

# Control and Restraint

Delegate's Handout

**InPractice**

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## **Introduction**

This training day will give an overview of the legal context for the use of control and restraint.

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## Content

Introduction.....	2
Content.....	3
The Standard of Care .....	4
Bolam.....	4
Bolitho .....	4
Wilsher.....	4
The Legal Framework.....	5
1. Common Law – Significant Harm.....	6
2. Mental Capacity Act.....	7
Informed Consent – An Overview.....	9
The Mental Capacity Act - Overview.....	10
Capacity Test.....	11
Capacity Assessment “Essay Plan” .....	12
Patients Who Lack Capacity.....	16
Doctrine of Emergency .....	16
Doctrine of Best Interests.....	17
Best Interests “Essay Plan” .....	17
Deprivation of Liberty Safeguards .....	20
What Constitutes Deprivation? .....	20
What are the Safeguards? .....	29
Human Rights .....	32
Human Rights Decision Making Map .....	32
Human Rights Act Articles.....	33
3. Criminal Law Act.....	38
4. Common Law – Breach of the Peace.....	39
5. Mental Health Act.....	41
Case Studies.....	45

## **The Standard of Care**

*Bolam*

*Bolitho*

*Wilsher*

Control and Restraint – Delegate’s Workbook

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No action should be taken on the information contained in this workbook. Delegates are advised to consult their own legal advisors.

## The Legal Framework

1. Common Law – significant harm
2. Mental Capacity Act
3. Criminal Law Act
4. Common Law – breach of the peace
5. Mental Health Act

## 1. Common Law – Significant Harm

R (on the application of Munjaz) v Mersey Care NHS Trust [[2003] EWCA Civ 1036; [2003] MHLR. 362 at para 46 Hale LJ said:

“There is a general [common law] power to take steps as are reasonably necessary and proportionate to protect others from the immediate risk of significant harm. This applies whether or not the patient lacks the capacity to make decisions for himself”

## 2. Mental Capacity Act

If the patient is mentally incapacitated, s.6 of the Mental Capacity Act 2005 enables the patient to be restrained when: (1) the person using the restraint reasonably believes that its use is necessary to prevent harm to the patient; and (2) its use is proportionate both to the likelihood and seriousness of the harm and is in the patient's best interests.

Section 5 acts: limitations

6.—(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.

(6) Section 5 does not authorise a person to do an act which conflicts with a decision made, within the scope of his authority and in accordance with this Part, by-

- (a) a donee of a lasting power of attorney granted by P, or
- (b) a deputy appointed for P by the court.

(7) But nothing in subsection (6) stops a person-

- (a) providing life-sustaining treatment, or
- (b) doing any act which he reasonably believes to be necessary to prevent a serious deterioration in P's condition, while a decision as respects any relevant issue is sought from the court.

Acts in connection with care or treatment

5.—(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-

(a) before doing the act, D takes reasonable steps to establish whether P lacks capacity in relation to the matter in question, and

(b) 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-

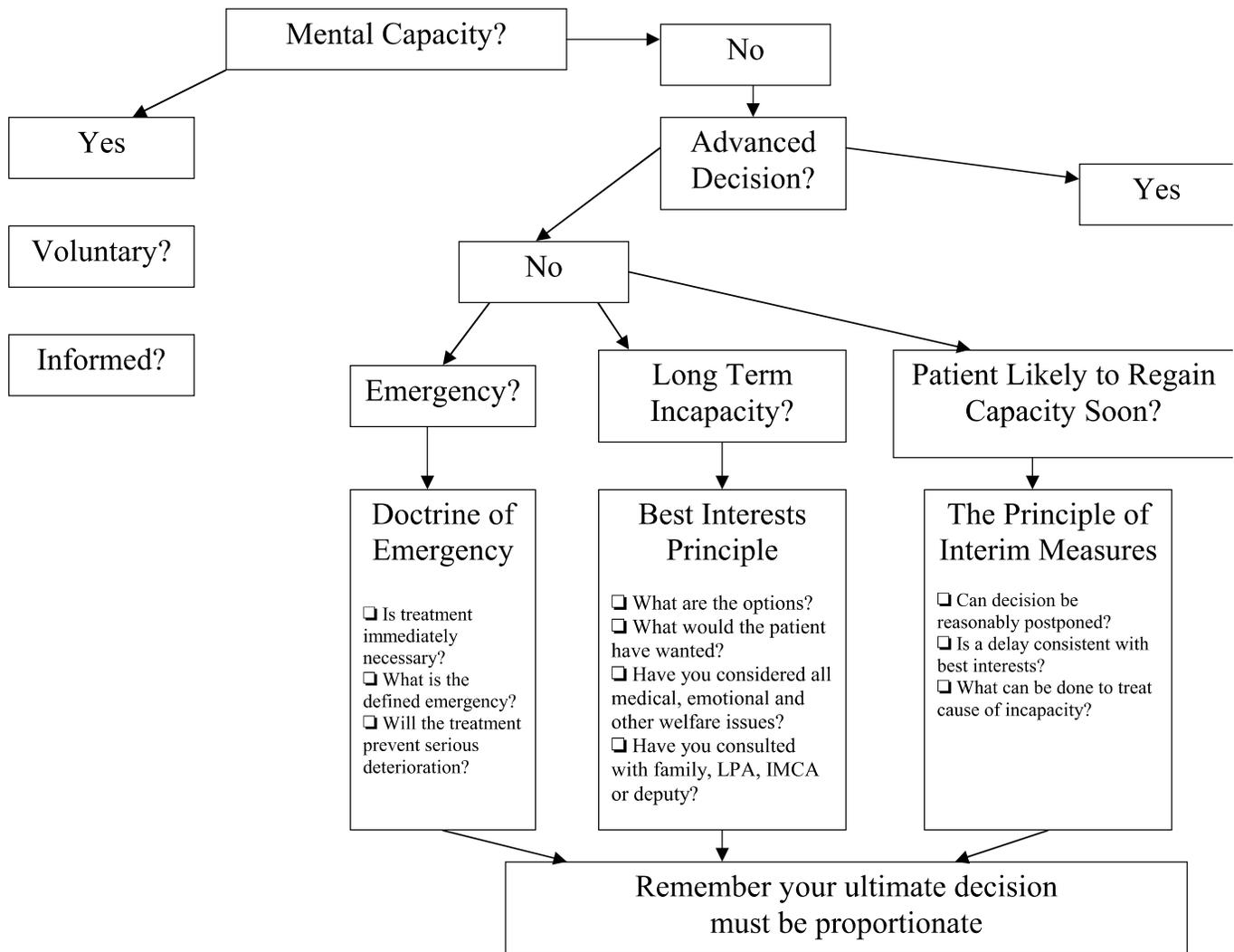
(a) had had capacity to consent in relation to the matter, and

(b) 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).

## *Informed Consent – An Overview*



## ***The Mental Capacity Act - Overview***

1. Presumption of capacity
2. Duty to help patients make their own decisions
3. Respect for personal value systems
4. Best interests checklist
5. Proportionality

## ***Capacity Test***

There is a two stage capacity test.

This test (and some guidance on applying it) is contained in **Section 3** of Part 1 of the Act which is entitled 'Persons Who Lack Capacity'.

A person will be deemed unable to make his or her own decisions i.e. lacking capacity, if he/she;

- a) has an impairment of , or a disturbance in the functioning of, their mind or brain and
- b) this renders the person unable to make the specific decision in question

## ***Capacity Assessment “Essay Plan”***

What has pushed the presumption of capacity to one side?

What is the decision?

What is the information relevant to the decision?

Does the patient have an impairment or disturbance of their mind or brain and if so what is it?

Can the patient understand the information and how did you assess this?

Can the patient retain the information and how did you assess this

Can the patient weigh up the information to arrive at a choice and how did you assess this (this includes referencing the patient’s rationale)

Can the patient communicate a choice and what steps did you take to facilitate this?

**“Section 3**

***A person is unable to make a decision if he/she is unable:***

***(1)***

***a. to understand the treatment relevant to the decision***

***b. to retain that information***

***c. to use or weigh that information as part of the process of making the decision or***

***d. to communicate his decision (whether by talking, using sign language or any other means)”***

***“(2) A person is not to be regarded as unable to understand the information relevant to a decision if he is able to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means).***

***(3) The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.***

***(4) The information relevant to a decision includes information about the reasonably foreseeable consequences of-***

***(a) deciding one way or another, or***

***(b) failing to make the decision.”***

Section 1 sets out the principles regarding capacity.

***“Section 1 The principles***

***(1) The following principles apply for the purposes of this Act.***

***(2) A person must be assumed to have capacity unless it is established that he lacks capacity.***

***(3) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.***

***(4) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.***

***(5) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.***

***(6) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.***

Section 2 warns healthcare professionals that a person cannot be judged to lack capacity simply because of his age, appearance or behaviour.

**“Section 2**

***(1) For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.***

***(2) It does not matter whether the impairment or disturbance is permanent or temporary.***

***(3) A lack of capacity cannot be established merely by reference to-***

***(a) a person's age or appearance, or***

***(b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity.***

***(4) In proceedings under this Act or any other enactment, any question whether a person lacks capacity within the meaning of this Act must be decided on the balance of probabilities.***

***(5) No power which a person ("D") may exercise under this Act-***

***(a) in relation to a person who lacks capacity, or***

***(b) where D reasonably thinks that a person lacks capacity, is exercisable in relation to a person under 16.***

***(6) Subsection (5) is subject to section 18(3).”***

## *Patients Who Lack Capacity*

### **Doctrine of Emergency**

Positive duty to do what is immediately necessary in the defined emergency to prevent a serious deterioration in physical or mental well being but no intervention beyond the point of crisis.

## **Doctrine of Best Interests**

When a clinician treats a patient who lacks capacity in the long term they do so under the doctrine of best interests.

### **Best Interests “Essay Plan”**

1. Options

2. Profile Patient

Current wishes

Past wishes

Consult interested parties where appropriate and practicable

Other factors

3. Revise Options

4. Select Option Giving Reasons

***“ Section 4 Best interests***

***(1) In determining for the purposes of this Act what is in a person's best interests, the person making the determination must not make it merely on the basis of-***

***(a) the person's age or appearance, or***

***(b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about what might be in his best interests.***

***(2) The person making the determination must consider all the relevant circumstances and, in particular, take the following steps.***

***(3) He must consider-***

***(a) whether it is likely that the person will at some time have capacity in relation to the matter in question, and***

***(b) if it appears likely that he will, when that is likely to be.***

***(4) He must, so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him.***

***(5) Where the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.***

***(6) He must consider, so far as is reasonably ascertainable-***

***(a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),***

***(b) the beliefs and values that would be likely to influence his decision if he had capacity, and***

***(c) the other factors that he would be likely to consider if he were able to do so.***

***(7) He must take into account, if it is practicable and appropriate to consult them, the views of-***

***(a) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,***

***(b) anyone engaged in caring for the person or interested in his welfare,***

***(c) any donee of a lasting power of attorney granted by the person, and***

***(d) any deputy appointed for the person by the court, as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6).***

## ***Deprivation of Liberty Safeguards***

The MHA 07 introduced DOLS into the MCA 05.

The safeguards became a statutory obligation from April 1 2009.

DOLS was introduced as a result of the Bournemouth ruling.

### **What Constitutes Deprivation?**

Deprivation of liberty is not defined because the Government decided that each case should be decided on its facts.

#### HL v UK October 2004 ECtHR

“the distinction between a deprivation of and a restriction upon liberty is merely one of degree or intensity and not one of nature or substance”

The ECtHR and UK courts have determined a number of cases about deprivation of liberty. Their judgments indicate that the following factors can be relevant to identifying whether steps taken involve more than restraint and amount to a deprivation of liberty. It is important to remember that this list is not exclusive; other factors may arise in future in particular cases.

- Restraint is used, including sedation, to admit a person to an institution where that person is resisting admission.
- Staff exercise complete and effective control over the care and movement of a person for a significant period.
- Staff exercise complete control over assessments, treatment, contacts and residence.
- A decision is taken by the institution that the person will not be released into the care of others, or permitted to live elsewhere, unless the staff in the institution consider it appropriate.
- A request by carers for a person to be discharged to their care is refused.
- The person is unable to maintain social contacts because of restrictions placed on their access to other people.
- The person effectively loses autonomy because they are under continuous supervision and control.

When considering whether an intervention constitutes deprivation the Code of Practice suggests the decision maker should consider the following:

“

- all the circumstances of each and every case
- what measures are being taken in relation to the individual?
- When are they required?
- For what period do they endure?
- What are the effects of any restraints or restrictions on the individual?
- Why are they necessary?
- What aim do they seek to meet?
- what are the views of the relevant person, their family or carers?
- Do any of them object to the measures?
- how are any restraints or restrictions implemented?
- Do any of the constraints on the individual’s personal freedom go beyond ‘restraint’ or ‘restriction’ to the extent that they constitute a deprivation of liberty?
- are there any less restrictive options for delivering care or treatment that avoid the deprivation of liberty altogether?
- does the cumulative effect of all the restrictions imposed on the person amount to a deprivation of liberty, even if individually they would not?”

### **Cases where the courts found that the steps taken did not involve a deprivation of liberty**

*LLBC v TG* (judgment of High Court of 14 November 2007)

TG was a 78-year-old man with dementia and cognitive impairment.

TG was resident in a care home, but was admitted to hospital with pneumonia and septicaemia. While he was in hospital, there was a dispute between the local authority and TG’s daughter and granddaughter about TG’s future. The daughter and granddaughter wanted TG to live with them, but the local authority believed that TG needed 24-hour care in a residential care home.

The council obtained an order from the court, directing that TG be delivered to the care home identified as appropriate by the council. Neither the daughter nor granddaughter was informed that a court hearing was taking place. That order was subsequently changed and TG was able to live with his daughter and granddaughter. TG's daughter and granddaughter claimed that the period of time he had spent at the care home amounted to a deprivation of his liberty.

The judge considered that there was no deprivation of liberty, but the case was borderline. The key factors in his decision included:

- The care home was an ordinary care home where only ordinary restrictions of liberty applied.
- The family were able to visit TG on a largely unrestricted basis and were entitled to take him out from the home for outings.
- TG was personally compliant and expressed himself as happy in the care home. He had lived in a local authority care home for over three years and was objectively content with his situation there.
- There was no occasion where TG was objectively deprived of his liberty.

The judge said:

‘Whilst I agree that the circumstances of the present case may be near the borderline between mere restrictions of liberty and Article 5 detention, I have come to the conclusion that, looked at as a whole and having regard to all the relevant circumstances, the placement of TG in Towerbridge falls short of engaging Article 5.’

#### *Nielsen v Denmark (ECtHR; (1988) 11 EHRR 175)*

The mother of a 12-year-old boy arranged for his admission to the state hospital's psychiatric ward. The boy had a nervous disorder and required treatment in the form of regular talks and environmental therapy. The treatment given, and the conditions under which it was administered, was appropriate. The duration of treatment was 5½ months. The boy, however, applied to the ECtHR, feeling that he had been deprived of his liberty.

The restrictions placed on the applicant's freedom of movement and contacts with the outside world were not much different from restrictions that might be imposed on a child in an ordinary hospital. The door of the ward was locked to prevent children exposing themselves to danger or running around disturbing other patients. The applicant was free to leave the ward with permission and to go out if accompanied by a member of staff. He was able to visit his family and friends, and towards the end of his stay to go to school.

The Court held:

‘The restrictions imposed on the applicant were not of a nature or degree similar to the cases of deprivation of liberty specified in paragraph (1) of Article 5. In particular, he was not detained as a person of unsound mind. .... Indeed, the restrictions to which the applicant was subject were no more than the normal requirements for the care of a child of 12 years of age receiving treatment in hospital.

The conditions in which the applicant stayed thus did not, in principle, differ from those obtaining in many hospital wards where children with physical disorders are treated.’

It concluded:

‘the hospitalisation of the applicant did not amount to a deprivation of liberty within the meaning of Article 5, but was a responsible exercise by his mother of her custodial rights in the interests of the child.’

*HM v Switzerland (ECtHR; (2002) 38 EHRR 314)*

An 84-year-old woman was placed indefinitely in a nursing home by state authorities. She had had the possibility of staying at home and being cared for there, but she and her son had refused to co-operate with the relevant care association, and her living conditions had subsequently deteriorated. The state authorities placed her in the home in order to provide her with necessary medical care and satisfactory living conditions and hygiene.

The woman was not placed in the secure ward of the home but was free to move within the home and to have social contacts with the outside world. She was initially undecided as to what solution she preferred and, after moving into the home, the applicant had agreed to stay there. However, she subsequently applied to the courts saying that she had been deprived of her liberty.

The Court held that she had not been deprived of her liberty:

‘Bearing these elements in mind, in particular the fact that [the authorities] had ordered the applicant’s placement in the nursing home in her own interests in order to provide her with the necessary medical care and satisfactory living conditions and standards of hygiene, and also taking into consideration the comparable circumstances of *Nielsen v Denmark* [see case summary above], the Court concludes that in the circumstances of the present case the applicant’s placement in the nursing home did not amount to a deprivation of liberty within the meaning of Article 5(1), but was a responsible measure taken by the competent authorities in the applicant’s best interests.’

## **Cases where the courts have found that the steps taken involve a deprivation of liberty**

*DE and JE v Surrey County Council (SCC)* (High Court judgment of 29 December 2006)

DE was a 76-year-old man who, following a major stroke, had become blind and had significant short-term memory impairment. He also had dementia and lacked capacity to decide where he should live, but was still often able to express his wishes with some clarity and force. DE was married to JE. In August 2003, DE was living at home with JE. There was an occasion when JE felt that she could not care for DE, and placed him on a chair on the pavement in front of the house and called the police. The local authority then placed him in two care homes, referred to in the judgment of the court as the X home and the Y home. Within the care homes, DE had a very substantial degree of freedom and lots of contact with the outside world. He was never subject to physical or chemical restraint.

DE repeatedly expressed the wish to live with JE, and JE also wanted DE to live with her. SCC would not agree to DE returning to live with, or visit, JE and made it clear that if JE were to persist in an attempt to remove DE, SCC would contact the police. DE and JE applied to the courts that this was a deprivation of his liberty.

In his judgment, Justice Munby said:

‘The fundamental issue in this case ... is whether DE has been and is deprived of his liberty to leave the X home and whether DE has been and is deprived of his liberty to leave the Y home. And when I refer to leaving the X home and the Y home, I do not mean leaving for the purpose of some trip or outing approved by SCC or by those managing the institution; I mean leaving in the sense of removing himself permanently in order to live where and with whom he chooses, specifically removing himself to live at home with JE.’ He then said:

‘DE was not and is not “free to leave”, and was and is, in that sense, completely under the control of [the local authority], because, as [counsel for DE] put it, it was and is [the local authority] who decides the essential matters of where DE can live, whether he can leave and whether he can be with JE.’

He concluded:

‘The simple reality is that DE will be permitted to leave the institution in which [the local authority] has placed him and be released to the care of JE only as and when, – if ever; probably never, – [the local authority] considers it appropriate. [The local authority’s] motives may be the purest, but in my judgment, [it] has been and is continuing to deprive DE of his liberty.’

*HL v United Kingdom (ECtHR; (2004) 40 EHRR 761)*

A 48-year-old man who had had autism since birth was unable to speak and his level of understanding was limited. He was frequently agitated and had a history of self-harming behaviour. He lacked the capacity to consent to treatment.

For over 30 years, he was cared for in Bournemouth Hospital. In 1994, he was entrusted to carers and for three years he lived successfully with his carers. Following an incident of self-harm at a day centre on 22 July 1997, the applicant was taken to Bournemouth Hospital where he was re-admitted informally (not under the Mental Health Act 1983). The carers wished to have the applicant released to their care, which the hospital refused. The carers were unable to visit him.

In its judgment in *HL v the United Kingdom*, the ECtHR said that: ‘the key factor in the present case [is] that the health care professionals treating and managing the applicant exercised complete and effective control over his care and movements from the moment he presented acute behavioural problems on July 22, 1997 to the date when he was compulsorily detained on October 29, 1997.

‘His responsible medical officer (Dr M) was clear that, had the applicant resisted admission or tried to leave thereafter, she would have prevented him from doing so and would have considered his involuntary committal under s. 3 of the 1983 Act; indeed, as soon as the Court of Appeal indicated that his appeal would be allowed, he was compulsorily detained under the 1983 Act. The correspondence between the applicant’s carers and Dr M reflects both the carer’s wish to have the applicant immediately released to their care and, equally, the clear intention of Dr M and the other relevant health care professionals to exercise strict control over his assessment, treatment, contacts and, notably, movement and residence; the applicant would only be released from hospital to the care of Mr and Mrs E as and when those professionals considered it appropriate. . . . it was clear from the above noted correspondence that the applicant’s contact with his carers was directed and controlled by the hospital, his carers visiting him for the first time after his admission on 2 November 1997. ‘Accordingly, the concrete situation was that the applicant was under continuous supervision and control and was not free to leave.’

*Storck v Germany (ECtHR; (2005) 43 EHRR 96)*

A young woman was placed by her father in a psychiatric institution on occasions in 1974 and 1975. In July 1977, at the age of 18, she was placed again in a psychiatric institution. She was kept in a locked ward and was under the continuous supervision and control of the clinic personnel and was not free to leave the clinic during her entire stay of 20 months. When she attempted to flee, she was shackled. When she succeeded one time, she was brought back by the police. She was unable to maintain regular contact with the outside world. She applied to the courts on the basis that she had been deprived of her liberty. There was a dispute about whether she consented to her confinement.

The Court noted:

‘the applicant, on several occasions, had tried to flee from the clinic. She had to be shackled in order to prevent her from absconding and had to be brought back to the clinic by the police when she managed to escape on one occasion. Under these circumstances, the Court is unable to discern any factual basis for the assumption that the applicant – presuming that she had the capacity to consent – agreed to her continued stay in the clinic. In the alternative, assuming that the applicant was no longer capable of consenting following her treatment with strong medication, she cannot, in any event, be considered to have validly agreed to her stay in the clinic.’

These cases reinforce the need to carefully consider all the specific circumstances of the relevant individual before deciding whether or not a person is being deprived of their liberty. They also underline the vital importance of involving family, friends and carers in this decision-making process: a significant feature of a number of the cases that have come before the courts is a difference of opinion or communication issue between the commissioners or providers of care and family members and carers.

### ***What are the Safeguards?***

Anyone appropriate can request in writing an assessment for Deprivation of Liberty, giving reasons for the request.

Less restrictive options should be exhausted before making a request.

An IMCA should be sought to advocate for people who do not have the support of family or friends.

The request is made by the Managing Authority to the relevant “supervisory body”.

Unless there is a Court of Protection decision on the matter, the MCA will not permit any deprivation without authorisation.

In emergencies the Managing Authority can give itself an urgent authorisation lasting 7 days, while they apply for a standard authorization. This may be extended for a further 7 days by the Supervisory Body in exceptional circumstances.

On request for authorisation the supervisory body has 21 days to obtain the following 6 assessments. For DOLS to be agreed, the person will need to meet the criteria for all of these assessments. There must be at minimum of two assessors and the mental health and best interests assessors must be different people.

**1Age assessment** – Determines whether the person is 18 and above.

**2Mental health assessment** – The person has mental disorder. This is not an assessment to determine whether the person requires mental health treatment. It is recommended that a doctor who is section 12 approved or a doctor with at least 3 years post-registration experience in the diagnosis or treatment of mental disorder (e.g. a GP with a special interest).

**3Mental capacity assessment** - The person lacks capacity to decide. This is undertaken by anyone who is eligible to act as a mental health or best interests assessor.

**4Eligibility assessment** – The person is eligible unless subject to the Mental Health Act (1983). The eligibility assessor must either be Section 12 approved or an AMHP.

**5No refusals assessment** – To check whether the authorisation would conflict with a Donee or Deputy decision, or a valid and applicable Advance Decision made by the person. This can be undertaken by anyone eligible to be a best interests assessor.

**6Best Interest Assessment** – The purpose of this assessment is to establish:

- whether deprivation of liberty is occurring (or is going to occur) and if so:
- it is in the best interests of the person to be deprived of their liberty.

The assessment will also consider whether the deprivation is necessary to prevent harm to the person and whether it is a proportionate response to the likelihood and seriousness of that harm.

Best interests assessments must be undertaken by an AMHP, social worker, nurse, occupational therapist or chartered psychologist with at least 2 years post registration experience. They must have successfully completed best interests assessor training.

# Human Rights

## *Human Rights Decision Making Map*

1. *Is there IN FACT going to be a breach of human rights?*
2. *If so, which right?*
3. *Is it an absolute or qualified right?*
4. *Is there a law that allows me to interfere with that right?*
5. *Does the interference fit within one of the qualifications?*
6. *Is my proposed interference proportionate?*

## ***Human Rights Act Articles***

### *THE ARTICLES*

#### *PART I THE CONVENTION*

#### *RIGHTS AND FREEDOMS*

#### *ARTICLE 2*

#### *RIGHT TO LIFE (Absolute)*

- 1. Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.*
- 2. Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary:*
  - (a) in defence of any person from unlawful violence;*
  - (b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;*
  - (c) in action lawfully taken for the purpose of quelling a riot or insurrection.*

#### *ARTICLE 3*

#### *PROHIBITION OF TORTURE (Absolute)*

*No one shall be subjected to torture or to inhuman or degrading treatment or punishment.*

#### *ARTICLE 4*

#### *PROHIBITION OF SLAVERY AND FORCED LABOUR (Absolute)*

- 1. No one shall be held in slavery or servitude.*
- 2. No one shall be required to perform forced or compulsory labour.*
- 3. For the purpose of this Article the term "forced or compulsory labour" shall not include:*

*(a) any work required to be done in the ordinary course of detention imposed according to the provisions of Article 5 of this Convention or during conditional release from such detention;*

*(b) any service of a military character or, in case of conscientious objectors in countries where they are recognised, service exacted instead of compulsory military service;*

*(c) any service exacted in case of an emergency or calamity threatening the life or well-being of the community;*

*(d) any work or service which forms part of normal civic obligations.*

## ARTICLE 5

### *RIGHT TO LIBERTY AND SECURITY (Limited)*

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

*(a) the lawful detention of a person after conviction by a competent court;*

*(b) the lawful arrest or detention of a person for non-compliance with the lawful order of a court or in order to secure the fulfilment of any obligation prescribed by law;*

*(c) the lawful arrest or detention of a person effected for the purpose of bringing him before the competent legal authority on reasonable suspicion of having committed an offence or when it is reasonably considered necessary to prevent his committing an offence or fleeing after having done so;*

*(d) the detention of a minor by lawful order for the purpose of educational supervision or his lawful detention for the purpose of bringing him before the competent legal authority;*

*(e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants;*

*(f) the lawful arrest or detention of a person to prevent his effecting an unauthorised entry into the country or of a person against whom action is being taken with a view to deportation or extradition.*

*2. Everyone who is arrested shall be informed promptly, in a language which he understands, of the reasons for his arrest and of any charge against him.*

*3. Everyone arrested or detained in accordance with the provisions of paragraph 1(c) of this Article shall be brought promptly before a judge or other officer authorised by law to exercise judicial power and shall be entitled to trial within a reasonable time or to release pending trial. Release may be conditioned by guarantees to appear for trial.*

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

*5. Everyone who has been the victim of arrest or detention in contravention of the provisions of this Article shall have an enforceable right to compensation*

## ARTICLE 6

### *RIGHT TO A FAIR TRIAL(Limited)*

*1. In the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law. Judgment shall be pronounced publicly but the press and public may be excluded from all or part of the trial in the interest of morals, public order or national security in a democratic society, where the interests of juveniles or the protection of the private life of the parties so require, or to the extent strictly necessary in the opinion of the court in special circumstances where publicity would prejudice the interests of justice.*

*2. Everyone charged with a criminal offence shall be presumed innocent until proved guilty according to law.*

*3. Everyone charged with a criminal offence has the following minimum rights:*

*(a) to be informed promptly, in a language which he understands and in detail, of the nature and cause of the accusation against him;*

*(b) to have adequate time and facilities for the preparation of his defence;*

*(c) to defend himself in person or through legal assistance of his own choosing or, if he has not sufficient means to pay for legal assistance, to be given it free when the interests of justice so require;*

*(d) to examine or have examined witnesses against him and to obtain the attendance and examination of witnesses on his behalf under the same conditions as witnesses against him;*

*(e) to have the free assistance of an interpreter if he cannot understand or speak the language used in court.*

#### ARTICLE 7

##### *NO PUNISHMENT WITHOUT LAW (Absolute)*

*1. No one shall be held guilty of any criminal offence on account of any act or omission which did not constitute a criminal offence under national or international law at the time when it was committed. Nor shall a heavier penalty be imposed than the one that was applicable at the time the criminal offence was committed.*

*2. This Article shall not prejudice the trial and punishment of any person for any act or omission which, at the time when it was committed, was criminal according to the general principles of law recognised by civilised nations.*

#### ARTICLE 8

##### *RIGHT TO RESPECT FOR PRIVATE AND FAMILY LIFE (Qualified)*

*1. Everyone has the right to respect for his private and family life, his home and his correspondence.*

*2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.*

#### ARTICLE 9

##### *FREEDOM OF THOUGHT, CONSCIENCE AND RELIGION (Qualified)*

*1. Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance.*

*2. Freedom to manifest one's religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others.*

## ARTICLE 10

### *FREEDOM OF EXPRESSION (Qualified)*

- 1. Everyone has the right to freedom of expression. This right shall include freedom to hold opinions and to receive and impart information and ideas without interference by public authority and regardless of frontiers. This Article shall not prevent States from requiring the licensing of broadcasting, television or cinema enterprises.*
- 2. The exercise of these freedoms, since it carries with it duties and responsibilities, may be subject to such formalities, conditions, restrictions or penalties as are prescribed by law and are necessary in a democratic society, in the interests of national security, territorial integrity or public safety, for the prevention of disorder or crime, for the protection of health or morals, for the protection of the reputation or rights of others, for preventing the disclosure of information received in confidence, or for maintaining the authority and impartiality of the judiciary.*

## ARTICLE 11

### *FREEDOM OF ASSEMBLY AND ASSOCIATION (Qualified)*

- 1. Everyone has the right to freedom of peaceful assembly and to freedom of association with others, including the right to form and to join trade unions for the protection of his interests.*
- 2. No restrictions shall be placed on the exercise of these rights other than such as are prescribed by law and are necessary in a democratic society in the interests of national security or public safety, for the prevention of disorder or crime, for the protection of health or morals or for the protection of the rights and freedoms of others. This Article shall not prevent the imposition of lawful restrictions on the exercise of these rights by members of the armed forces, of the police or of the administration of the State.*

## ARTICLE 12

### *RIGHT TO MARRY (Limited)*

*Men and women of marriageable age have the right to marry and to found a family, according to the national laws governing the exercise of this right.*

### 3. Criminal Law Act

Under s.3(1) of the Criminal Law Act 1967 “a person may use such force as is reasonable in the circumstances in the prevention of crime, or in effecting or assisting the lawful arrest of offenders or suspected offenders or persons unlawfully at large”.

This provision, which could apply to both informal and detained patients, enables a member of staff to use reasonable force to either restrain the patient or place him or her in seclusion in self-defence or in the defence of others or to protect property. It does not apply where the patient is insane within the meaning of the M’Naghten rules because such a person is deemed not capable of committing a crime. The test of insanity established by the House of Lords in the M’Naghten case [1843-60] All E.R. 229, is that:

“it must be clearly be proved that, at the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing was wrong, or, if he did know it, that he did not know he was doing what was wrong.”

Caselaw has established that “disease of the mind”; (i) covers disease of the body affecting the operation of the mind (R v Kemp [1957] 1 Qb 399); and (ii) includes patients who suffer from epilepsy (R v Sullivan [1983] 1 All ER 673) and diabetic patients who suffer from hyper-glycaemia because of a failure to take insulin (R v Hennessy) [1989] 1 All ER 9). “Defect of reason” does not cover patients who retain the power of reasoning but who in moments of confusion or absentmindedness fail to use their powers to the full (R v Clarke [1972] 1 All ER 219) or who know their actions are unlawful (R v Windle [1952] 2 QB 826)

## 4. Common Law – Breach of the Peace

The common law power to prevent a breach of the peace was summarised by Lord Bingham in *R. (on the application of Laporte) v Chief Constable of Gloucestershire Constabulary* [2006] UKHL 55; [2007] 2 All Er 529 at para 29:

“ Every constable, and also every citizen, enjoys the power and is subject to the duty to seek to prevent, by arrest or other action short of arrest, any breach of the peace occurring in his presence, or any breach of the peace which (having occurred) is likely to be renewed, or any breach of the peace which is about to occur.”

A breach, which can take place in public or on private property, involves “actual harm done either to a person or to a person’s property in his presence or some other form of violent disorder or disturbance and itself necessarily involves a criminal offence” (ibid, per Lord Brown at para 111). Harm to property will constitute a breach only if done or threatened in the owner’s presence because the natural consequence of such harm is likely to be a violent retaliation (*Percy v Director of Public Prosecutions* [1995] 3 All ER 124 DC).

The power to prevent a breach of the peace would enable a nurse to physically restrain a patient whose words or behaviour are such that imminent violence is expected on a hospital ward. Detention under this power can only be justified for a short time. Prolonged detention must be authorised either by the Mental Health Act or by arresting the person concerned (see below) and bringing him or her before a magistrate.

With regard to the use of this power, the Court of Appeal has held that: (i) there has to be a sufficiently real and present threat to the peace to justify the extreme step of depriving a citizen of his liberty when that citizen is not at that time acting unlawfully (*Foulkes v Chief Constable of Merseyside Police* [1998] 3 All ER 705); and (ii) a breach can occur on private premises even if the only person likely to be affected by the breach are inside the premises and no member of the public outside the premises is involved (*McConnell v Chief Constable of the Great Manchester Police* [1990] 1 All ER 423)

In *Black v Forsey* 1987 SLT 681, a case under the Mental Health (Scotland) Act 1984, the House of Lords confirmed that the common law confers upon a private individual power lawfully to detain, in a situation of necessity, a person of unsound mind who is a danger to him or herself or others. A person exercising the power must be able to justify his or her action, if challenged, by proving the mental disorder of the detainee and the necessity of detention. In the opinion of Lord Griffiths, the power is:

“confined to imposing temporary restraint on a lunatic who has run amok and is a manifest danger either to himself or to others – a state of affairs as obvious to a layman as to a doctor. Such a common law power is confined to the short period of confinement necessary before the lunatic can be handed over to a proper authority”.

The combination of powers set out above provide sufficient authority for a mental health professional or members of the public to act swiftly to prevent a mentally disordered person from causing harm to himself, to another person or to property as long as the force used is both necessary and proportionate to the harm threatened. It must be emphasised that these powers only allow for an informal patient to be detained for a limited period and will fall away when the crisis has subsided; they cannot be used as an alternative to the procedures set out in the Act.

Apart from the powers noted above, the extent to which common law powers enable informal patients to be subject to the control of staff is unclear. In *Poutney v Griffiths* [1976] AC 314, the House of Lords noted that it had been conceded by counsel for a Broadmoor Hospital patient that hospital staff have “powers of control over all mentally disordered patients, whether admitted voluntarily or compulsorily, though the nature and duration of control varies with the categories to which the patient belongs.”

The Report of the Committee of Inquiry of Complaints About Ashworth Hospital (Cm 2028-1) considered, at p196, that this statement “would be likely to receive the endorsement of the courts today.....see *R v Deputy Governor of Parkhurst Prison and others Ex p Hauge*; sub nom. *Hague v Deputy Governor of Parkhurst Prison*; *Weldon v Home Office* [1992] 1 AC 58.”

## 5. Mental Health Act

### Admission for assessment in cases of emergency

4.— (1) In any case of urgent necessity, an application for admission for assessment may be made in respect of a patient in accordance with the following provisions of this section, and any application so made is in this Act referred to as "an emergency application".

(2) An emergency application may be made either by an approved mental health professional or by the nearest relative of the patient; and every such application shall include a statement that it is of urgent necessity for the patient to be admitted and detained under section 2 above, and that compliance with the provisions of this Part of this Act relating to applications under that section would involve undesirable delay.

(3) An emergency application shall be sufficient in the first instance if founded on one of the medical recommendations required by section 2 above, given, if practicable, by a practitioner who has previous acquaintance with the patient and otherwise complying with the requirements of section 12 below so far as applicable to a single recommendation, and verifying the statement referred to in subsection (2) above.

(4) An emergency application shall cease to have effect on the expiration of a period of 72 hours from the time when the patient is admitted to the hospital unless—

(a) the second medical recommendation required by section 2 above is given and received by the managers within that period; and  
(b) that recommendation and the recommendation referred to in subsection (3) above together comply with all the requirements of section 12 below (other than the requirement as to the time of signature of the second recommendation).

(5) In relation to an emergency application, section 11 below shall have effect as if in subsection (5) of that section for the words "the period of 14 days ending with the date of the application" there were substituted the words "the previous 24 hours".

## Application in respect of patient already in hospital

5.— (1) An application for the admission of a patient to a hospital may be made under this Part of this Act notwithstanding that the patient is already an inpatient in that hospital or, in the case of an application for admission for treatment that the patient is for the time being liable to be detained in the hospital in pursuance of an application for admission for assessment; and where an application is so made the patient shall be treated for the purposes of this Part of this Act as if he had been admitted to the hospital at the time when that application was received by the managers.

(2) If, in the case of a patient who is an in-patient in a hospital, it appears to the registered medical practitioner or approved clinician in charge of the treatment of the patient that an application ought to be made under this Part of this Act for the admission of the patient to hospital, he may furnish to the managers a report in writing to that effect; and in any such case the patient may be detained in the hospital for a period of 72 hours from the time when the report is so furnished.

(3) The registered medical practitioner or approved clinician in charge of the treatment of a patient in a hospital may nominate one (but not more than one) person to act for him under subsection (2) above in his absence.

(3A) For the purposes of subsection (3) above—

(a) the registered medical practitioner may nominate another registered medical practitioner, or an approved clinician, on the staff of the hospital; and

(b) the approved clinician may nominate another approved clinician, or a registered medical practitioner, on the staff of the hospital.

(4) If, in the case of a patient who is receiving treatment for mental disorder as an in-patient in a hospital, it appears to a nurse of the prescribed class—

(a) that the patient is suffering from mental disorder to such a degree that it is necessary for his health or safety or for the protection of others for him to be immediately restrained from leaving the hospital; and

(b) that it is not practicable to secure the immediate attendance of a practitioner or clinician for the purpose of furnishing a report under subsection (2) above, the nurse may record that fact in writing; and in that event the patient may be detained in the hospital for a period of six hours from the time when that fact is so recorded or until the earlier arrival at the place where the patient is detained of a practitioner or clinician having power to furnish a report under that subsection.

(5) A record made under subsection (4) above shall be delivered by the nurse (or by a person authorised by the nurse in that behalf) to the managers of the hospital as soon as possible after it is made; and where a record is made under that subsection the period mentioned in subsection (2) above shall begin at the time when it is made.

(6) The reference in subsection (1) above to an in-patient does not include an in-patient who is liable to be detained in pursuance of an application under this Part of this Act or a community patient and the references in subsections (2) and (4) above do not include an in-patient who is liable to be detained in a hospital under this Part of this Act or a community patient.

(7) In subsection (4) above "prescribed" means prescribed by an order made by the Secretary of State.

### Section 139 (1) Mental Health Act

139.—(1) No person shall be liable, whether on the ground of want of jurisdiction or on any other ground, to any civil or criminal proceedings to which he would have been liable apart from this section in respect of any act purporting to be done in pursuance of this Act or any regulations or rules made under this Act, unless the act was done in bad faith or without reasonable care.

This section applies to patients who are subject to guardianship and CTO.

In *Lebrooy v Hammersmith and Fulham LBC* the court rejected a submission that s139 (1) only applies to those who have been detained under the MHA. The section therefore, applies to patients who are not detained if the individual undertaking the act of restraint genuinely believes at the relevant time that the patient was detained.

## Case Studies

- a) Adam is an adult with severe learning disabilities and complex physical needs. He lives in a group home. He has been unwell for a number of days and the GP believes Adam has developed Type 1 diabetes. Adam is close to collapse and needs urgent treatment for dehydration and ketoacidosis. Whilst waiting for the ambulance to arrive Adam's GP tries to establish IV access but Adam will not cooperate.
- b) Jessica is an adult who has been in ICU for some time and is sedated on a ventilator. Her condition has improved and she is being weaned off both sedation and the ventilator. However, she has started to pull out IV lines.
- c) Frederick is an older adult who has been admitted to a care home for a period of respite. He is very unsettled at night and is finding it hard to sleep. He constantly walks around the home, testing the doors and windows, looking for his wife, who visits him during the day. He becomes very distressed when he cannot get out.
- d) Iain is an adult who has suffered a head wound and is under the influence of alcohol. He has been brought to A&E by friends. He is verbally abusive to staff and is punching out whenever anyone tries to examine him. He clearly wants to leave.
- e) Jennifer is an adult who has a diagnosis of a personality disorder. She has drunk anti-freeze in an attempt to take her own life. She presents at hospital asking for pain relief but stating that she does not want her life to be saved. She says she will leave the hospital if anyone tries to do anything other than give her pain relief.