Neutral Citation Number: **[2023] EWFC 92**

Case No: FD23F00014

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION
AND SITTING IN THE COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 17 June 2023

Before:

MR DAVID LOCK KC
SITTING AS A DEPUTY HIGH COURT JUDGE

Between:

NORFOLK AND SUFFOLK NHS FOUNDATION TRUST	**Applicant**
- and –	
HJ	**Respondent**

(by her litigation friend, the Official Solicitor)

- -

Ms Nicola Greaney KC (instructed by **Kennedys LLP**) for the **Applicant**
Mr Rhys Hadden (instructed by **the Official Solicitor)** for the Respondent

Hearing dates: 24 May 2022

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Judgment Approved

Mr David Lock KC:

1. This judgment concerns the lawfulness of care being provided to HJ who is now 64 years of age. HJ has long standing Bipolar Affective Disorder with psychotic symptoms which results in her experiencing hallucinations and delusions. She presents with signs of cognitive impairment. She has a diagnosis of acute oropharyngeal dysphagia as well as a number of physical health problems including renal impairment, chronic constipation, double incontinence, hypothyroidism. I will refer to the patient as "HJ" in this judgment

in order to anonymise her and I grant an injunction to restrain anyone identifying HJ as the person to whom this judgment relates.

2. The Norfolk and Suffolk NHS Foundation Trust ("**the Trust**") originally applied for a determination that it was lawful to deprive HJ of her liberty whilst Trust clinicians were administering enemas to treat HJ for constipation. For the reasons set out below, it is now agreed that the Trust does not need the relief that it originally sought. Nonetheless, as this case has given rise to a series of issues concerning the treatment of detained mental health patients for physical conditions, I have been asked by the parties to give a full judgment and do so. The parties were also not able to agree whether the engagement of HJ's rights under article 8 of the European Convention on Human Rights ("**ECHR**") imposed additional procedural duties on the Trust which should be included within a court order, including a duty to conduct regular reviews of the treatment regime.

3. The Trust was represented by Ms Nicola Greaney KC and the Official Solicitor was appointed act to act as HJ's litigation friend, and represented by Mr Rhys Hadden. I am grateful to both counsel for their oral and written submissions.

The facts.

4. HJ was admitted on 19 June 2020 to a hospital operated by the Trust and was detained there following an order made by a Responsible Clinician under section 3 of the Mental Health Act 1983 ("**MHA**"). Since her detention, HJ has been accommodated on an admission and assessment ward for those with acute mental illness who cannot safely be managed in the community.

5. The medical evidence in this case is not in dispute and I can therefore summarise it. HJ's mental health condition manifests in very challenging behaviour, which includes verbally and physically attacking other staff and patients, verbal outbursts and other disinhibited behaviour. She is treated with anti-psychotic medication which is administered covertly (following a best interest assessment) because she otherwise declines medication, although she will sometimes agree to depot antipsychotic medication. It is challenging for clinical staff to maintain a level of stability in her mental health due to the difficulty in ensuring that she takes all of her medication.

6. HJ also suffers from chronic constipation. Her constipation is not directly related to her mental health conditions but arises due to functional bowel disease and slow intestinal transit. The usual management for this condition for patients without mental health conditions is a combination of diet, exercise, laxatives and enemas as needed, along with seeking to avoid other medication that aggravates constipation. Following advice from a gastroenterologist, the Trust sought to increase HJ's dose of laxatives with a view to dropping or reducing the need for enemas. However, the laxatives stimulated strong peristaltic contractions and hence, the laxative dose was reduced to prevent those side effects. The combination of laxatives and regular enemas has managed to keep HJ's bowels reasonably open. She has also been prescribed linaclotide which is a drug for those with constipation refractory to laxatives.

7. The Trust accepts that HJ's resistance to treatment for her chronic constipation is closely related to the mental disorders from which she suffers. Her Bipolar Affective Disorder with psychotic symptoms results in her refusing other medications and care interventions, largely because she does not understand the potential benefit to her from some of medication prescribed for her or the consequences for her of not taking those medications. However, the Trust submits that her chronic constipation is a physical condition which has not been caused by HJ's mental disorder. On this point there is agreement between the Trust and the Official Solicitor, and I also agree.

8. The Trust also submits that her chronic constipation is not the primary or even a subsidiary cause of her mental disorder, although there is some evidence that she can present with an improved mental state after she has had an enema. That is the thrust of the medical evidence and I agree that this is the case. The fact that HJ's presenting mental health state can, to an extent, be improved or can deteriorate depending on her physical condition does not mean that her mental health condition is caused by her physical health problems. She may well present with fewer symptoms of her mental health condition when she is in good physical health and not in pain, but her gastrointestinal illness is not the cause of her Bipolar Affective Disorder. It follows that, as agreed between the parties, the administration of enemas falls outside the scope of section 63 MHA even applying the expanded scope of section 63 arising from cases such as *B v Croydon Health Authority* [1995] Fam 133.

9. Whilst her refusal of medication and the need to treat her with medication covertly might have an impact on the efficacy of laxatives and other medication, it seems to me that the Trust are correct to say that the key problem is that the treating team is fully justified in not increasing the dose of laxatives to the dosage initially recommended by the gastroenterologist because HJ cannot tolerate a higher dose of laxatives and experiences strong contractions. This appears to be a physical reaction to laxative medication and does not appear to be related to her mental disorder. In any event, the evidence suggests that some enemas may be needed even if HJ could tolerate an increased dose of laxatives.

10. Prior to her current admission, HJ had lived in the community for many years. In April 2018 she was admitted to a hospital operated by the Norfolk and Norwich University Hospitals NHS Foundation Trust with a urinary tract infection. At that point she presented with psychotic delusions and severe self-neglect. She was then detained under the MHA at the Trust hospital where she is now detained and subsequently discharged to a care facility where she was subject to a supervision regime which meant that she was deprived of her liberty. A standard authorisation order was made under Schedule A1 of the Mental Capacity Act 2005 ("**MCA**"). That standard authorisation meant that the deprivation of her liberty in that care facility was lawful. HJ was thereafter re-admitted to the Trust hospital and detained under s.3 MHA on 19 June 2020 following a decline in her mental health subsequent to a fall. She has thus been in hospital and receiving this treatment for the past 3 years.

11. HJ continues to suffer from chronic constipation and is prescribed regular enemas which are currently being administered every 2 to 3 days, alongside daily laxatives (lactulose and senna) and another medication (linaclotide) used to treat constipation. In order for an enema to be administered, HJ requires restraint from nursing staff and about 5 members of staff are usually required. The process of providing her with an enema was described by Nurse O who gave helpful evidence by video link to the court. She explained that when staff consider that HJ is suffering signs of distress and an enema may be needed, she is guided or physically escorted from the "pod area" towards her bed and placed in the prone position and rolled onto her left side. Staff will then go on either side of the bed and hold her arms for reassurance. Once HJ is on the bed, nursing staff explain to her that they need to administer an enema. At this time HJ will typically either attempt to pull at staff clothing or grip onto staff hands or body parts. The administration of the

enema itself requires 4 people to assist with the physical restraint required; one person on each side to restrain arms, one to administer the enema and a fourth person to hold both legs and prevent HJ from kicking staff. A fifth person is also required to open doors entering her room, support her head if needed and monitor her physical state during the restraint. HJ will continue to be loud and verbally aggressive towards staff throughout this process.

12. Nurse O further explained that:

(i) The typical duration of physical restraint when administering the enema with HJ on the bed is approximately "3-5 minutes in length";

(ii) It may take between "30 seconds to 5 minutes" for HJ to be physically escorted from the pod area to her bedroom. This escort may require some form of physical restraint (such as holding her forearms), although hand holding can be used more often than not;

(iii) HJ has had other forms of treatment provided via the same restraint procedure including: (i) administration of depot medication once per week (although this has not been required since March 2023); (ii) administration of rapid tranquilisation by intra-muscular injection on a PRN basis; (iii) taking blood samples; (iv) the administration of skin ointment (although she could not recall when this was last needed); and (v) transfers to an acute hospital for medical treatment;

(iv) The provision of enemas under restraint is reported to take "slightly more time" than other forms of treatment;

(v) HJ can remain agitated and/or distressed for up to an hour after the administration of an enema, although sometimes this can also resolve within a few minutes;

(vi) If HJ is not provided with an enema and has no bowel movement, it can become very painful for her in the short-term in addition to the serious longer-term risk of bowel perforation;

(vii) Two other service users within the ward also require physical restraint to deliver treatment, although not to the same extent, frequency or durations as HJ;

(viii) A record is kept in HJ's medical notes whenever physical restraint is used;

(ix) HJ's ongoing care and treatment is discussed and reviewed during MDT meetings on a weekly basis, although there is no formal review of the restraint plan; and

(x) Staff would be prepared to undertake a more structured review of HJ's restraint plan on a periodic basis, including consideration about whether this method of delivery remains necessary and proportionate and whether any less restrictive measures could be used.

13. There is no challenge to this evidence and I accept it. I should also record that I was impressed by the level of care and thought that has gone into the treatment regimes operated by the Trust and the extent to which staff have thought through how to deliver care which is consistent with maintaining HJ's dignity and, where she is resisting, that they should only provide care and treatment which is proportionate to the benefit that HJ is expected to receive from the care.

14. The present position is that HJ is clinically ready to be discharged but no arrangements for her aftercare have yet been settled. Norfolk County Council and NHS Norfolk and Waveney Integrated Care Board are the bodies with after-care responsibilities for HJ pursuant to s117 MHA, following her proposed discharge from detention under s3 MHA. The after-care bodies have yet to identify a suitable community placement and I am told that it may take some time to arrange a suitable community placement where HJ can continue to receive care for both her physical and mental health conditions. In the meantime, HJ remains detained in hospital under the MHA and the Trust are rightly concerned to ensure that it and its clinical staff are acting lawfully in treating her, including when administering enemas to HJ.

Does HJ have capacity to make her own medical treatment decisions?

15. The Trust's case is that applying the tests in the MCA, HJ lacks capacity to consent to medical treatment. The Trust relies on the capacity assessment by a registered mental health nurse. This assessment has been supported by a report by a consultant psychiatrist, Dr Tyrone Glover, who has provided an independent assessment of her capacity to make decisions about her medical treatment for chronic constipation, including the administration of enemas. Dr Glover concludes that HJ is unable to understand relevant information as a direct result of her mental disorder, whether that is a Bipolar Affective Disorder or a schizoaffective disorder, as she was originally diagnosed by Dr Fadlalla, her Responsible Clinician, but which, according to Dr Glover, is not the correct diagnosis. Whilst he was not able to assess this directly (due to HJ's refusal to engage

in an assessment with Dr Glover), the clear references in her notes that she is disinterested in her condition/treatment or actively hostile towards those caring for her, which represents a degree of persecutory thinking, means that she is unable to weigh relevant information in the balance to make a decision about treatment options. Dr Glover concludes that she lacks capacity to make decisions about medical treatment.

16. The Official Solicitor agrees HJ lacks capacity and I accept that evidence. It follows that I proceed on the basis that, whether she is detained under the MCA or not, HJ lacks capacity to make her own decisions concerning all material aspects of her medical treatment.

What is the legal consequences of HJ's lack of capacity?

17. Section 5 of the MCA 2005 defines the circumstances in which a person can provide care or treatment for a person lacking capacity to consent to that care or treatment without incurring personal liability. It states as follows:

> *"Acts in connection with care and treatment*
>
> *(1) If a person ("D") does an act in connection with the care or treatment of another person ("P"), the act is one to which this section applies if—*
>
> *(i) before doing the act, D takes reasonable steps to establish whether P lacks capacity in relation to the matter in question, and*
>
> *(ii) when doing the act, D reasonably believes—*
>
> *(i) that P lacks capacity in relation to the matter, and*
>
> *(ii) that it will be in P's best interests for the act to be done.*
>
> *(2) D does not incur any liability in relation to the act that he would not have incurred if P—*
>
> *(a) had had capacity to consent in relation to the matter, and*
>
> *(b) (b) had consented to D's doing the act.*
>
> *(3) Nothing in this section excludes a person's civil liability for loss or damage, or his criminal liability, resulting from his negligence in doing the act.*
>
> *(4) Nothing in this section affects the operation of sections 24 to 26 (advance decisions to refuse treatment)"*

18. I accept, as the Official Solicitor submits, that section 5 MCA 2005 effectively provides a codified defence of necessity and, in and of itself, does not provide a formal power to anyone to do anything. Instead, it provides that if reasonable steps are taken by a person, "D", to determine whether P lacks capacity in relation to a matter connected with their care and treatment, and D reasonably believes doing the act is in P's best interests, then P is treated in law as a person who has consented to the care or treatment being provided. Hence, assuming that D is neither negligent nor criminal in the way in which they carry out the action, then D will be protected from any form of legal liability. As Lady Black held in *NHS Trust v Y* [2018] UKSC 46 at [36]:

> *"36. Section 5 allows carers, including health professionals, to carry out acts in connection with personal care, health care, or treatment of a person who lacks capacity to consent. It provides a significant degree of protection from liability, provided that the act is done in the reasonable belief that capacity is lacking and that the act is in the patient's best interests. If these conditions are satisfied, no more liability is incurred than would have been incurred if the patient had had capacity to consent and had done so."*

19. Where any part of the care provided to P involves restraint, there are limitations to acts that can lawfully be provided to an adult who lacks capacity, as set out in section 6 MCA 2005. Section 6 MCA provides as follows:

> *"(1) If D does an act that is intended to restrain P, it is not an act to which section 5 applies unless two further conditions are satisfied.*
> *(2) The first condition is that D reasonably believes that it is necessary to do the act in order to prevent harm to P.*
> *(3) The second is that the act is a proportionate response to—*
> *(a) the likelihood of P's suffering harm, and*
> *(b) the seriousness of that harm.*
> *(4) For the purposes of this section D restrains P if he—*
> *(a) uses, or threatens to use, force to secure the doing of an act which P resists, or*
> *(b) restricts P's liberty of movement, whether or not P resists. …"*

20. For the patient who has capacity, physical restraint in the absence of consent or other lawful authority may amount to a civil trespass to the person and may amount to a crime, depending on the severity and impact of the restraining measure. The fundamental principle is that, in the absence of proper legal basis for the imposition of any form of restraint, any substantial restraint of a person is highly likely to amount to an assault.

21. However, section 6 of the MCA recognises that many patients who lack capacity will also resist having medical treatment or care which is entirely appropriate for them because they will not understand why they are being provided with care or treatment. The broad effect of section 6 MCA 2005 is that, where such treatment is reasonably believed to be in P's best interests, restraint short of a deprivation of liberty can lawfully be imposed on P without any further authorisation where it is reasonably believed by those providing the care that it is necessary to prevent harm and the restraint used is proportionate to the likelihood and seriousness of that harm.

22. The Trust submitted that, on the facts of this case, the treating clinicians are satisfied that administering enemas to HJ in the manner set out above is in HJ's best interests because it seeks to avoid the potentially serious and even life-threatening consequences of an unwanted build-up of faeces in her body. The Trust also submits that the evidence shows that only proportionate restraint is used and thus, on the facts of this case, the clinicians can bring themselves within the terms of section 6 MCA. Once the submission was put in that way, it was not opposed by the Official Solicitor. I agree that, given the evidence in this case, the clinicians can bring themselves within the terms of section 6 MCA and thus it is lawful for Trust clinicians to administer enemas to HJ in accordance with the procedures described in the evidence. I observe that, if matters had stopped at that point, there would have been no need for the Trust to come to court because the legal approvals needed under these procedures of the MCA do not require court oversight.

23. However, the Trust was concerned that the process of administering enemas was depriving HJ of her liberty and rightly observed that, if that was the position, it was not possible for a standard authorisation to be made to provide lawful authority for that deprivation of liberty because HJ, as a detained patient under the MHA in hospital, was ineligible to be subject to a standard authorisation or deprived of her liberty pursuant to sections 4A(3) and 16(2) MCA: see the ineligibility categories in Schedule 1A of the

MCA. The Official Solicitor originally agreed that the process of administering enemas was depriving HJ of her liberty, and that the standard authorisation was not available to the Trust, and thus a court order would be required so that the Trust could lawfully deprive HJ of her liberty. Hence this case came before me originally on the basis that the court would have to consider and approve the deprivation of HJ's liberty because there was no other mechanism to do so.

24. Despite the fact that both parties agreed that the process of administering enemas was depriving HJ of her liberty, in email exchanges before the case was heard I raised a concern with the parties that, as HJ was a person who was already deprived of her liberty because she was lawfully detained under the MHA, I was not satisfied that the process of administering enemas necessarily resulted in a further deprivation of her liberty. I therefore invited the parties to reconsider the position and make submissions as to which side of the line this case fell. Having considered the matter, the Trust reversed its position and submitted that the process of administering enemas did not deprive HJ of her liberty and invited me to make a declaration to that effect. The Official Solicitor, acting in her usual responsible and sensitive way, decided to hear the evidence about the way that enemas were administered to HJ and then reflect on it. Having done so, the Official Solicitor also confirmed that, on behalf of HJ, she accepted that the process of administering enemas did not deprive HJ of her liberty.

25. As this is a matter which came to court on the basis that both parties, advised by experienced solicitors and counsel considered that there was a deprivation of liberty but where, on further reflection, both parties concluded there was no deprivation of liberty and hence changed their positions, I have been invited to explain why I am satisfied that the final position reached by both parties is correct in law.

26. The primary purpose of article 5 ECHR is to prevent a person being subject to arbitrary detention by a state body. However, as the ECtHR explained in *Ashingdane v United Kingdom (1985) 7 EHRR 528,* once a lawful detention is established, "*Article 5(1)(e) is not in principle concerned with suitable treatment or conditions*". That general restriction does not mean that, once a person is lawfully detained, the person's article 5 rights cannot be breached as the European Court of Human Rights ("**ECtHR**") determined in in ECtHR in *Munjaz v United Kingdom* [2012] ECHR 1704, [2012] MHLR

351. Mr Munjaz was a British national who was a lawfully detained psychiatric patient at Ashworth Special Hospital. His route to detention was sections 47 and 49 MHA as opposed to section 3 MHA, but I do not consider that anything turns on the legal basis for his detention. Mr Munjaz challenged the lawfulness of the Ashworth policy on seclusion which was used to place him in seclusion for extended periods of time arguing that his seclusion within the hospital amounted to a breach of his ECHR rights, including his article 5 rights. The Trust argued that secluding Mr Munjaz was lawful because it followed the hospital's seclusion policy. One of the issues for the court was whether that policy was lawful because it departed from the form of policy recommended under the statutory MHA Code of Practice, particularly by reducing the number and frequency of reviews of his seclusion by a doctor from that laid down in the Code.

27. In the House of Lords, Lord Bingham referred to the article 5 question being whether the Ashworth seclusion policy lawfully "*permit[ted] a patient to be deprived of any residual liberty to which he is properly entitled*". Hence Lord Bingham proceeded on the basis that a person who was held by a state body in circumstances where that person was deprived of their liberty on a primary basis and where that deprivation of liberty satisfied the requirements of article 5 ECHR, nonetheless retained a measure of "residual liberty". Lord Bingham considered that, if that residual liberty were to be taken away, the person could suffer a deprivation of liberty which would have to be justified. That reasoning, namely that there was a possible breach of article 5 ECHR where a detained person had their residual liberty removed, was consistent with the ECtHR case of *Bollan v United Kingdom,* App No. 42117/98. In that case the ECtHR considered the case of a prisoner who complained that she was unlawfully deprived of her liberty by being secluded in her cell for two hours. The ECtHR (albeit in an admissibility decision) said "*The court does not exclude that measures adopted within a prison may disclose interferences with the right to liberty in exceptional circumstances*". However, the ECtHR also said in that case that "*modifications of the conditions of lawful detention … fall outside the scope of Article 5 § 1 of the Convention*". Hence, it was a question of fact and degree as to whether a change in detention conditions which further curtailed a detained person's liberty amounted to a further deprivation of liberty. The question of justification or otherwise of that further deprivation of liberty would only arise if the line was crossed so that a further deprivation of liberty was established.

28. The ECtHR confirmed at paragraph 65 on *Munjaz* that a detained person was capable of being subject to a further deprivation of liberty but it said that "*whether or not there has been a further deprivation of liberty in respect of a person who is already lawfully detained must depend on the circumstances of case*". On the facts, the ECtHR found there was no further deprivation of liberty in the case of Mr Munjaz, despite his long periods in seclusion. Amongst the four reasons given by the Court at paragraphs 69 to 72 was that "*the aim of seclusion at the hospital is to contain severely disturbed behaviour which is likely to cause harm to others*" and that the period of seclusion was a matter of clinical judgment.

29. There have been a series of subsequent cases where detained persons have sought to argue that the conditions in which they are detained breach their rights to residual liberty under article 5 ECHR. In *R (Idira) v The Secretary of State for the Home Department* [2015] EWCA Civ 1187 the Court of Appeal considered the case of a time-served convicted foreign national offender who objected to being held in prison whilst he was awaiting deportation as opposed to being held in the more liberal conditions of an Immigration Detention Centre. His claim that the refusal of the Secretary of State to transfer him to an IRC constituted a breach of his article 8 rights failed. The Master of the Rolls examined the relevant cases and said at paragraph 38:

> *"I accept that the language used in these three cases appears to lend support to the idea that the court is not concerned with the appropriateness of the place and conditions of detention in a broad sense, but rather with the narrow question whether the place and conditions of the detention are closely connected with the purpose for which the person is being detained"*

30. However, the Master of the Rolls also said as follows at paragraph 50, referring to *Saadi v United Kingdom* (2008) 47 EHRR 17 in which the ECtHR considered the lawfulness of the UK's then fast track regime for asylum seekers:

> *"Thirdly, it should not be overlooked that the overarching purpose of article 5 is to protect the individual from arbitrariness. The three principles described in Saadi are criteria for determining whether detention is arbitrary. The first is that detention infected by bad faith or deception on the part of the authorities is*

arbitrary. The second is that detention which is not in furtherance of one of the purposes permitted by article 5(1) is also arbitrary. Both of these principles are fundamental and central to a fair and rational detention scheme. The third is that detention in an inappropriate place and in inappropriate conditions is also arbitrary. In my view, when articulating this third principle, the court must have had in mind serious inappropriateness. It would be difficult to describe anything less as "arbitrary" or belonging to the same category of seriousness as the other two principles. This conclusion is consistent with what the Supreme Court said in R (Kaiyam) v Secretary of State for the Home Department [2014] UKSC 66, [2015] 2 WLR 76 at para 25:

> *"In this as in other contexts, the Convention has not infrequently resorted to a concept of 'arbitrariness' to explain what it means by unlawfulness. The natural meaning of this English word connotes some quite fundamental shortcoming. But it is also clear that, when used at the international level, its sense can depend on the context"*

31. A further example is *R (Soltany & Ors) v Secretary of State for the Home Department* [2020] EWHC 2291 (Admin) where an article 5 challenge was made to the lawfulness of the regime at an IRC which required detainees to remain in their rooms. That claim examined *Munjaz* but failed because "*the night state was one of the conditions of lawful detention at an IRC*": see paragraph 275 of the judgment of Cavanagh J.

32. Pulling the threads of the reasoning in these cases together, in my judgment the following principles apply to as assessment as to whether medical treatment provided to someone in lawful detention amounts to a further deprivation of their liberty:

(a) the starting point should be that it will only be in exceptional cases (see *Bollan/Munjaz*) where something that happens to a person who has already been lawfully deprived of their liberty will amount to a further deprivation of that person's residual liberty;

(b) Article 5 will only arise in an exceptional case because the usual position is that "*Article 5(1)(e) is not in principle concerned with suitable treatment or conditions*" (*Ashingdane*); and

(c) the acid test for the engagement of article 5 in any case involving an alleged deprivation of residual liberty is whether there is an unacceptable element of arbitrariness in the actions which are taken by a state body and which are said to deprive a person of their residual liberty (see *Idira*).

33. Applying that approach, it must follow that, save in exceptional circumstances, any proper and lawful exercise of clinical judgment by clinicians in administering medical treatment to a detained person will not amount to a deprivation of the person's residual liberty because there is no element of arbitrariness in the actions of the clinical staff. If restraint is imposed in order to enable treatment to be administered for a physical health condition for a person who lacks capacity to consent under the MCA, the tests for the lawfulness of that restraint are set out in section 6 MCA. If those conditions are satisfied, the usual consequence will be that there will be no independent breach of the patient's rights under article 5 ECHR. Part of the reason that, in my judgment, there will be no breach of article 5 rights in such circumstances is that the Trust owes a common law duty of care to HJ. That duty means that, whilst she is detained in hospital, Trust staff are required to provide her with appropriate medical treatment to meet her physical and psychological needs. The Trust discharge that duty by administering medical treatment to her, including enemas as described above, and there is nothing arbitrary about their application in HJ's case. On the contrary, as set out above, this is a carefully thought-out treatment plan which is designed to meet her medical needs in a lawful and proportionate manner. I do not consider that acts taken by clinical staff to discharge that duty are capable of amounting to the type of exceptional circumstances which could lead to a further deprivation of HJ's residual liberty. In my judgment, HJ cannot be deprived of her liberty as a result of actions of Trust staff that, to discharge their duty of care to HJ, they are required to take. I therefore consider that the revised position adopted by the Trust was correct and that the Official Solicitor was also correct to make the concession that HJ was not being deprived of her liberty when she was being administered enemas.

Does article 8 ECHR require a regular review of the Trust's plans?

34. I accept that HJ's article 8 rights are engaged by decisions made to apply enemas to her and the accompanying decisions to use restraint to enable that treatment to be administered. The Official Solicitor submits that, based on case such as *J Council v GU*

& Ors (Rev 1) [2012] EWCOP 3531, the procedural requirements of article 8 require a framework to be put in place to monitor these decisions. There is no dispute that article 8 contains procedural as well as substantive obligations. In *R (TB) v The Combined Court At Stafford* [2006] EWHC 1645 (Admin) May LJ said at paragraph 23:

> *"More generally, although Article 8 contains no explicit procedural requirements, the court will have regard to the decision making process to determine whether it has been conducted in a manner that, in all the circumstances, is fair and affords due respect to the interests protected by Article 8. The process must be such as to secure that the views of those whose rights are in issue are made known and duly taken account of. What has to be determined is whether, having regard to the particular circumstances of the case and notably the serious nature of the decisions to be taken, the person whose rights are in issue has been involved in the decision making process, seen as a whole, to a degree sufficient to provide them with the requisite protection of their interests"*

35. The process leading up to the administration of enemas is required by section 4 MCA to fully take into account HJ's views, albeit they are not decisive. Overall, the sections 4 and 6 MCA decision making process is a process mandated by statute and, if followed, in my judgment satisfies the requirements of fairness and properly respects a patient's article 8 rights. However, as any restraint which is applied to HJ takes place within a mental health unit, there are the additional procedural obligations imposed by the Mental Health Units (Use of Force) Act 2018 ("**the 2018 Act**"). The 2018 Act came into force in November 2018 and is concerned, *inter alia*, with *the oversight and management of the appropriate use of force in relation to people in* mental health units. The 2018 Act is accompanied by statutory guidance, namely the Mental Health Units (Use of Force) Act 2018: statutory guidance for NHS organisations in England, and police forces in England and Wales. In summary, the 2018 Act requires:

(i) each mental health unit to have a "responsible person" (section 2) who must be a permanent member of staff within the organisation and be a member of the organisation or trust board. The role may be undertaken by, for example, the Chief Nursing Officer or Medical Director, and may be delegated to a relevant person if they are of an appropriate level of seniority (section 10).

(ii) The responsible person must:

(a) publish and keep under review a policy regarding the use of force on patients by staff who work in the mental health units run by that organisation or trust (section 3);
(b) Publish information about the use of force (section 4);
(c) Provide training for staff in the appropriate use of force (section 5).

36. The Trust has explained how it is complying with the terms of the 2018 Act. It has appointed a responsible person or suitable seniority, adopted a policy regarding the use of force on patients by staff who work in its mental health units and is providing appropriate training. None of the steps taken by the Trust to implement the terms of the 2018 Act have been criticised by the Official Solicitor and it appears to me that the evidence provided about the way restraint is applied to HJ is consistent with the Trust policy and the recording of the use of restraint follows (if not exceeds) the requirements of the 2018 Act. I also note that the requirements of the 2018 Act supplement the duty on the Trust to have regard to the Statutory Code of Practice published under the MHA.

37. In *J Council v GU & Ors* Mostyn J considered that the procedural requirements under article 8 required an additional degree of oversight because restraint was taking place outside of mental health detention and was thus occurring in a setting where there were "*no equivalent detailed procedures and safeguards stipulated anywhere for persons detained pursuant to orders made under the Mental Capacity Act 2005*": see judgment at paragraph 14. This case is different because (a) it takes place within the legal framework applying to patients who are detained under the MHA and (b) the procedural requirements of the 2018 Act are required to be followed and, on the evidence, are being followed. In those circumstances, I do not accept that the existing legal obligations on the Trust need to be supplemented in order to ensure compliance with HJ's article 8 rights. On the contrary, it seems to me that the requirements on the Trust to continue to comply with the best interests decision making processes under section 4 MCA, the need to ensure that any level of restraint is justified under section 6 MCA and the additional procedural requirements imposed on the Trust by a combination of the MHA framework and the 2018 Act provide an entirely adequate procedural framework to protect HJ's

article 8 rights. I therefore do not accept that it is either necessary or appropriate to supplement these obligations with provisions within a court order.

38. I am however prepared to make a Declaration under section 15 of the MCA that the Trust is acting lawfully in administering enemas to HJ in accordance with the protocols described in the evidence in this case. No Declaration is needed under the inherent jurisdiction because I am satisfied that the MCA provides a sufficient framework for governing the lawfulness of the actions of the Trust and clinical staff employed by the Trust.