Neutral Citation Number: [2024] EWHC 2515 (KB)

Case No: KB-2024-BHM-000208

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION
BIRMINGHAM DISTRICT REGISTRY

Birmingham Civil Justice Centre
Bull Street,
Birmingham
B4 6DS
Date: 7th October 2024

Before:

HIS HONOUR JUDGE TINDAL
(Sitting as a Judge of the High Court)

NORTHAMPTON GENERAL HOSPITAL NHS TRUST

Claimant

- and -

JESSICA MERCER

Defendant

- -

MR SIMON SINNATT instructed by **Capsticks Solicitors** for the Claimant
THE DEFENDANT appeared in person but represented by her mother

- -

JUDGMENT

Hearing Date: 4th October 2024

HIS HONOUR JUDGE TINDAL

JUDGE TINDAL:

Background

1. Bed-blocking in NHS Hospitals is a huge problem. According to the Nuffield Trust - Delayed discharges from hospital | Nuffield Trust - on the latest available figures for what the NHS calls 'delayed discharge', in May 2024 over 12,000 people were in hospital in England who no longer needed to be there, slightly down from a peak over 14,000 in January 2024. This excludes patients who do need to be in hospital and so also increases waiting lists. Delayed discharge often happens due to delays in putting in place a package of care at home, in a short-term placement or a in a long-term care home, especially with older people. As a result, many people stay in for weeks after they are medically fit for discharge. This is an everyday challenge which NHS hospitals manage as best they can.

2. Occasionally however, people who have been assessed as medically fit for discharge stay in hospital for very long periods. The Claimant, Ms Mercer, is one of them. She has been medically fit for discharge from Northampton Hospital (the 'Hospital'), the Claimant, since April 2023, but is still there almost 18 months later. She refuses to leave hospital so the Claimant seeks a possession order. Neither the Hospital nor Ms Mercer, who represents herself with the help of her mother Mrs Mercer, have asked for her to be anonymous and the criteria for an anonymity order under Civil Procedure Rule ('CPR') 39.2 are not met. A BBC journalist has attended a remote hearing (and I made a 'transmission direction') and a physical hearing the week before. Nevertheless, I will not go into more detail about Ms Mercer's health or the facts than necessary for my decision.

3. Ms Mercer is aged 34 and has several disabilities. She is wheelchair-dependent and requires support with her personal care and medication, but also has diagnoses of Autistic Spectrum Disorder and Emotionally Unstable Personality Disorder. She has lived in residential accommodation for most of her adult life. Before she was admitted to Northampton Hospital ('the Hospital') on 14th April 2023 for cellulitis of her right leg, she had lived at a home called St Matthews for nine years. She was transferred to the Claimant Hospital's Willow Ward for treatment to her leg and on 25th April 2023 she was declared medically fit for discharge. The original plan was for her to return to St Matthews, but that fell through because of a dispute between it and Ms and Mrs Mercer. Despite placement searches by the Adult Social Care team at North Northamptonshire Council ('NNC'), she has been in the Hospital ever since, mostly on Willow Ward. However, a placement has been now found which the Hospital and NNC believe will meet Ms Mercer's needs: 24-care in a Supported Living placement.

4. This would be an entirely new lifestyle for Ms Mercer and she is extremely anxious. She and her mother feel she may hurt herself or others there. Therefore, she refuses to move and wants a placement in residential accommodation, either St Matthews or a similar care home closer to her mother. But she has been assessed as not needing that. So, after a year of accommodating Ms Mercer whilst NNC tried to find a suitable placement to accept them, the Hospital have decided that enough is enough and on 14th August 2024, sought this possession order.

5. At a hearing on 26th September 2024, the Hospital attended, but Ms Mercer did not. That was the main reason I adjourned the hearing until 4th October to enable Ms Mercer

to attend remotely from hospital, because she obviously wanted to participate – she had sent in written representations, which I will set out in part:

> "I have been in hospital after my nursing home terminated my placement whilst I was ill in hospital. The hospital found me a placement they are making me go without my agreement. It's in an area [of] bad memories and only two carers then taking it down to one… Yet part of the reason [I] was terminated from my nursing home was they could not cope with my behaviour to staff and they had more staff to help. I'm really concerned about my mental health as these people from placement think just had mental health issues in hospital. This is untrue, I have been mentally ill for years without ever receiving proper help."

Ms Mercer then went on to list how she has been affected by the prospect of leaving the hospital. In a public judgment, it suffices to say she has self-harmed and has had suicidal thoughts. Her mother Mrs Mercer also emailed the Court:

> "My daughter will not be at court today as she is in hospital, can't walk and will be self-harming. She has got a Personality disorder …and serious mental health. The hospital who are trying to evict her don't know all the issues she has as only been to see her to threaten her about where to live. They say has capacity then try and force her. Also, she is on a waiting list for an advocate. She has been given no advice or support or legal representation. She has told them she doesn't understand all the things about court, yet are still doing it."

6. Therefore, I adjourned the hearing until 4th October and directed that it be heard remotely, so that Ms Mercer and her mother could have time to instruct a lawyer or if unable to do so, at least to participate themselves and set out their views, which remained the same. In an email to me before the hearing, Mrs Mercer said:

> "If you make her homeless she would hurt people and throw things at them….If sent to the streets or the flat will have killed herself in hours… The carer said will try and keep her safe only one person can't do that. Just some of the reasons has to be in a secure unit….This is about her being put somewhere she feels safe and secure which isn't on the streets. She was also getting fully funded nursing care and been told due to risks to her and others can't ever be in the community… She has been in secure units for a reason."

7. I understand Mrs Mercer was unable to find a solicitor despite being told of these proceedings by the Hospital back in August. At the start of the adjourned hearing on 4th October, there were some initial technical problems with the remote hearing and Ms Mercer became very distressed. As her mother supported her position entirely, I asked Ms Mercer whether she wanted her mother to speak for her, which she did. So, I gave Mrs Mercer rights of audience for the hearing, as she had no conflict of interest and was a close relative of Ms Mercer who was struggling to participate (that I considered consistent with the *Practice Guidance on McKenzie Friends and Lay Advocates* [2010] 1 WLR 1881 para. 21).

8. However, another reason I had adjourned the first hearing was because the Hospital had not provided all necessary information justifying possession. In the leading case (out of

only three previous cases I am aware of on this unusual issue) *University College London Hospitals NHS v MB* [2020] EWHC 882, Chamberlain J had detailed statements from the treating clinician and in response from the defendant; and submissions from Counsel on both sides, with Mr Sinnatt for the hospital there as here. Yet *MB* was decided during the COVID possession stay so Chamberlain J made an injunction excluding the anonymised defendant, which explains why he went into rather more detail on the facts than in the two previous possession cases or than I will. In the present case, not only was the possession claim initially wrongly issued in the County Court, the Hospital's evidence has only come out in stages. At the last hearing, I had a short statement from an Internal Medicine Consultant Dr Baratashvili confirming Ms Mercer had been medically fit for discharge since April 2023 and then two statements from Ms Mallender, the Claimant's Head of Capacity and Operational Transformation. At the last hearing, Ms Mallender also produced a third statement exhibiting capacity assessments by NNC from January 2024 and by Dr Ur-Rehman a Consultant Physician on 25th September 2024, who each concluded Ms Mercer had mental capacity to make decisions about where she should live.

9. However, Dr Ur-Rehman had not assessed Ms Mercer's capacity to conduct proceedings (as I shall explain, different). Nor was there evidence of compliance by the Hospital with its 'Public Sector Equality Duty' under s.149 Equality Act 2010 (which I explain later), such as by an 'Equality Impact Assessment' ('EIA'). That was my other reason to adjourn the hearing to 4th October 2024. In between times, Ms Mallender then produced in a fourth statement including Dr Ur-Rehman's assessment dated 1st October 2024 concluding that Ms Mercer had litigation capacity, NNC's EIA of the same date that the proposed placement met her needs and Ms Mallender's EIA explaining why possession was proportionate.

10. At the adjourned hearing, I heard representations from Mr Sinnatt, Mrs Mercer and from Ms Mercer's social worker Ms Sgoluppi who also attended the hearing to support her. At the end I explained I was going to make a possession order and gave brief reasons for it in simple language, but said I would give full reasons in this written judgment. Since the present case raises some different issues than in *MB*, it also provides an opportunity to give some legal and practical guidance in what I hope will be a helpful 'checklist' to hospitals dealing with these cases.

Legal Framework

11. Hospitals and patients will not always agree about when the patient should be discharged. Sometimes a patient will 'self-discharge' when the hospital feel that is premature. But a patient with mental capacity to make decisions about their medical treatment has the right to decline it, both at common law and under the Mental Capacity Act 2005 ('MCA'), as Lady Hale (one of the MCA's authors) explained in *Aintree Hospital NHS Trust v James* [2014] AC 591 (SC) at [19]. The European Court of Human Rights Grand Chamber has just adopted a similar autonomy-focussed view of Art.8 European Convention of Human Rights ('ECHR') (except in life-threatening emergencies with reasonable grounds to doubt the patient objects to treatment): *Pindo Mulla v Spain* [2024] ECHR 753.

12. However, autonomy has rather a different role where the patient *wants* treatment that the hospital (or any medical professional) does *not* consider is needed. A patient has no

right at common law to invoke autonomy to demand treatment that a clinician does not consider is clinically appropriate, as recently reaffirmed in *R(JJ) v Spectrum Community Health* [2024] PTSR 1 (CA). The MCA does not change that, as Court of Protection Judges make decisions on behalf of people who lack capacity to do so and have no greater power under the MCA than the individual if capacious would have, as Lady Hale explained in *James* at [18]:

> "[The MCA] is concerned with enabling the court to do for the patient what he could do for himself if of full capacity, but it goes no further. On an application under this Act, therefore, the court has no greater powers than the patient would have if he were of full capacity… [I]n *R(Burke) v General Medical Council* [2006] QB 273, Lord Phillips of Worth Matravers MR accepted…that…a patient cannot demand that a doctor administer a treatment which the doctor considers is adverse to the patient's clinical needs' (para 55). Of course, there are circumstances in which a doctor's common law duty of care towards his patient requires him to administer a particular treatment, but it is not the role of the Court of Protection to decide that. Nor is that court concerned with the legality of NHS policy or guidelines for particular treatments. Its role is to decide whether a particular treatment is in the best interests of a patient… incapable of making the decision for himself."

13. Of course, as Lady Hale mentioned, judges in clinical negligence claims commonly scrutinise clinicians' decision-making, but only with evidence from clinician experts in the relevant field, usually on both sides. Even then, because of the well-known '*Bolam* test', (*Bolam v Friern Hospital* [1957] 1 WLR 582), a clinician 'is not guilty of negligence if he has acted in accordance with a practice accepted by a responsible body of medical [people] skilled in that particular art' merely because 'there is a body of opinion which would take a contrary view'. Indeed, in judicial review claims to decide legality of guidelines or policies, medical evidence is rarely admitted at all, as Chamberlain J said in *MB* at [43]:

> "A decision by an NHS hospital not to provide in-patient care in an individual case might, in principle, be challengeable on public law grounds by judicial review if the decision were tainted by improper purpose or had been made in breach of statutory duty or otherwise contrary to law. But if such a decision were taken on clinical grounds, it would not be open to a claimant in such proceedings to adduce expert evidence with a view to impugning the clinical basis of the decision. Any attempt to adduce such evidence for that purpose would go well beyond the limited circumstances in which expert evidence is admissible in judicial review proceedings … [I]nsofar as [a claimant] seeks to raise collateral challenges to the hospital's clinical judgment by way of public law defences [in possession proceedings], it is difficult to see why the court should ….entertain evidence….not be admissible on direct challenge."

Judges are not clinicians and it is not our role to substitute our own judgment for a clinician's judgement (especially in a hospital's possession claim like this).

14. In any event, judges will only extremely rarely need to become involved in cases of dispute over discharge between hospital and patient. The vast majority of patients do

not want to stay in hospital longer than they have to – including many whose discharge is delayed by circumstances beyond their control like delays in care. Moreover, hospitals do have legal powers to remove people, including patients, who do not need to stay. Whilst doctors know real life will be infinitely variable, it may be helpful to consider three very loose categories of such patient.

15. Firstly, for patients and others who are actually *disruptive*, s.119 Criminal Justice and Immigration Act 2008 contains a bespoke criminal offence punishable by fine (quite aside from the offence under s.1 Assaults on Emergency Workers (Offences) Act 2018 that is punishable by imprisonment). s.119 provides that:

> "A person commits an offence if— (a) the person causes without reasonable excuse and while on NHS premises, a nuisance or disturbance to an NHS staff member who is working there… (b) the person refuses, without reasonable excuse, to leave the NHS premises when asked to do so by a constable or an NHS staff member, and (c) the person is not on the NHS premises for the purpose of obtaining medical advice, treatment or care for himself or herself."

However, whilst of course hospitals can and do call the Police to arrest disruptive patients and others, that will not apply to people whose discharge is simply delayed, even for a long period.

16. Secondly, there are patients who are not disruptive as such, but medically fit for discharge from hospital but are reluctant to leave when their refusal is not affected by any sort of mental health or mental capacity issue. Of course, in those circumstances, the hospital will in the first instance try to engage with that reluctant patient to reassure them and encourage them to leave. Hospitals also have this duty under s.74 Care Act 2014 ('CA') as amended from June 2022):

> "(1) Where a relevant trust is responsible for an adult hospital patient and considers th[ey are] likely to require care and support following discharge from hospital, the relevant trust must, as soon as is feasible after it begins making any plans relating to the discharge, take any steps that it considers appropriate to involve (a) the patient, and (b) any carer of the patient.
>
> (2) In performing the duty under subsection (1), a relevant trust must have regard to any guidance issued by NHS England."

17. That NHS England Guidance was updated in January 2024 and provides that:

> "Planning and implementation of discharge should respect an individual's choices and provide them with the maximum choice and control possible from suitable and available options…
> People should be supported to participate actively in making informed choices about their care, including [discussing]… longer-term financial impact of different care options after discharge. Conversations should begin early as part of discharge planning..not wait until the person is ready to be discharged…..
> Where an individual wishes to return home and their family member or unpaid carer is unwilling or unable to provide the care needed, NHS bodies, local authorities and care providers should work together to assess and provide the appropriate health and social care provision required to

> facilitate the individual's choice, where possible, and enable a safe discharge.....
> ….If a person does not accept a short-term package or temporary placement from [available] options…following discussion they should be discharged to an alternative…appropriate for their short-term recovery needs. People do not have the legislative right to remain in a hospital bed if they no longer require care in that setting, including to wait for their preferred option to become available."

18. Therefore, a patient who is fit but unwilling for discharge does not have the right to remain in hospital, but the hospital should engage with them and comply with both that national guidance and any internal policy within the hospital. In this case, the Claimant hospital's own policy is consistent with that in stating:

> "Refusal by the patient or carer to accept discharge arrangement should have the consequences and risks fully explained and documented and escalated to Discharge Lead Nurse, and IDT. Direction of Choice should be engaged with immediate effect. Consideration should be given to the patient's mental capacity…"

19. Perhaps it may be helpful for a hospital in 'involving' the patient and their carer in discharge planning under s.74(1) CA to explain to them three things: *how* any ongoing medical or care needs will be met, *who* is responsible for meeting them and *what* the patient or carer can do if they are unhappy about the provision. Lady Hale in *R(Forge Care Homes) v Cardiff NHS* [2017] PTSR 1140 (SC) at [17] explained that if a patient is to be discharged to a care home, the interface of the predecessors of the Care Act 2014 and Health and Social Care Act 2012 distinguished three groups: (i) those assessed by the NHS as having a 'primary health need' eligible for 'NHS Continuing Healthcare' for whom the NHS is responsible and pays; (ii) those without a 'primary health need' but who need nursing care funded by the NHS with other care and accommodation arranged and funded by the patient or the local authority (who can charge them if their means are above a certain level); and (iii) where the patient requires no nursing and care is arranged and funded by the patient or local authority (on the same basis). People can apply to their local authority for a needs assessment under s.9 CA and if their needs are 'eligible' under s.13 CA and Regulations (in short, if they cannot manage certain practical tasks unaided, having a significant impact on their 'well-being' under s.1 CA), that authority is under a duty to meet those eligible needs under s.18 CA and may meet non-eligible needs under s.19 CA. But it does not necessarily have to achieve the outcome the person wants: *R(Davey) v OCC* [2018] PTSR 281 (CA). Provision under s.8 CA can be 'care and support at home or in the community' or 'accommodation in a care home or premises of some other type'. However, the latter 'premises' will need to provide care and support as well, rather than simply be ordinary housing that a local housing authority can provide under the Housing Act 1996 ('HA'): *R(Campbell) v Ealing LBC* [2024] EWCA Civ 540. Indeed, the HA is unavailable if the person lacks mental capacity to hold a tenancy: *WB v WDC* [2018] HLR 30 (CA).

20. If the patient's care and accommodation will be the responsibility of the local authority and the patient objects to it, the hospital should involve that authority and explain to the patient that they need to take up concerns with it (and escalate them to the Local Government and Social Care Ombudsman or claim Judicial Review as the CA's

appeals mechanism is not in force: *R(HL) v SoSSC* [2023] ACD 79), rather than remaining in the hospital. However, ultimately if a hospital has done that and followed national guidance and its own policy, but reached an impasse with a patient whose refusal to leave is not affected by a mental health or mental capacity issue, strictly speaking the hospital could simply evict the patient. A hospital bed or room – even if occupied long-term – is probably not a 'dwelling' requiring a court order for eviction under s.3 Protection from Eviction Act 1977, any more than temporary homeless accommodation is (see *R(N) v Lewisham LBC* [2014] 3 WLR 1548 (SC). But hospitals may prefer to obtain a High Court possession order or injunction.

21. In *MB*, Chamberlain J made an injunction because possession had been stayed nationally during the COVID Pandemic, but he summarised the simple point which typically justifies possession in these rare cases at [37]:

> "The Claimant brings this claim to enforce its private law rights as property owner. [In] private law, MB became entitled to occupy the room she is currently in because the Claimant permitted her to do so by admitting her to the Hospital. The Claimant has now terminated her licence to occupy that room. It follows that she is now a trespasser. Ordinarily, the Claimant would be entitled to an order for possession pursuant to CPR Pt 55 *Barnet Primary Care Trust v H* [2006] EWHC 787 (QB), (2006) 92 BMLR 17 (Wilkie J) and *Sussex Community NHS Foundation Trust v Price* (HHJ Coe QC)."

In *H*, a patient remained in hospital for almost three years when medically fit for discharge, obstinately refusing suitable placements and a possession order was eventually obtained. In *Price*, the patient behaved similarly for nearly a year and was not only evicted, but also required to pay the hospital's legal costs of £10,000.

22. Moreover, in *MB*, Chamberlain J also rejected several other arguments raised on behalf of the patient in that case who had been on a hospital ward for a year where the Trust urgently needed her bed in April 2020 for the rising numbers of people hospitalised due to COVID. Therefore, he made an injunction requiring her to leave within 24 hours. As he explained at [39] of *MB*, even though a patient who is not medically fit for discharge has no *private law* defence to a possession, as the hospital is a public body, the patient may raise a *public law* defence to possession: *Wandsworth v Winder* [1985] AC 461 (HL). Chamberlain J added at [51]:

> "Patients have no right to occupy beds or rooms in hospitals except with the hospital's permission. A hospital is entitled as a matter of private law to withdraw that permission. In deciding whether to [do so], the hospital is entitled and indeed obliged to balance the needs of the patient currently in occupation against the needs of others who it anticipates may require the bed or room in question. Unless its decision can be stigmatised as unlawful as a matter of public law, there is no basis for the court to deny the hospital's proprietary claim to restrain the patient from trespassing on its property."

23. As discussed already, in *MB* Chamberlain J rejected a patient's application to rely on their own expert medical evidence questioning the hospital's decision that she was medically fit for discharge. Nevertheless, other public law defences may be available, such as a failure by the hospital to have regard to national NHS guidance under s.74(2)

CA. In my judgement, the legal status of that guidance is similar to the Code of Practice under s.118 Mental Health Act 1983 ('MHA') described by Lord Bingham in *R(Munjaz) v Mersey Care NHS* [2005] 3 WLR 793 (HL) at [21]:

> "[T]he Code does not have the binding effect a statutory provision or a statutory instrument would have. It is …guidance and not instruction… [B]ut it is much more than mere advice an addressee is free to follow or not as it chooses. It is guidance which any hospital should consider with great care, and from which it should depart only if it has cogent reasons for doing so…In reviewing any challenge to a departure from the Code, the Court should scrutinise the reasons given by the hospital for departure with the intensity that the importance and sensitivity of the subject matter requires."

A related form of public law defence may be a failure by the hospital to follow its own policy without good reason, held to prevent a local housing authority from obtaining a possession order when it had failed to follow its own anti-social behaviour policy in *Barber v Croydon LBC* [2010] HLR 26 (CA).

24. A further public law defence to a hospital's possession or injunction application may be its duty as a public authority under s.6 Human Rights Act 1998 not to violate the ECHR. However, its traction here is very limited:

    i) As to the Art.2 ECHR right to life, the European Court of Human Rights Grand Chamber in *Lopes de Sousa v Portugal* (2018) 66 EHHR 28 at [185]-[196] held that Art.2 will only be violated by a hospital knowingly endangering a patient's life by denial of access to life-saving emergency treatment, or where they are deprived of it by systemic dysfunction.

    ii) As to the Art.3 ECHR prohibition on inhuman or degrading treatment, in *MB* Chamberlain J rejected that on the facts and in principle at [57]:

> "[T]he reason why a decision to require a patient to leave a hospital is unlikely to infringe Art.3 ECHR is because it is based on a prior decision not to provide in-patient care. Such a decision engages the state's positive (and limited) obligation to take steps to avoid suffering reaching a level that engages Art.3, rather than its negative (and absolute) obligation not itself to inflict such suffering. Where a decision to discontinue in-patient care involves the allocation of scarce public resources, the positive duty can only be to take *reasonable* steps to avoid such suffering: cf *R (Pretty) v DPP* [2002] 1 AC 800, [13]-[15]. It is difficult to conceive of a case in which it could be appropriate for a court to hold a hospital in breach of that duty by deciding, on the basis of an informed clinical assessment and against a background of a desperate need for beds, to discontinue in-patient care in an individual case and accordingly, to require the patient to leave the hospital…"

    iii) As to Art.8 ECHR right to a private life and autonomy, whilst clinicians must respect it when a capacious patient *refuses* treatment save in emergency situations when the refusal is uncertain (*Pindo Mulla*), it is unlikely to give rise to a *positive obligation to provide* treatment (especially since even the

Art.2 ECHR right to life only does so in the very limited circumstances discussed in *Lopes De Sousa*), as once again Chamberlain J explained in *MB* at [59]:

> "[For the] argument based on Art.8 ECHR…the difficulties ….are even more pronounced. Lord Brown said this in *R(McDonald) v LBKC* [2011] HRLR 36 at [16]: '[C]lear and consistent jurisprudence of the Strasbourg Court establishes 'the wide margin of appreciation enjoyed by states' in striking 'the fair balance … between the competing interests of the individual and of the community as a whole'… is even wider when issues involve an assessment of the priorities in the context of the allocation of limited state resources'. Even though the decisions to cease to provide in-patient care to MB and to require her to leave plainly interfere with her right to respect for private and family life…the interference is justified…to protect the rights of others, namely those who, unlike MB, need in-patient treatment ..bearing in mind the broad discretionary area of judgment."

(iv) As to the Art.5 ECHR right to liberty, there will only be a 'deprivation of liberty' in social care provision if the individual's 'concrete situation' is such that they are 'under continuous supervision and control and not free to leave', which is attributable to the state and to which they do not or mentally cannot consent: *Cheshire West v P* [2014] AC 896 (SC). But whilst that is a common argument to the Court of Protection under s.21A and Sch.A1 MCA by patients in such regimes in hospitals and care homes who *want* to go home, it cannot work in reverse for patients who want to stay in hospital *not* to go home.

v) Finally, Art.14 ECHR discrimination is once again unlikely to have much impact in this context, as Chamberlain J again explained in *MB* at [60]:

> "Nor does reliance on Article 14, read with Article 3 or Article 8, take matters any further. The decision to decline in-patient care to MB does not discriminate against her on the ground of her disabilities. The Hospital has treated her in the same way as a patient with different disabilities or with none: it has determined whether to continue to offer her in-patient care on the basis of her clinical need for such care. To the extent that this is itself discrimination against those, like MB, whose disabilities make them perceive a need for things for which there is in fact no objective need, the discrimination would be justified even outside the context of a public health emergency…."

25. Nevertheless, those last two references to Art.5 and Art.14 ECHR as impacting on the human rights of disabled people leads me on to the third and most complex category of patient who is refusing to leave hospital despite being medically fit to do so – those whose refusal to leave is affected by a mental health or mental capacity issue. Of course, by definition, many patients admitted to hospital will have a disability under s.6 Equality Act 2010 (EqA'), namely if they have a *'physical or mental impairment with a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities'*. That will often be why the patient came into hospital and still a (hopelessly lessened) challenge when they are discharged. Nevertheless, people with

physical but not mental disabilities can understand (even if they object to) the clinical opinion that they are medically fit for discharge and form their own decision whether to agree or disagree. It adds another layer of legal complexity if the patient's refusal to leave is influenced by their mental disability, let alone if they lack mental capacity to consent or object (and indeed additional clinical complexity too: see the fascinating article Staying Against Advice: Refusal to Leave the Hospital - PMC (nih.gov)).

26. This is why the Claimant Hospital's own policy rightly stresses the importance of the hospital staff assessing a patient's mental capacity before compelling discharge against their will. So does the national NHS guidance:

> "Mental capacity is decision-specific and time-specific and assessments should not be of [a patient's] ability to make decisions generally. If there is a reason to believe a person may lack the mental capacity to make relevant decisions about their discharge arrangements at th[at] time….a capacity assessment should be carried out as part of the discharge planning process. Where the person is assessed to lack the mental capacity to make a relevant decision about discharge, any best interests decision must be made in line with the Mental Capacity Act. No one who lacks the relevant capacity should be discharged to somewhere assessed to be unsafe… Capacity assessments and best interests decisions must consider the available options. Onward care and support options which are not suitable…or available…at the time of hospital discharge cannot be considered in either mental capacity assessments or 'best interests' decision-making. Just as a person with the relevant capacity does not necessarily have a legislative right to remain in an acute or community hospital bed if they no longer require care in that setting, neither is this an option for a person who lacks the mental capacity to make relevant decisions about discharge. In certain circumstances during discharge planning, health and care providers might determine that someone is, or will be, 'deprived of their liberty'…[which must comply with Art.5]."

The legislation relating to mental health is extremely complex - ranging over three very different statutes: the Mental Health Act 1980 ('MHA'), Mental Capacity Act 2005 ('MCA') and to a lesser but still crucial extent the Equality Act 2010 (EqA'). Moreover, mental disability can also give rise to needs for care and support under the Care Act 2014 ('CA') and Health and Social Care Act 2012 ('HSCA') already discussed. Naturally hospitals, above all other institutions, understand each of these statutes and how they inter-relate, but I will summarise.

27. Under the MHA, leaving aside those detained by Criminal Courts under ss.37 or 41 MHA, patients with a 'mental disorder' in the sense of a 'disorder or disability of the mind' (s.1 MHA) can be 'detained' for assessment under s.2 MHA or 'treatment' under s.3 MHA. However, it seems very unlikely that hospitals will resort to seeking possession orders to evict previously-detained mental health patients. Firstly, in my experience, people detained under the MHA typically want to *leave* hospital not stay there. Secondly, even if they want to stay, the golden thread of the MHA is that patients should only remain 'detained' if that is 'necessary' for their treatment: *Re RM* [2024] 1 WLR 1280 (SC). Therefore, if their detention is no longer 'necessary', it is not only poor use of NHS resources but actually *unlawful* for them to remain detained. Thirdly, the MHA has a variety of unique tools to 'transition' a reluctant

patient to the community. Clinicians could end detention but agree temporary voluntary admission (see s.131 MHA), grant temporary leave in the community under s.17 MHA (see *Re RM*), or sanction the 'halfway house' of a Community Treatment Order ('CTO') under s.17A MHA with 'aftercare' under s.117 MHA, albeit not into a placement amounting to a 'deprivation of liberty' under Art.5 ECHR (as defined in *Cheshire West*) even if a patient consents to such a placement: *M v SoS Justice* [2018] 3 WLR 1784 (SC).

28. Turning to the MCA, it is imperative that a hospital contemplating a possession claim considers whether there is reason to believe the patient may lack mental capacity. This was not discussed in detail in *H, Price,* or even *MB*, where the hospital had assessed the patient as having capacity to make all relevant decisions and to litigate (which was not disputed by her lawyers: see [40]-[41]). Moreover, even if the patient has capacity to litigate, or the possession or injunction proceedings, they may still be a 'vulnerable party' requiring 'participation directions' under CPR PD1A (which could include a remote hearing).

    i) Firstly, with a MHA informal patient fit for discharge but refusing to leave, the complex interface between the MHA and MCA contains several tripwires for a hospital which might make a possession order inappropriate. As discussed in this article: Can the use of the Mental Health Act be the 'least restrictive' approach for psychiatric in-patients? (northumbriajournals.co.uk), psychiatrists may assume that applying the 'least restrictive principle' in the MHA Code of Practice and also under s.1(6) MCA points towards use of 'Deprivation of Liberty Safeguards' ('DOLS') arrangements in a community placement rather than MHA detention in a hospital, but that does not necessarily follow. *M* shows 'DOLS' is not available through a CTO and whilst the Court of Protection can 'co-ordinate' with a Tribunal to move an incapacious patient from discharge under the MHA to authorisation of DOLS under the MCA (*MC v Cygnet Behavioural Health* [2020] UKUT 230 (AAC)), DOLS is unavailable if the patient is 'ineligible' under Sch.1A MCA. They will be if still subject to a MHA treatment regime in hospital, in the community under a CTO/Guardianship and even if not but are still 'within scope' of the MHA, like an informal mental health patient: *Manchester Hospitals v JS* [2023] EWCOP 12. In practical terms, if a discharged MHA patient is refusing to move from hospital to a community placement which would be a deprivation of liberty under Art.5 ECHR, that requires authorisation by the Court of Protection under the MCA, pending which a High Court possession order may well be inappropriate and which it may therefore refuse.

    ii) Secondly, a patient with no history of MHA detention or admission may still lack capacity to make decisions about where they should live under ss.2-3 MCA. It is true that s.1 MCA states there is a 'presumption of capacity' and that people should not be assumed to lack capacity because they make unwise decisions and/or without all practicable steps to enable capacity. However, failure to undertake a capacity assessment if there is any 'reason to believe the patient may lack capacity' would breach NHS guidance, so may justify refusal of a possession order (c.f. *Barber*) because the consequences are so serious either way. If a hospital do not take reasonable steps to assess a patient's capacity and treats them as *not having* capacity to consent to treatment or discharge when in fact *they do have* it, the hospital will not have a defence

under ss.5-6 MCA to otherwise tortious acts like medication or restraint, even if clinicians believed those acts were in the patient's best interests, like the Police in *ZH v CPM* [2013] 1 WLR 3021 (CA). Conversely, if a hospital fails to assess capacity of a patient and assumes they *do* have it when they *do not*, they *cannot* consent to leaving hospital, which therefore requires a best interests decision under s.4 MCA, if there is objection by the Court of Protection under ss.16-17 MCA, or if not by the hospital under s.5 MCA (only dispute requires Court involvement: *NHS v Y* [2018] 3 WLR 751 (SC)). If a hospital fails to comply with the MCA in discharging an incapacious patient to an unsuitable placement, they can be liable in tort for resulting injury, as in *Esegbona v King's NHST* [2019] EWHC 77 (QB).

iii) Thirdly, s.2 MCA states that *'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'* and s.3 MCA states the person is unable to make a decision if unable to understand, retain or use the information relevant to the decision (or to communicate it). As explained in *A Local Authority v JB* [2021] 3 WLR 1381 (SC), this means 'capacity' under the MCA is 'issue-specific' and 'time-specific', so someone can have mental capacity to make one decision (e.g. to see their relatives) but lack capacity about another (e.g. to manage their financial affairs or where they should live). The 'relevant information' under s.3 MCA which must be understood for capacity to consent to *treatment* (*Hemachandran v Thirumalesh* [2024] EWCA Civ 896) is slightly different than for capacity to consent to *discharge from hospital*, which is in turn slightly different than for capacity to consent to *living at a particular placement* – see *Wiltshire CC v RB* [2023] EWCOP 26. In *RB* itself, a patient fit for discharge from hospital objected to her return to accommodation where she had suffered trauma and was held to have been wrongly assessed as lacking capacity as the assessment elided issues of discharge and placement. Moreover, as also stressed in *RB*, an individual's capacity to litigate (e.g. to defend a possession claim by a hospital) is a separate issue of capacity again. If a patent lacks capacity to defend a possession claim by a hospital, under CPR 21 they require a Litigation Friend and without it the order would be invalid and may be set aside: *Dunhill v Burgin* [2014] 1 WLR 933 (SC). Moreover, service of proceedings must be on an Attorney, Deputy, or carer – see CPR 6.13.

29. Indeed, finally turning to the EqA, at the first hearing I raised the absence of not only assessment of Ms Mercer's litigation capacity, but also evidence of the Hospital's compliance with the Public Sector Equality Duty ('PSED') under s.149 EqA and evidence relevant to a potential public law EqA disability discrimination defence. Again, there are three key points about EqA 'mental disabilities':

i) Firstly, a patient may fall outside the scope of the MHA, also have capacity under the MCA to make all relevant decisions, yet still have a 'mental impairment with a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities' amounting to a disability under s.6 EqA. A 'mental disability' has a 'long-term effect' if it has lasted or is likely to (in the sense of 'may well') last for at least 12 months (para.2 Sch.1 EqA), whereas mental capacity under the MCA relates to the ability to make a particular decision at a particular time, so a

person may lose and regain capacity from time to time: see *MOC v DWP* [2022] PTSR 576 (CA). Therefore, a MCA capacity assessment may not necessarily reveal a EqA 'mental disability'.

ii) Secondly, as Chamberlain J analysed in *MB* at [61], a hospital is a 'service-provider' under s.29 EqA, which can be liable for disability discrimination if it fails in its duty under ss.20-21 EqA to make reasonable adjustments for a disabled patient before seeking possession (or an injunction to exclude). Oh course, as in *MB*, if a hospital has taken all reasonable steps (and complied with national guidance and its own policy), there will be no breach. However, it does not appear the patient's lawyers in *MB* raised s.15 EqA, which provides that a service provider or landlord discriminates against a disabled person if it 'treats them unfavourably because of something arising in consequence of their disability (if they were or ought to have been aware aware of it) and cannot show the 'treatment is a proportionate means of achieving a legitimate aim'. If a hospital seeks possession ('unfavourable treatment') because of a patient's refusal to leave hospital ('something') due to a known mental disability, it will have to prove possession would be proportionate. In *Aster v Akerman-Livingstone* [2015] 2 WLR 721 (SC), Lady Hale explained s.15 EqA has a higher onus of proof than the 'proportionality test' for possession under Art.8 ECHR and a summary possession order is not a given. But it may be more likely for a hospital against a patient than a landlord against a tenant, providing all reasonable lesser alternatives have been tried but not succeeded in the patient leaving.

iii) Finally, quite aside from actual disability discrimination under ss.15 or 20-21 EqA, a hospital is a 'public authority' owing the PSED to 'have regard' to the needs 'to advance equality of opportunity' for disabled people and to take different steps for them than for non-disabled people under s.149 EqA. On one hand, this is a duty of substance not form, which can be complied with without explicit reference to s.149 EqA (*McDonald*, *MB*). On the other, such cases of inadvertent compliance are rare and a public authority would generally be wise to carry out and record a specific, open-minded and conscientious consideration of the impact of possession on the disabled person and whether that can be safely managed, though breach of the PSED will not defeat possession if highly likely it would have resulted even if the PSED had been complied with (*Luton Housing v Durdana* [2020] HLR 27 (CA) and *Metropolitan Housing Trust v MT* [2022] 1 WLR 2161 (CA)).

30. Drawing the threads together, I suggest the following may be a helpful checklist for a hospital seeking possession (or a injunction in more complex cases e.g. with risks to staff), in relation to a patient whose refusal to leave hospital may be affected by a mental health or mental capacity issue. (However, I do not suggest a failure to take any or even all of these steps will necessarily bar such orders):

(i) *Has there been full and holistic preparation of the patient for discharge ?*

- Has NHS guidance / local policy on 'patient involvement' been followed ?
- Has there been sufficient liaison with the relevant local authority if it will be responsible for accommodation and/or care provision and funding ?
- Has it been explained to the patient and carer: *how* ongoing medical/care needs will be met, *who* is responsible for meeting them and *what* the patient or carer can do if they are unhappy about the provision ?

(ii) Have there been all necessary mental capacity assessments of the patient ?

- Does the patient have capacity to consent or object to (1) discharge and/or (2) placement (as opposed to treatment) ? If not, an application to the Court of Protection may be required if there is any dispute.
- If both, do they have capacity to defend possession/injunction proceedings ? If not, a suitable Litigation Friend will need to be found (who may be the person required to be served with the claim under CPR 6.13).
- Either way, if the patient would struggle to attend or participate physically and is a 'vulnerable party' under CPR 1A, the claimant hospital could suggest to the Court a remote hearing and facilitate it from hospital.

(iii) Has the proportionality of possession (or an injunction) been assessed ?

- Is the patient's refusal to leave in consequence of a mental disability ?
- Have all reasonable lesser alternatives to possession or an injunction been tried but not succeeded in the patient leaving the hospital voluntarily ?
- Can the physical and psychological impact on the patient of being removed from hospital home or to the proposed placement be safely managed ?

I emphasise that whilst the few cases so far suggest possession or an injunction has been ordered after a patient has been fit for discharge for around a year, that particular *quantity* of time is less important than the *quality* of the evidence on those issues justifying possession or an injunction.

Conclusions

31. Prior to the first hearing, the Claimant Hospital had evidenced much of this. Dr Baratashvili's statement proved Ms Mercer had been medically fit for discharge since April 2023. Ms Mallender's first two statements proved the Claimant had complied with the national NHS guidance and the Hospital's own policy. I reject Ms and Mrs Mercers' allegations that Ms Mallender has 'lied', which stem from their misunderstanding (e.g. they thought reference to past case-law breached confidentiality). Ms Mallender has showed why Ms Mercer's return to St Matthews broke down in May 2023 (due to a dispute between it and Ms Mercer) and how Ms Mercer had been assessed as the responsibility of the local authority NNC. It had investigated almost 120 different placements for Ms Mercer and found a Supported Living placement specialising in working with those with Ms Mercer's disabilities, initially with 2:1 care day and night during transition, before reducing to 1:1 care with 2:1 at specific times, meeting all her care needs.

32. However, even aside from Ms Mercer and her mother being unable to participate effectively at the last hearing, there was relatively little information about Ms Mercer's undisputed and long-term diagnoses of Autistic Spectrum Disorder ('ASD') and Emotionally Unstable Personality Disorder ('EUPD') relevant to both disability under the EqA and capacity under the MCA. The Claimant Hospital had provided assessments from Dr Ur-Rehman of Ms Mercer's capacity to consent or object to her discharge and placement, but there was no assessment of her capacity to litigate. Moreover, there was no Equality Impact Assessment ('EIA') addressing the proportionality of possession and whether all lesser alternatives had first been explored. This was in part why I adjourned the first hearing.

33. By contrast, at the adjourned hearing, not only was Ms Mercer able to attend remotely (although as I said, preferred her mother to speak for her), the Hospital and Ms Mercer herself had between them filled those gaps in the evidence. There were EIAs from NNC giving more details about the proposed placement and from Ms Mallender explaining that possession was proportionate because Ms Mercer did not need to be in the Hospital, which urgently needed her bed. Dr Ur-Rehman had assessed Ms Mercer as having capacity to defend the proceedings and as Mr Sinnatt said, that view was underlined by Ms Mercer providing medical assessments about her ASD and EUPD. Moreover, Mrs Mercer accepted Ms Mercer could understand discharge, placement and possession. I am entirely satisfied Ms Mercer had mental capacity in all relevant areas.

34. Nevertheless, at that adjourned hearing, I listened to and considered Ms Mercer's concerns, articulated clearly by her mother and indeed by her social worker, Ms Sgoluppi. After all, Ms Mercer has been in institutional care all her adult life, St Matthews for 9 of the last 10 years and the Hospital for the last 18 months. As Ms Sgoluppi said, Ms Mercer has clearly become institutionalised and that in combination with her ASD and EUPD has led her to severe anxiety over the proposed move to a Supported Living placement for the first time. Mrs Mercer fears her daughter will self-harm, hurt her carers, or even attempt suicide. I do understand and entirely sympathise. It is sad and ironic that NNC's assessment of Ms Mercer's care, in seeking to find the least restrictive option (consistently with the MHA, MCA and CA, as well as proportionality under the EqA), has caused Ms Mercer more anxiety than a more familiar institutional placement.

35. However, that is NNC's assessment of her needs for care and support and if Ms Mercer wishes to challenge it, she must do so with NNC in the first instance, then by complaint to the Ombudsman, or by claiming Judicial Review of NNC's assessment. What she cannot do is continue to avoid her departure by remaining in the Claimant Hospital when she does not need a bed there (and has not done for over a year) but other patients do. More positively, the proposed placement will initially have 2:1 care available day and night to help Ms Mercer, which will be reviewed before it reduces to 1:1 care. NNC assesses that as enough to keep Ms Mercer safe and her social work team will review her progress closely. I understand from NNC's EIA that Mrs Mercer has already met the care team (although still has concerns). Moreover, the Hospital also agreed to my suggestion of deferring possession for a week to help Ms Mercer prepare. So, at the hearing, I was satisfied possession was a proportionate means of achieving a legitimate aim even if s.15 EqA (and Art.8/14 ECHR) were engaged and that the Hospital had complied with the PSED. There was no arguable public or private law defence, so I granted summary possession. We must hope the transition goes smoothly.