the High Court.

47. The HSE only contemplates placements of adults in this jurisdiction because it considers that the appropriate and necessary facilities are unavailable in Ireland. This requires the broader canvas to be considered. The individual who is being treated, it must be remembered, is not making an autonomous decision to relocate. The entire infrastructure of the adult's family life remain in Ireland. The hearings logically are more conveniently held in a court which can be attended by parents and/or family members, in a court process which is not alien to them. A foreign jurisdiction would inevitably increase the anxiety that all lay people feel attending at any court. I am told that SM's parents have not missed a single hearing in Ireland and have been afforded the opportunity to address the court at every stage.

48. The HSE also identified that families are inevitably apprehensive when one of their vulnerable members requires to be treated abroad in circumstances such as those contemplated here. A requirement to participate in an alien jurisdiction would, it is submitted, exacerbate the fear that their family member had been "*abandoned*" in a foreign jurisdiction. Crucially, to my mind, at every review hearing the Irish High Court considers the necessity of the adult's ongoing placement abroad and focuses on whether the adult's needs may have changed and potentially be met in Ireland. There is an emphasis on the adult returning home as soon as is feasible. Though I am told and accept the fact that the HSE treats the return of the adult to Ireland as "*a priority*", it requires to be recognised that the Irish court retains the authority to compel return where that is considered to be in the adult's best interests.

49. Finally, the striking benefit of the Schedule 3 regime is that it provides clarity of responsibility. There is a clear, unbroken chain of command from patient to court. It also provides an avoidance of "*jurisdictional confusion*", which ought always to be regarded as inherently dangerous and potentially inimical to the welfare of the adult concerned.

50. I must record that counsel make the following written submission:

> "*The HSE readily accepts that none of these advantages would weigh heavily in the balance were the regime put in place under the orders recognised and enforced to be manifestly inferior in terms of its protections to those available under the English domestic MHA. However, for the reasons set out in the appendix, the HSE submits that such is not the case*."

51. The above passages address the first two questions that I raised with counsel in the course of the hearing. The third question was to enquire as to what the locus, scope and ambit of the MCA is if, during the period of SM's detention and treatment, her habitual residence does not change. In the course of addressing this difficult issue, counsel have provided a number of recent examples illustrating swift and effective resolution by the Irish High Court of concerns relating to placements in England and Wales. I do not propose further to burden this already extensive judgment with an analysis of those cases, though I am grateful to counsel for doing so. Schedule 3, of course, provides for recognition of protective measures and, as with a patient detained under the MHA, capacity to consent to treatment is taken into account by the treating team (even though, strictly speaking, it does not need to be).

52. It is submitted that the treating teams in a hospital or facility in England and Wales will automatically direct themselves to the domestic guidance applicable under the MHA

and, where relevant, the MCA. By way of illustration, it is pointed out that the MHA Code in England, which has a broadly equivalent Welsh counterpart, has a substantive chapter (Chapter 13), addressing mental capacity and deprivation of liberty. This directs all the relevant professionals to focus on a key imperative:

> "*The MCA should be central to the approach professionals take to patients who lack capacity in all health and care settings (including psychiatric and general hospitals). The starting point should always be that the MCA should be applied wherever possible to individuals who lack capacity and who are detained under the Act*."

53. The same point applies, by parity of analysis, in the context of the 'appropriate medical treatment test' (Chapter 23 of the MHA Code). This provides that the appropriate treatment test should be applied so as to take account of all the circumstances of the patient's case, including their "*views and wishes about what treatment works for them and what doesn't*". It is submitted, as I understand it, that in **JK v A Local Health Board [2019] EWHC 67 (Fam)**, Lieven J has equated the concept of 'appropriateness' under the MHA with that of 'best interests' under the MCA. I am bound to say I do not read her judgment as "*equating the two concepts*". However, the point is made here with sufficient force by the assertion that the treating team in England and Wales would, in accordance with good practice, follow the guidance in Chapter 23. The point, it seems to me, is that this is no more or less likely to be followed merely because it is a court of England and Wales rather than a Irish court responsible for overview of the case. Indeed, returning to the point that I have probably laboured too heavily, the frequency and intensity of the reviews by the Irish High Court are most likely to protect the concepts intrinsic to the MCA, many of which were themselves gleaned from the declaratory relief procedure that operated under the inherent jurisdiction of the High Court of England and Wales prior to the introduction of the MCA.

54. It is the Court of Protection that has jurisdiction, exercised in comity with the Irish High Court, concerning the execution and implementation of orders under Schedule 3. This is predicated on the adult's physical presence. In terms of any matters falling outside the scope of the Irish Order, but not, as the applicant put it, "*outside the purview of the Irish wardship jurisdiction*", it is contended, and I agree, that the wording of the MCA does not tether the Court's jurisdiction to the adult's habitual residence. Paragraph 7(1)(c) of Schedule 3 provides that the Court of Protection may exercise its functions *"in so far as it cannot otherwise do so"* in relation to an adult person present in England and Wales if the matter is urgent:

> *"7. (1) The court may exercise its functions under this Act (in so far as it cannot otherwise do so) in relation to—*
>
> *(a) an adult habitually resident in England and Wales,*
>
> *(b) an adult's property in England and Wales,*
>
> ***(c) an adult present in England and Wales or who has property there, if the matter is urgent,*** *or*
>
> *(d) an adult present in England and Wales, if a protective measure which is temporary and limited in its effect to England and Wales is proposed in relation to him."*

55. I accept this submission and consider that the reasoning is equally applicable in relation to any admission under the MHA. It is, I think, important that I again emphasise that the HSE is the only party represented at this hearing and thus I have heard no contrary submissions on what is an important and highly technical point. Recognising this, and in the best tradition of the independent Bar, Mr Setright, Mr Ruck Keene and Ms Barnes have, as they put it, sought to "*stress test*" the regime both against the questions posed by the court and more generally. I extract the following from their thoughtful and erudite supplemental written submissions:

> "*In that spirit, the HSE's legal representatives have identified (at paragraph [21] above) a potential recital that could be included as to this Court's expectation as to what the English clinicians would do in the event of doubt as to how to proceed in relation to SM's treatment*."

I consider this to be a helpful and pragmatic suggestion. It is the principle rather than the detail of the recital that is important here and I do not therefore need to read the recital into this judgment.

CONCLUSIONS

56. At the conclusion of this extensive survey of the applicable law and the applications of recognition and enforcement of protective measures, I have come to the clear conclusion that the necessary criteria are met for recognition and enforcement of the Irish Order of 4th February 2020.

57. SM is an adult. The Irish Order records that SM lacks the capacity to litigate for the reason by which she is found to lack the capacity to refuse care or treatment. The protective measures identified in the Irish Order therefore stand as protective measures for the purpose of Schedule 3 MCA (i.e. by reason of her condition and diagnosis, SM requires a period of assessment and treatment in a specialist facility which is not available in Ireland).

58. Further, the protective measures were taken on the basis that SM was habitually resident in Ireland. The Irish Order records that:

> "*[SM] is an Irish citizen domiciled and habitually and ordinarily resident in this State and has remained so during the period of her temporary treatment at Springfield University Hospital and will remain so during the period of her further temporary treatment at Ellern Mede Moorgate*."

It also declares at paragraph 5 that:

> "*the Ward is habitually resident and domiciled in Ireland and that she will attend at Ellern Mede temporarily for the purpose of receiving the appropriate assessment and treatment required for her present needs*."

59. Crucially, SM has had a proper opportunity to be heard before the Irish High Court for the purposes of paragraph 19(3)(b) of Schedule 3 MCA. SM was represented in the Irish proceedings by her committee, Ms Hickey. Ms Hickey provided an affidavit to

which were appended various emails from SM in which SM expressed her preference to be transferred to the Schoen Clinic. SM's views were also set out in Dr O'Mahoney's affidavit. In his decision, the President of the Irish High Court gave specific consideration to SM's expressed wishes despite ultimately departing from them:

> *"I have taken into account her [SM's] views as expressed to me through the General Solicitor and […] I have read the email correspondence which she asked to have drawn to my attention and in particular the rather poignant and sad final email indicating to me that the trauma is so bad that she wants to end her life and she sees the Schoen Clinic as the only sliver of hope."*

60. As such, there can be no doubt that SM had the opportunity to be heard, and, indeed, was heard, in the Irish proceedings. Further and in any event, it is to be noted that the latest expression of SM's views, as communicated by Ms Hickey, is that SM acquiesces to the transfer to Ellern Mede (a placement that SM had in fact previously favoured).

61. The Applicant supplements the above with two further important submissions with which I agree and record in full:

> "*SM satisfies the criteria for detention under Article 5(1)(e) of the ECHR. The Irish Order dated 4 February 2020 records that 'in the existing circumstances the Ward's health, welfare and development would be impaired if she were not to transfer from her current placement at Springfield University Hospital to Ellern Mede Moorgate for the purposes of such assessment and treatment there as may be clinically indicated' and that SM 'is at risk of potential harm and lack of progress in treating her condition without such assessment and treatment'.*
>
> *That SM will be afforded a regular right of review in the Irish High Court of her detention so as to comply with the requirements of Article 5(4) ECHR. The Irish Order of 4 February 2020 ordered at paragraph 21 that 'the proceedings herein shall be listed before the President and shall be the subject of regular intensive welfare reviews during the currency of the Ward's detention Ellern Mede Moorgate to enable the President to ascertain whether there persists a basis for the treatment and therapies provided there in the Ward's best welfare interest [sic]'. The first intensive review has been set for 24 March 2020**, a date which comes within a month of the proposed transfer, and avoids any delay in bringing any matters arising to the attention of the Irish High Court*."

62. Finally, having regard to the analysis of the case law above, I should expressly make clear that there is nothing to indicate that the structure of protective measures I have approved would be manifestly contrary to public policy for the purposes of paragraph 19(4)(a) of Schedule 3 MCA, nor would it be inconsistent with a mandatory provision of the law of England and Wales for the purposes of paragraph 19(4)(b). Accordingly, for all these reasons, I am able both to recognise and declare enforceable the protective measures in the Irish Order of 4th February 2020, specifically to enable SM to be transferred to Ellern Mede to receive the urgent treatment she requires in a regime in which the curtailments on her liberty is proportional to the objective (i.e. to promote her health and protect her life).

APPENDIX: DOMESTIC REGIMES APPLICABLE TO SM AND THOSE IN HER POSITION

Mental Health Act 1983

Application of the MHA

1. There are various ways in which a patient may be admitted for assessment and treatment, including in circumstances amounting to a deprivation of liberty, under the Mental Health Act 1983 ("MHA"). These are summarised below. However, it is important to state at the outset that there is no MHA "jurisdiction" as such – its provisions are applicable to anyone who meets the relevant statutory criteria on the basis of their physical presence in this country. In this regard, s.1 MHA provides (in so far as relevant):

> *"1.— Application of Act: "mental disorder".*
> *(1) The provisions of this Act shall have effect with respect to the reception, care and treatment of mentally disordered patients, the management of their property and other related matters. (2) In this Act—*
> *"mental disorder" means any disorder or disability of the mind; and*
> *"mentally disordered" shall be construed accordingly;*
> […]
> *(2A) But a person with learning disability shall not be considered by reason of that disability to be–*
> *(a) suffering from mental disorder for the purposes of the provisions mentioned in subsection (2B) below; or*
>
> *(b) requiring treatment in hospital for mental disorder for the purposes of sections 17E and 50 to 53 below,*
>
> *unless that disability is associated with abnormally aggressive or seriously irresponsible conduct on his part."*

Hospital admission under the MHA

2. Section 131 MHA provides for the voluntary admission of a person to hospital for the purposes of both assessment and treatment. The person need not have capacity to consent to the admission as long as he consents to it. However, if the person lacks capacity and the circumstances of their admission would amount to a confinement, then he cannot be admitted under this section as there would not be the procedure prescribed by law required to satisfy Article 5 ECHR.[2]

[2] The relevant principles, and the test for what constitutes a confinement, being most conveniently summarised in *Cheshire West and Chester Council v P* [2014] UKSC 19.

3. If the person's admission to hospital amounts to a confinement (and they lack capacity to consent or they object to the admission) then recourse may be had to s.2 MHA (admission for assessment) or s.3 MHA (admission for treatment). In brief:

   (a) An application for admission for assessment under s.2 MHA can only be made on the grounds that the person:
      (i) is suffering from a mental disorder of a nature and degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period;
      (ii) ought to be so detained in the interests of his own health and safety or with a view to the protection of other persons;

   (b) An application for admission for treatment under s.3 MHA can only be made on the grounds that:
      (i) the person is suffering from a mental disorder of a nature and degree which makes it appropriate for him to receive medical treatment in hospital;
      (ii) it is necessary for the health and safety of the person or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section;
      (iii) appropriate medical treatment is available for the person.

4. In the case of both s.2 and s.3 MHA, it is necessary (in the normal course of events[3]) that the application be made upon the basis of two medical recommendations, at least one of which should be provided by a practitioner approved for these purposes by the Secretary of State for Health.
5. The application for admission is then made either by the nearest relative of the person[4] or (more usually) an Approved Mental Health Practitioner ('AMHP'), acting on behalf of the local social services authority. Before making such an application, which can only be made if the AMHP is satisfied that it ought to be made and it is necessary and proper for it to be made by him, the AMHP is required to complete a series of procedural steps. These include consulting with the person appearing to be the patient's nearest relative unless such consultation is not reasonably practicable or would involve unreasonable delay.

6. Upon receipt by the hospital managers, the application for admission provides the authority to the managers of the relevant hospital to detain the person for a (non-renewable) period of 28 days for assessment under s.2 MHA 1983 or for a (renewable) period of 6 months for treatment under s.3 MHA 1983 (that period being renewable in the first instance for another 6 months, and then for 1 year at a time[5]).

Treatment under the MHA

7. The vast majority of detained patients unable or refusing to consent to treatment will be treated under the provisions of Part 4 MHA. General authority to give medical treatment for mental disorder without consent is provided by s.63 MHA, which provides that the

[3] In an emergency, it is possible to dispense with one medical recommendation (s.4 MHA).
[4] As defined by a statutory list in s.26 MHA.
[5] By operation of s.28 MHA.

consent of the patient is not required to give medical treatment for mental disorder. This is subject to the following four exceptions, most of which depend upon consideration of whether the patient has the capacity to consent to or refuse the specific treatment:

(a) Very serious treatment for mental disorder, currently limited solely to neurosurgery and surgical implantation of hormones to reduce male sex drive. A patient who does not have capacity to consent to such treatment can never be administered this treatment;[6]

(b) Specified forms of treatment that can be given after 3 months of being liable to detention under the Act either with the patient's capacitous consent or, where the capacitous patient refuses or is not capable of consent, only subject to a second opinion (an example is treatment with antipsychotic medication).[7] The 'second opinion appointed doctor' regime is administered by the Care Quality Commission (in England[8]) and is thus entirely independent of the treating hospital;

(c) Treatment (currently limited to Electro-Convulsive Therapy (ECT)) that can only be administered to a patient capable of (and in fact) consenting or to an incapable patient subject to a second opinion, subject to the delivery of such treatment not conflicting with: (1) a valid and applicable advance decision to refuse ECT (see further for advance decisions); (2) the decision of a donee or court appointed deputy; or (3) a decision of the Court of Protection;[9]

(d) Treatment in an emergency. This will primarily be of relevance in the case of ECT, which can be administered without the protections set out above where it is immediately necessary to save the patient's life or prevent serious deterioration of their condition. [10]

8. Where the provisions of Part 4 MHA apply, s.28 MCA provides that nothing in the MCA authorises anyone to give the patient medical treatment for mental disorder, or to consent to a patient being given medical treatment for mental disorder. This means that the Court of Protection cannot (for instance), by making an order under s.16(2)(a) MCA, decide on behalf of a patient to consent to or refuse medical treatment for mental disorder. The MHA does not provide authority to (1) treat a patient for physical disorders unrelated to the mental disorder (or disorders) underpinning the detention; or (2) make decisions about other aspects of the patient's life – for instance as to the management of their finances or as to contact.

Representation and support

9. Under ss.130A-130L, a patient detained under the MHA is entitled to support from an Independent Mental Health Advocate (commissioned by the local social services authority

[6] The combined effect of s.57 MHA and s.28 MCA.
[7] Section 58 MHA.
[8] In Wales, the scheme is administered by Health Inspectorate Wales.
[9] Section 58 MHA.
[10] Section 62 MHA. Treatments falling within ss.57 and 58 MHA could, theoretically, also be delivered on the same emergency basis, but by the nature of the treatments in question, it is very unlikely in practice that s.62 could ever properly be invoked in relation to such treatments. In relation to neuro-surgery, it is also difficult to see how this could be said to be anything other than irreversible, a further reason why s.62 would not apply
[24] Somewhat different arrangements apply in Wales, but the position set out in this paragraph pertains equally there.

for the area).[24] The task of an IMHA is to support people to understand their rights under the Act and participate in decisions about their care and treatment. They do not give legal advice, although they can support a patient to access legal advice.

Challenging detention

10. A system exists by which the patient and/or their nearest relative is able to challenge the adult's detention before the First-Tier Tribunal (Health, Education and Social Care Chamber) (Mental Health) ("the Tribunal"). The Tribunal has the power (under Rule 11(7) of the Tribunal Procedure Rules 2008) to appoint a legal representative for a person who lacks the capacity to appoint one, where the Tribunal considers that it is in their best interests for them to be represented. It should perhaps be noted that a directly appointed legal representative is not a litigation friend (nor would, for instance, the Official Solicitor act as a litigation friend before the Tribunal); they are the functional equivalent of accredited legal representatives now appointed by the Court of Protection under rule 1.2 of the Court of Protection Rules 2017.

11. In the event that the patient or his nearest relative do not make an application for discharge to the Tribunal, the hospital managers retain a discretion to discharge the patient at any time under the provisions of s.23 MHA. Section 23 is silent as to the persons who can make an application for discharge. It is clearly established that the following categories of person can make such an application:

> (a) The responsible clinician (if they consider that the criteria for detention are no longer satisfied);
> (b) The nearest relative (albeit that, if the nearest relative wishes to make such an application, they must give 72 hours' notice of their intention and the adult's responsible clinician can nullify their application by reporting within the 72 hours to the hospital managers that in their opinion the patient would be dangerous if discharged);
> (c) a deputy appointed by the Court of Protection under s.16(2)(b) MCA to make personal welfare decisions on behalf of the patient, if such a power has been conferred by the Court, and the patient lacks the capacity to make the request.

12. *Prima facie*, therefore, there is nothing in s.23 MHA which would prevent a request for discharge being made to the hospital managers by (for instance) the HSE at the direction of the High Court (or indeed, by the Guardian *ad Litem* appointed to represent the person's interests in the proceedings before the Irish High Court). However, s.23 MHA only gives the hospital managers the power to discharge absolutely or to refuse to discharge; it does not imbue them with any power to direct the patient's return to a foreign jurisdiction. The HSE returns below to the only power which exists under the MHA 1983 which caters for such eventuality.

13. The MHA also contains a backstop to secure the Article 5(4) rights of a patient who is 'unbefriended' and does not take any steps to challenge their detention, requiring the hospital managers to refer their case to the Tribunal on a regular basis if no application has been made.

14. One point which is perhaps obvious from the foregoing, but bears emphasis, is that the process for application and detention under the MHA is a self-contained process in which Parliament has made it very clear that the individual actors (the two doctors providing medical recommendations, the AMHP making the application, and the hospital managers deciding whether to accept the application) all have individual responsibilities and act independently. Subject only to the (exceptional) route of challenge by way of judicial review, the actors within the system would not be amenable to external direction, for instance by way of order of the Court of Protection.[11]

Removal of alien patients

15. The Secretary of State has power under s.86 MHA to authorise the removal of an "alien" patient detained under s.3 MHA 1983 (but not s.2) from the place in which the patient is detained and make directions for his conveyance to a specified port or place to a country outside the United Kingdom. A number of points should be noted about this power:

(a) For these purposes, an alien patient is defined as a patient who is not a British citizen;
(b) Before exercising his powers, the Secretary of State must:

(i) be satisfied that proper arrangements have been made for the patient's removal to that country and for his care and treatment there; (ii) be satisfied that it is in the patient's best interests to remove him; and, (iii) obtain the approval of the Tribunal.
(c) The Ministry of Justice, in a guidance document entitled "Foreign National Restricted Patients: Guidance on Repatriation," indicates that the use of s.86 is not appropriate where the patient is likely to be discharged within 6 months. However, this guidance properly only relates to restricted patients (i.e. those who are detained by way of a hospital order made by the Crown Court under s.37 MHA as an alternative to a custodial sentence, and are then subject to further restrictions imposed under s.41 MHA, the most relevant of these for present purposes being that the Secretary of State for Justice's consent is required for the patient's discharge). There is nothing on the wording of s.86 MHA itself to support the limitation upon the use of s.86 in the case of those who are likely to be discharged within 6 months;
(d) Section 86 MHA is silent as to the identity of those entitled to make requests for transfer to the Secretary of State, such that it would be entirely possible for the HSE to make the request at the direction of the Irish High Court (or, indeed, for the request to be made directly by the Irish High Court itself).

Mental Capacity Act 2005 (excluding the provisions of Schedule 3)

16. If the patient lacks capacity to consent to admission to a hospital or care home, and their admission will amount to a deprivation of liberty, it may potentially be authorised by the making of an order under s.16(2)(a) MCA or by way of a standard authorisation granted by the relevant local authority (as supervisory body) under Schedule A1 to the MCA. In short,

[11] And, indeed, s.28 MCA 2005 makes express that no person may (a) give a patient medical treatment for mental disorder or (b) consent to a patient being given medical treatment for mental disorder, if at the time when it is proposed to treat the patient, his treatment is regulated by Part 4 of the MHA.

Schedule A1 (the 'Deprivation of Liberty Safeguards' regime) allows the grant of authorisations by supervisory bodies to regularise the deprivation of liberty in hospitals and care homes of those without capacity to decide whether to reside there to receive care and treatment.

17. Importantly, however, at present if a person meets the criteria for detention under the MHA and they object to being a mental health in-patient or to being given some or all of the mental health treatment to be administered at the hospital, then they cannot be deprived of their liberty under the MCA, whether through a standard authorisation or a court order.[12]
18. In future, when the Mental Capacity (Amendment) Act 2019 comes into force, the administrative route to deprivation of liberty under Schedule AA1 to the MCA (the 'Liberty Protection Safeguards') will remain barred in the case of objecting mental health patients.[13]However, s.16A will be repealed, which means that, in theory at least, there would be nothing preventing the Court of Protection making an order under s.16(2)(a) MCA authorising the in-patient admission in circumstances of deprivation of liberty of a patient who meets the criteria for detention under the MHA.

19. If an incapacitous patient does not object to being admitted for assessment or treatment for mental disorder in circumstances of confinement, then a choice will exist at present, and in future, as to whether the administrative routes available under the MHA or the MCA should be used, guided by which is the least restrictive route to bring about the assessment and treatment of the person.[14]

Inherent jurisdiction of the High Court

20. For completeness these submissions also deal, briefly, with the inherent jurisdiction of the High Court, the other mechanism through which an admission to hospital amounting to a deprivation of liberty could be authorised. The circumstances under which it could be permissible to have recourse to the 'great safety net' of the inherent jurisdiction would be very limited, given that there are two comprehensive, and overlapping, statutory regimes – described above – providing for in-patient admission for assessment and treatment, and the inherent jurisdiction "*cannot be used to simply reverse the outcome under a statutory scheme, which deals with the very situation in issue, on the basis that the court disagrees with the statutory outcome*."[15]

21. For completeness, the HSE notes that Baker J (as he then was) had recourse to the inherent jurisdiction in the case of an inpatient in a psychiatric hospital in *NHS Trust v Dr A* [2013] EWHC 2442 (COP), [2013] COPLR 605, but that was because the wording of s.16A MCA could not authorise the (additional) deprivation of liberty to which the patient, detained under the MHA, was to be subject to bring about his force-feeding where such did not fall within the scope of medical treatment for mental disorder. In essence, Baker J found (see

[12] The bar arises by virtue of the operations of paragraphs 2, 5, 12 and 13 of Schedule 1A to the MCA, read together with s.16A and paragraph 17 of Schedule A1 (see *PA, PB and PC* [2015] EWCOP 38, [2015] COPLR 447 at [98] (Baker J)).
[13] By operation of Part 7 of Schedule AA1.
[14] *AM v (1) South London & Maudsley NHS Foundation Trust and (2) The Secretary of State for Health* [2013] UKUT 0365 (AAC), [2013] COPLR 510 at [75] (Charles J).
[15] *JK v A Local Health Board* [2019] EWHC 67 (Fam) at [57] (Lieven J).

paragraph 93) that Parliament had not anticipated the situation which confronted him, such that it was appropriate to have recourse to the inherent jurisdiction to secure Dr A's right to life.

22. By parity of reasoning, the HSE submits that it would only be if a similar unanticipated gap was identified (perhaps in the unusual context of these cross-border cases) that would it be permissible to have recourse to the inherent jurisdiction.

Comparison of protections under MHA and under Schedule 3

23. As set out above in the body of the additional submissions herein, the HSE submits that the procedural safeguards afforded SM and those others in her position are, at a minimum, functionally equivalent to those available to a person detained under the MHA:

(a) Just as the MHA provides for the lawfulness of the detention to be examined by the Tribunal, under the Schedule 3 regime the Irish High Court conducts regular intensive reviews of the protective arrangements. Importantly, the maximum period for which the Irish Court will authorise detention is six months, in circumstances where under the MHA, detention can be renewed for up to a year at a time after detention has been renewed for the first time. Furthermore, whilst the MHA gives 'one bite of the cherry' each detention period in terms of an application to the Tribunal,[16] the Irish High Court can consider arrangements on an *ad hoc* basis if a concern arises. Indeed, this is exactly what happened in SM's case; the HSE speedily applied to the Irish Court to alter the protective measures in light of Dr Galavotti having raised concerns about her deteriorating mental health. Arguably, therefore, and as set out above, this means that the scope for the court's scrutiny of the arrangements is better under Schedule 3 than the MHA;

(b) The Tribunal (and hospital managers) are restricted by the ambit of their statutory powers to consider solely whether the patient meets the criteria for detention or not.
They do not have the power, for instance, to consider questions of treatment. The Irish High Court is under no such restrictions;

(c) In terms of treatment, SM or a person in her position will have her treatment considered both by the treating team at the English facility and on behalf of the HSE for purposes of reporting to the Irish High Court. It is also possible – as has happened with SM – for an entirely independent doctor to be instructed in difficult cases;

(d) Throughout the length of the placement, whilst the adult will not have a statutory right to an (English) IMHA, they will not only be represented by their Committee in Ireland (i.e. the General Solicitor Ms Hickey) but also have an advocate in England funded by the HSE. An IMHA will not, usually, be legally

[16] A hospital managers hearing could be convened on a discretionary basis even where an application to the Tribunal has been unsuccessful.

qualified. By contrast, in SM's case, as in others, the advocate in question is, in fact, a qualified English solicitor (Maria Nicholas of Messrs Guile Nicholas, known to the HSE's legal team). The advocate can therefore provide a clear, and legally informed, point of contact on the ground through which P's wishes and feelings, including any concerns, can be relayed to P's Committee and to the Irish High Court. An example of such leading to rapid action is referred to [in paragraph 50 of the judgment].