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The great safety net: the inherent jurisdiction and vulnerable adults

ARTICLE

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SUMMARY

Clinicians should be aware of the inherent jurisdiction of the High Court in providing a 'safety net' to protect 'vulnerable' adults who are not within the scope of the Mental Capacity Act 2005 (MCA) or the Mental Health Act (MHA) 1983. Many situations in which the inherent jurisdiction has been deployed have been to safeguard vulnerable adults where there is abuse, coercion or undue influence, but the person does not lack decision-making capacity under the MCA. We explain the nature of the inherent jurisdiction, including descriptions of concepts surrounding 'vulnerability'; as an intervention of last resort, we consider what statutory alternatives may exist, including safeguarding law under the Care Act 2014; we discuss decision-making capacity in relation to contact with others and, using real cases, the types of order that may be made under the court's inherent jurisdiction. It is important to be mindful that although there may be a legal remedy to safeguard this 'vulnerable but capacitous' group, there is a delicate and challenging balance between protecting those at risk and respecting their autonomy.

LEARNING OBJECTIVES

After reading this article you will be able to:

- describe the orders a court may make, under its inherent jurisdiction, to protect vulnerable but capacitous individuals
- assess the capacity a person has in relation to contact with others
- reflect on some of the legal issues that must be considered when investigating a person at risk of abuse or neglect.

KEYWORDS

Inherent jurisdiction; vulnerable adults; consent and capacity; psychiatry and law; human rights.

The 'inherent jurisdiction' is the power of the High Court to hear any matter it believes it should hear unless there is a statute or rule that prevents it from doing so. The High Court is the third highest court in England and Wales (below the Court of Appeal and the Supreme Court) and it deals with civil cases (non-criminal) and appeals of decisions made in lower courts. Before the Mental Capacity Act 2005 (MCA), when someone lacked capacity, the High Court had the right to make declarations about issues relating to best interests or medical treatments and this was established by the court's inherent jurisdiction. That jurisdiction ceased once there was relevant statute law, in this case the MCA. The MCA itself is very much based on the jurisprudence (case law) of the High Court, as the court developed what it means to lack capacity and how to determine what is in an incapacitous person's best interests.

This inherent jurisdiction is rooted in the common law and is in the armoury of powers of courts in England and Wales that may apply across a range of different scenarios (Box 1). Some clinicians may be familiar with the High Court exercising its inherent jurisdiction in decisions relating to children, for example making a child a 'ward of court'. It is a wide-ranging power that the court possesses in protecting children in areas where statutory remedies, such as under the Children Act 1989, are insufficient. In relation to adults there are also gaps in the statutes where it has been necessary for the court to exercise its inherent jurisdiction. One group to which this has been applied are those adults who may not have lacked decision-making capacity but were 'vulnerable' (or 'at risk') for some reason. It is this group that we will focus on for most of our discussions and which exemplifies a complex and emerging area of case law.

Mental health teams may be involved with an individual for whom safeguarding interventions are necessary or ongoing. Clinicians may then take part in safeguarding discussions, care planning, assessments of relevant decision-making capacity and consideration of practical and applicable solutions, for example the appropriateness of using the Mental Health Act 1983 (MHA). Where criteria for detention under the MHA are not met, it may not simply be the case that if capacity is present, the requirement to respect unwise decision-making and personal autonomy draws a line under the issue. It is important that clinicians are aware that there may be legal routes that can be pursued to protect individuals even when capacity is preserved, which may include a decision under the court's inherent jurisdiction. It is unlikely that the onus would be on a clinical service itself to bring proceedings to court and, on most occasions, this will be the

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BOX 1 Understanding the inherent jurisdiction

One way for a clinician to understand this jurisdiction is to note the following:

- that Parliament has, over the years, legislated to protect the vulnerable by way of an almost comprehensive number of Acts of Parliament such as the Mental Health Act, the Children Act, the Mental Capacity Act and the Care Act
- most of these acts create a court or tribunal with strictly delineated powers (or a specific *jurisdiction*, e.g. the Court of Protection for those who lack capacity) that can only be used if the vulnerable person meets tightly drawn criteria
- that framework covers most eventualities and must be used where it applies
- but these pieces of legislation do not remove the centuries-old jurisdiction of the High Court – its inherent jurisdiction
- the High Court can intervene and make orders, should a vulnerable person need protection and they fall between the gaps in the statutory framework.

responsibility of the local authority. However, if the intervention of the court is ultimately thought to be necessary, practitioners should be mindful that documentation of these different elements or considerations highlighted above will be submitted as evidence. The flow diagram in Fig. 1 illustrates how in a typical case the inherent jurisdiction may be applied.

In the first instance we will discuss 'the vulnerable', considering some of the potential legal alternatives to court proceedings under the inherent jurisdiction, before discussion of the legal basis of safeguarding. We will then outline one of the most likely aspects of capacity that clinicians (or others) may be called on to assess, that is the capacity for an individual to decide on the contact he or she should have with another. Finally, we will discuss some cases in the sphere of the inherent jurisdiction and how it has been deployed in delivering outcomes.

To whom does the inherent jurisdiction apply?

The inherent jurisdiction is often called the 'great safety net' (*Re F (Mental patient: Sterilisation)* [1989]) allowing the court to intervene where there is no other course of action available. Many of the cases brought under the inherent jurisdiction have related to people with intellectual disabilities (commonly referred to as learning disabilities in UK health services) or older people in volatile or abusive relationships, although practically it could apply to someone without any physical or cognitive disability (see *Al-Jeffery v Al-Jeffery* [2016]). Vulnerability in this context may result from an inability to make a free choice because of abuse, neglect, undue influence or coercion *rather than* because of a disturbance or impairment in mind or brain (in which case the MCA would apply). An 'impairment' may be present but capacity, in the usual sense, is retained. Strictly, the inherent jurisdiction exists to facilitate the process of unencumbered decision-making by those who would otherwise be controlled by external pressures. In other words, it is to allow people enough breathing space to make their own decisions.

A seminal case, which is the start of a series of court judgments that make up the modern view on the inherent jurisdiction, is that of SA (*A Local*

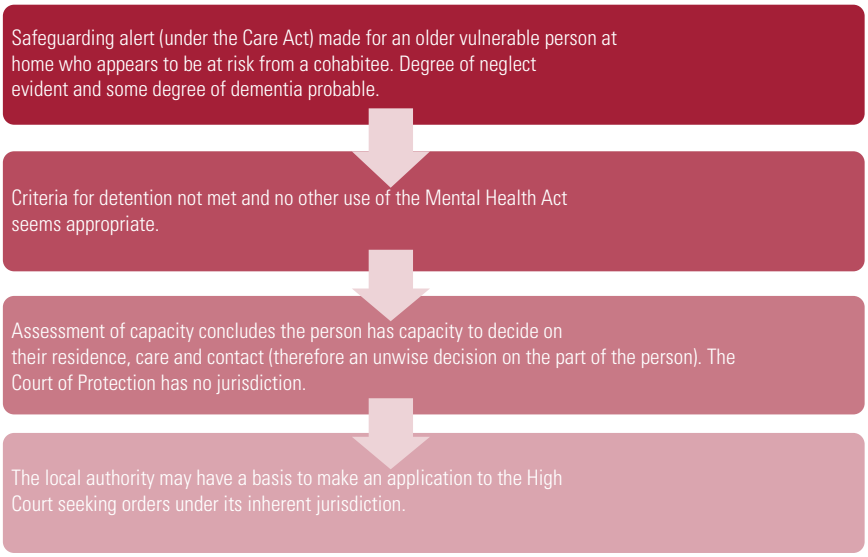

FIG 1 Flow diagram to illustrate how the inherent jurisdiction may be applied.

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Authority v MA & Ors [2005]). As a child there had been court judgments protecting SA from the risk of an unsuitable arranged marriage. Given she had turned 18, the key issue was whether the court could invoke its inherent protective jurisdiction in respect of a vulnerable adult who had capacity to marry. The judge in the case, Mr Justice Munby, decided it could. A description of vulnerability was given in the following way:

> '[…] the inherent jurisdiction can be exercised in relation to a vulnerable adult who, even if not incapacitated by mental disorder or mental illness, is, or is reasonably believed to be, either (i) under constraint or (ii) subject to coercion or undue influence or (iii) for some other reason deprived of the capacity to make the relevant decision, or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent.'

These concepts were elaborated further:

> 'i) 'Constraint: It does not matter for this purpose whether the constraint amounts to actual incarceration. The jurisdiction is exercisable whenever a vulnerable adult is confined, controlled or under restraint […] It is enough that there is some significant curtailment of the freedom to do those things which in this country free men and women are entitled to do.
> ii) Coercion or undue influence: [is] where a vulnerable adult's capacity or will to decide has been sapped and overborne by the improper influence of another. In this connection I would only add […] that where the influence is that of a parent or other close and dominating relative, and where the arguments and persuasion are based upon personal affection or duty, religious beliefs, powerful social or cultural conventions, or asserted social, familial or domestic obligations, the influence may […] be subtle, insidious, pervasive and powerful. In such cases, moreover, very little pressure may suffice to bring about the desired result.
> iii) Other disabling circumstances: What I have in mind here are the many other circumstances that may so reduce a vulnerable adult's understanding and reasoning powers as to prevent him forming or expressing a real and genuine consent, for example, the effects of deception, misinformation, physical disability, illness, weakness (physical, mental or moral), tiredness, shock, fatigue, depression, pain or drugs. No doubt there are others.'

There are important qualifications to these general descriptions in that just because someone is disabled, or has some sort of impairment, it does not necessarily mean they are considered 'vulnerable' for the purposes of deploying the inherent jurisdiction. An example of this is Mr N, aged 25 at the time of court proceedings, and diagnosed with severe autism, an anxiety disorder and traits of an emotionally unstable personality disorder but no significant intellectual impairment (*Wakefield MDC and Wakefield CCG v DN and MN* [2019]). He had been convicted of several criminal offences and was required to live in supported living accommodation in circumstances that ostensibly appeared to be a 'deprivation of his liberty' (see later), thereby requiring the authority of the court. Mr N experienced what were described as 'meltdowns' when particularly anxious or aroused and, at those times, he lacked capacity to manage his behaviour and 'the ability to think rationally and weigh up his decisions'. When in a 'meltdown' he became highly agitated, using 'extremely threatening and violent language [and] intimidating behaviour'. Although he was vulnerable in some ways, the court did not find that he was vulnerable in the context described above. He was not regarded as requiring the intervention of the High Court under its inherent jurisdiction as he was able to consent to his residence and care arrangements. Declarations under the MCA could be made to cover occasions when he had meltdowns and lost capacity. In the same vein, although wide-ranging in its powers, the inherent jurisdiction is not applicable to all potentially vulnerable individuals and it is not 'a lawless void permitting Judges to do whatever we consider to be right for children or the vulnerable' (*London Borough of Redbridge Council v SNA* [2015]).

Alternatives to the inherent jurisdiction

Because the inherent jurisdiction applies where there are no statutory powers to intervene, we must first consider what legal alternatives may be available (Fig. 2) and, within those alternatives, where safeguards in relation to Article 5 rights (the right to liberty and security) of the European Convention on Human Rights are derived. For example, if a person has a mental disorder within the meaning of the MHA (i.e. any disorder or disability of mind) and additional statutory criteria are met, then it may be that the MHA can be applied. Readers will be aware that the MHA is the main piece of legislation that covers the assessment, treatment and rights of people with a mental disorder. The First-tier Tribunal in England (the Mental Health Review Tribunal in Wales) is the legal forum that determines whether grounds for detention under the MHA exist. It is the means by which a patient's rights under Article 5 may be challenged.

The MCA has been in force since 2007 and applies where a person is unable to make a decision about a specific matter *because of* an 'impairment or disturbance in the functioning of the mind or the brain' (MCA, section 2(1)). If a person lacks mental capacity about an issue then, under the MCA, a decision can be made in their best interests using that Act (section 4). It applies in England and Wales to people over 16 years of age who are unable to

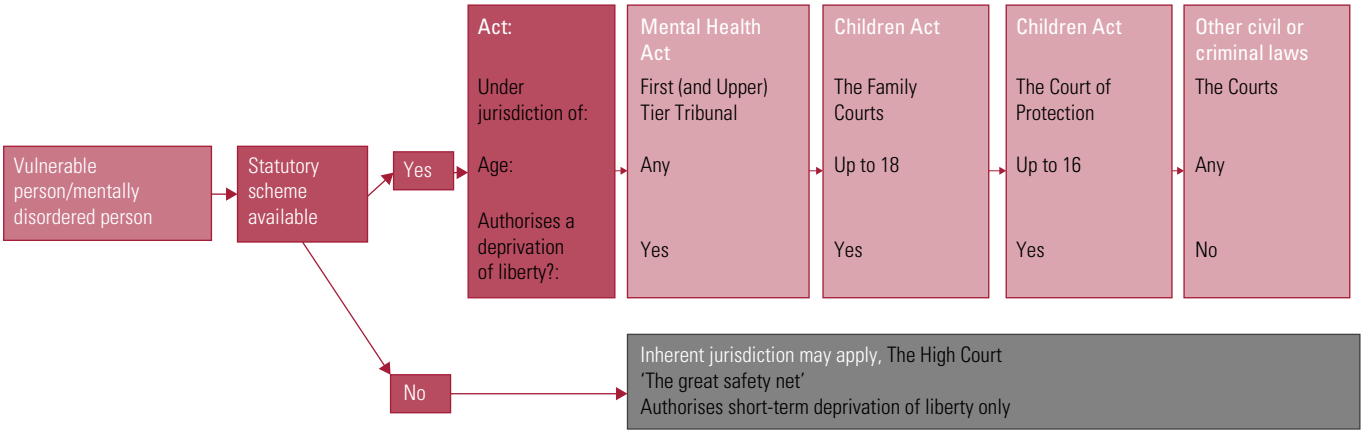

FIG 2 Statutory alternatives to the inherent jurisdiction.

make some or all decisions for themselves. The primary objective of the MCA is to promote and safeguard decision-making within a legal framework. It is the Court of Protection that has jurisdiction when there is a dispute under the MCA and it has considerable importance in clinical and social care. The general powers of the Court of Protection include deciding whether a person has capacity to make a particular decision, whether an action is in a person's best interests, confirming or revoking the validity of a lasting or enduring power of attorney, appointing deputies and ruling whether a person is being deprived of their liberty.

There may be other powers available to the person at risk that may be deployed against the perpetrator (s). An adult being abused can apply for a 'non-molestation order' (section 42 of the Family Law Act 1996) or 'protection from harassment injunctions' (Protection from Harassment Act 1997), although under the circumstances that we are discussing this may be unrealistic. If a crime or domestic violence is suspected, there are powers available to the police and the courts. It will be the facts of a particular case that determine the available options. By way of an example, in the case of Mr and Mrs L discussed below (*DL v A Local Authority* [2011]), to protect the couple from the alleged abuses of their son the local authority had considered, and rejected, several alternatives before bringing proceedings to court. These were prosecution using the criminal law, applying to the Court of Protection, making an application for an antisocial behaviour order (ASBO) under the Crime and Disorder Act 1998 and applying for an injunction under the Housing Act 1996.

Safeguarding under the Care Act

Pursuing proceedings under the court's inherent jurisdiction is lengthy and expensive and therefore all other means of resolution must have been exhausted, and in any event, one is only to turn to it if the available statutes do not cover the scenario. In the circumstances of suspected abuse, safeguarding processes will be activated and should facilitate close multi-agency and multiprofessional working. The Care Act 2014 (and the Social Services and Well-being Act 2014 in Wales) imposes duties on a local authority in relation to safeguarding and adult protection. The main safeguarding sections in the Care Act are summarised in Box 2.

BOX 2 The main safeguarding duties placed on a local authority in the Care Act 2014

Section 42: Enquiry by local authority

Places a duty on local authorities to carry out an enquiry when an adult with care and support needs is suffering or likely to suffer abuse or neglect; and because of their care and support needs, they are unable to protect themselves.

Section 43: Establishment of a statutory Safeguarding Adults Board

Requirement for all local authorities to establish a Safeguarding Adults Board (SAB) responsible for effective multi-agency safeguarding arrangements in their area.

Section 44: Safeguarding adults review

Requirement on SABs to carry out a Safeguarding Adults Review when an adult dies or is seriously injured and it is felt that partner agencies could have done more to protect the person.

Section 45: Supply of information

A person must supply information on request by the SAB if he or she is likely to have information relevant to the SAB's functions.

Section 46: Abolition of local authority's power to remove persons in need of care

Section 47 of the National Assistance Act 1948 ceases to apply to persons in England.

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These acts are primarily about care and support for adults and their carers, with the purpose of consolidating a raft of legislation in relation to social care. Safeguarding in the statutory guidance means protecting an adult's right to live in safety, free from abuse and neglect. It also includes the processes of 'adult protection', which refers to the investigations and interventions when abuse is suspected. The Care Act also sets out 'key principles' that underpin all adult safeguarding work (Box 3).

The duties of a local authority specifically apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs)
- is experiencing, or at risk of, abuse or neglect, and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse or neglect.

If an organisation works with vulnerable adults there should be adult safeguarding policies and procedures. A local authority must carry out an assessment in a safeguarding case even if the person refuses. What happens as a result of any inquiry will depend on factors such as the degree of risk and what is required to protect the person concerned. The inquiry may result in the formulation of an Adult Safeguarding Plan recorded on the person's care plan. This should be timely and follow from the conclusion of the inquiry. The purpose of the plan is to formalise and coordinate the range of actions to protect the adult and help the person to recover from the experience of abuse or neglect. The local authority will take responsibility for organising and coordinating the formulation of the plan. It should set out:

- what steps are to be taken to assure the adult's safety in future
- the provision of any support, treatment or therapy, including advocacy
- any modifications needed in the way services are provided
- how best to support the person through any action they take to seek justice or redress, and
- any on-going risk management strategy as appropriate.

Once the steps are in place and recorded in a care plan, they should be taken and kept under review by an identified lead professional. In most cases this will be the responsible manager from the local authority. There is also recognition of the role of carers in relation to safeguarding in recognising abuse, being victims of abuse and being either intentional or inadvertent perpetrators of abuse. An important element of supporting someone at the centre of safeguarding proceedings may be the appointment of an advocate (under section 68 of the Care Act).

Capacity in relation to contact with others

If a safeguarding notification is being made, consent for this should be sought (but may not be required) by giving the individual information about the safeguarding process. Following from this, depending on the risks, assessments of capacity may be necessary in relation to decisions such as where the person lives or the care they receive. Where there is suspected coercion or abuse, the assessment of capacity to decide on whether one person should have contact, or not, with another is a relatively common requirement for local authorities. These challenges certainly arise in routine clinical practice, for example whereby a person with dementia is at risk or subject to exploitation from a family member or other. The tension may be in differentiating between what amounts to unwise but otherwise autonomous decision-making regarding the contact and incapacity that requires action in the person's best interests.

Capacity is clearly decision specific, but in relation to contact capacity, the information required to make the decision will vary because the risks of contact will depend on the individual and the circumstances. Therefore, the courts have decided that, unlike sexual capacity or marriage, the identity of the person in relation to contact is important. Decisions relating to a 'status or right' (marriage and sex) are therefore seen as different from those 'grounded in the specific factual context' (contact)

BOX 3 Principles of safeguarding in the Care Act 2014

Empowerment People being supported and encouraged to make their own decisions and informed consent.

Prevention It is better to take action before harm occurs.

Proportionality The least intrusive response appropriate to the risk presented.

Protection Support and representation for those in greatest need.

Partnership Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

Accountability Accountability and transparency in safeguarding practice.

(*A Local Authority v TZ (No. 2)* [2014]). Because of this difference, the lower threshold that applies to the former means that a person may have capacity to consent to marriage or sex but lack capacity to maintain contact with an individual (a case relating to marriage is *PC and NC v City of York Council* [2013]). This is not perhaps as counterintuitive as it first appears, as the court can make declarations about limiting or preventing the contact with an alleged abuser, even if capacity in relation to engaging in sexual relations is retained.

As with all capacity assessments, the starting point in assessing contact capacity are the principles of the MCA and the information and support provided to assist the individual in making the decision. In the case of Mr L, with intellectual disabilities, the information required for him to have contact with his father is given in Box 4. In any assessment of capacity, the information will be individual and situation specific, but it is helpful to look at the factors that were relevant in this man's case. In the event, he was assessed as having capacity and the inherent jurisdiction was invoked in order for him to be safeguarded (*LBX v K, L and M* [2013]).

In the context of a safeguarding investigation, the determination of a lack of contact capacity (and if relevant, including whether the person can grasp that someone else may have interests contrary to theirs) will identify whether they fall under the scope of the MCA and thereby the jurisdiction of the Court of Protection (see Ruck Keene 2020). If capacity is present, and they remain at risk, it may then be necessary to apply to the High Court to make a declaration under its inherent jurisdiction.

What actions can be taken under the court's inherent jurisdiction?

In considering what actions can be taken under the inherent jurisdiction, it is worth highlighting some key points made by the judge in the case of BF (*A Local Authority v BF* [2018]; see also the case of Mr Meyers below). The inherent jurisdiction may be deployed for the protection of vulnerable adults; in some cases, a vulnerable adult may not be incapacitated within the meaning of the MCA, but may nevertheless be protected under the inherent jurisdiction; in some of those cases, capacitous individuals may be of unsound mind, i.e. experience a mental disorder; in exercising its powers under the inherent jurisdiction, the court must only impose orders that are necessary and proportionate and at all times have proper regard to the personal autonomy of the individual.

The aim underpinning the inherent jurisdiction is to facilitate the process of unencumbered decision-making, thereby promoting the autonomy of the person who requires safeguarding, pursuing the least intrusive option. This reflects the safeguarding principles referred to above. Orders under the inherent jurisdiction should be directed against alleged perpetrators of abuse and only under exceptional circumstances should they restrict the abused. It may be appropriate for a court to take or maintain interim protective measures (as was the case for Mr Meyers) in relation to the abused while carrying out necessary investigations or interventions. There are additional considerations for a local authority when seeking a court order (or injunction) designed to 'regulate the conduct of the subject', which may include the abuser or the person being abused (*Redcar & Cleveland Borough Council v PR* [2019]). If the person is unlikely to comprehend the purpose of the injunction, or will not be told of the injunction or will not understand the effect of a breach of the injunction, then the application should not be made, because any injunction is just not likely to be effective. An alternative course of action may be required.

In the case of on older married couple (Mr and Mrs L referred to above) the local authority brought proceedings to protect the couple from alleged abuses by their son DL *(DL v A Local Authority* [2011]). To put the case into context, some of the facts of the

BOX 4 Information required by the High Court in assessing Mr L's capacity to decide as to contact with others (*LBX v K, L and M* [2013])

Relevant information

- Who the contacts will be and in broad terms the nature of Mr L's relationship with them
- What sort of contact he could have with each of them, including different locations, differing durations and differing arrangements regarding the presence of a support worker
- The positive and negative aspects of having contact with each person. The person's evaluations will be irrelevant if they are based on demonstrably false beliefs
- What a family relationship is and that it is in a different category to other categories of contact
- Whether the person with whom contact is being considered has previous convictions or poses a risk to Mr L

Not relevant information

- Abstract notions such as the nature of friendship and the importance of family ties
- The long-term possible effects of contact decisions
- Risks that are not in issue, such as the risk of financial abuse

BOX 5 The case of Mr and Mrs L (in *DL v A Local Authority* [2011] in the High Court)

- At the time of proceedings Mr L was 85 and Mrs L was 90
- Mrs L was physically disabled and in receipt of a home care package
- They lived in their own house with their son DL (in his 50s)
- The local authority alleged that DL was physically assaultive and verbally aggressive to his parents, controlled their movements and who visited them, and interfered with the provision of care to Mrs L
- DL was alleged to have sought to transfer ownership of the house into his own name and pressurised them both to have Mrs L moved into a care home against her wishes
- Mr and Mrs L had no lack of capacity by reason of an impairment or disturbance of functioning of mind or brain, so the Mental Capacity Act could not be used to protect them
- The local authority brought proceedings to protect Mr and Mrs L from DL, in the High Court

case are detailed in Box 5. The view of the independent social worker appointed was that both Mr and Mrs L were unduly influenced such that their capacity to make balanced and considered decisions was impeded. Using its inherent jurisdiction, the court issued injunctions (later supported by the Court of Appeal) against DL, restraining him from:

- assaulting or threatening to assault his parents
- preventing his parents from having contact with friends and family
- seeking to persuade or coerce his father, Mr L, into transferring the family home to him
- seeking to persuade or coerce his mother, Mrs L, into moving into a care home
- engaging in behaviour towards his parents that is otherwise degrading or coercive
- giving orders to carers
- interfering in the provision of care and support to Mrs L
- refusing access to health and social care practitioners
- behaving in an aggressive and/or confrontational manner to carers and management.

A follow-on decision to the BF case referred to above is that of *Southend-on-Sea Borough Council v Meyers* [2019], in which BF is named as Mr Meyers. The details of his situation, his contact with the local authority and the passage of his case through the courts are complex, however some points of the case are given in Box 6. The case is unusual in that it was the local authority that was seeking a declaration that it had in fact discharged its responsibilities to Mr Meyers but it does illustrate the actions a court may make. Court proceedings commenced in 2017 and continued for 2 years. Ultimately, a judge held that Mr Meyers did not lack capacity but was a vulnerable adult and therefore within the scope of the inherent jurisdiction. Under the inherent jurisdiction it was decided that Mr Meyers should be prevented from living with his son (referred to as KF), either in the bungalow or in alternative accommodation, and contact with his son should be restricted. The court refused the declaration sought by the local authority and required the local authority to investigate whether KF could be removed from the bungalow in order that that Mr Meyers could return with a suitable package of care. It was also suggested that the local authority should promote the reunification of Mr Meyers with his wider family, who had become estranged because of KF's behaviour, in order to support the care arrangements.

BOX 6 The case of Mr Meyers (in *A Local Authority v BF* [2018] and *Southend-on-Sea Borough Council v Meyers* [2019] in the High Court)

- Mr Meyers was a 97-year-old man with diabetes, osteoarthritis and blind in both eyes
- Mr Meyers lived in a bungalow with his son KF following the death of his wife
- KF suffered from drug and alcohol addiction
- The condition of the property was squalid and unsafe
- KF was observed to intimidate visiting care staff such that all ultimately refused to provide his father with necessary care at home, which prompted the local authority to start legal proceedings in 2017
- Mr Meyers' health suffered as a result, culminating in hospital admissions
- In 2018 Mr Meyers was persuaded to stay in a care home
- Subsequent court proceedings prevented Mr Meyers from returning to his home
- KF refused to leave the bungalow
- Mr Meyers' relationship with KF was described as 'complex' and KF's influence on his father was described as 'insidious and pervasive'
- It was concluded that Mr Meyers had no mental disorder and had capacity to decide on his living arrangements and was aware of the risks posed by KF to himself and others

Inherent jurisdiction and deprivation of liberty

Everyone has the right not to be deprived of their liberty except in limited cases specified in Article 5 of the European Convention on Human Rights and provided there is a proper legal basis, i.e. it must be 'in accordance with a procedure prescribed by law' (Article 5.1). 'A person of unsound mind' is one of the specified cases (Article 5.1[e]). The legislation that authorises a deprivation of liberty (such as detention under a section of the MHA or a deprivation of liberty authorised by the deprivation of liberty safeguards/liberty protection safeguards as scheduled in the MCA) is compliant with Article 5.

The relationship between the inherent jurisdiction and a deprivation of liberty is confusing and perhaps inconsistent. The common law (judge-made law) is not a 'procedure prescribed by law' and therefore does not have the certainty, predictability and safeguards that a statute does and so is not considered to meet the terms of Article 5. The issue is whether the court can use the inherent jurisdiction to require a vulnerable adult to live in a particular location where they are subject to complete supervision and control and not free to leave. That is, the 'acid test' of the Cheshire West judgment (*P v Cheshire West and Chester Council and Anor and P and Q v Surrey County Council* [2014]) in the Supreme Court is met and the person is thereby deprived of their liberty (for a discussion of the case and its implications see Brindle 2015). The inherent jurisdiction has been used to authorise a deprivation of liberty in circumstances where there have been legislative gaps. In one case the court's inherent jurisdiction was used to authorise a deprivation of liberty of a patient with capacity who was subject to a conditional discharge under the MHA (*Hertfordshire County Council v AB* [2018]). In another case, that of Dr A, despite his lack of capacity, his refusal to eat was not considered a symptom or manifestation of his mental disorder. Thereby, the forced feeding he required, which amounted to a deprivation of liberty, fell in a gap between the MCA and the MHA and was then authorised under the inherent jurisdiction (*An NHS Trust v Dr A* [2013]).

In the case of Ms R (*Redcar & Cleveland Borough Council v PR* [2019]) temporary court orders were all that were needed to prevent her returning home to reside with her parents (after having made allegations against one of them) and to support her to move to alternative accommodation. Ultimately, she decided she did not want to live with them. The judge's view in this case was that the inherent jurisdiction *ought not* to be used to authorise the deprivation of liberty of a capacitous person.

For Mr Meyers, despite his clear and consistent wishes, the court's decision was that the restrictions imposed on him by preventing his return home and limiting contact with his son did not amount to a deprivation of liberty. Clinicians and practitioners must be able to recognise when deprivation of liberty might occur and be sensitive to the distinction between a restriction of and a deprivation of liberty. Given the low threshold that engages Article 5 of the European Convention on Human Rights in health and social care settings, it is likely that most would likely consider Mr Meyers to be deprived of his liberty. However, the judge's view was that he was restricting Mr Meyers' choices rather than depriving him of his liberty and, as with Ms R, it also was on a temporary basis. It seems unlikely that a long-term solution could have been achieved in this way, as that would have been deemed both disproportionate and a deprivation of liberty. For the court to authorise anything other than short-term and urgent restrictions, in the first instance, there would need to be evidence of an unsound mind (not present in the case of Mr Meyers) in order to comply with Article 5. Notwithstanding any interpretation of deprivation of liberty, this case demonstrates the power of the court in overriding capacitous decision-making and some of the legal complexities and challenges that emerge in protecting the vulnerable. Whatever the duration of an authorisation, the court will ask that the matter is brought back before it at regular intervals, keeping the arrangements under very regular review.

Conclusions

The Court of Protection exists, in part, to intervene in cases where relevant decision-making capacity is lacking, the individual is vulnerable to exploitation or abuse and there are unresolved disputes regarding best interests. The cases described here are perhaps not untypical of those arising in clinical practice when an individual remains vulnerable to undue influence or abuse, as described, but capacitous in their decision-making. Another avenue of intervention is therefore available through the High Court, empowered by its inherent jurisdiction to make orders to intervene in the lives of those who have decision-making capacity but are sufficiently vulnerable to fall under its scope.

It is also important to recognise that it is not wholly fixed as to the cases that are suitable for the courts to deal with in this way or how the courts should respond. For example, short-term orders restricting someone with capacity to a care home (for a matter of weeks) may be permitted by the courts and not amount to a deprivation of liberty. But what are the limits to this? How will the

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courts react if longer-term restrictions are deemed necessary, thereby tipping the balance towards what might be judged a deprivation of liberty? There is therefore a way to go before the domain of the inherent jurisdiction is settled and, in the meantime, it will likely appear somewhat fluid. If in doubt about a particular case consult your clinical leads, mental health legislation department or trust solicitors.

Author contributions

All authors made substantial contributions to: the conception or design of the work; drafting the work and revising it critically for important intellectual content; and approval of the version to be published; and all authors agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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Declaration of interest

None.

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MCQ answers
1 e 2 b 3 b 4 b 5 d

MCQs
Select the single best option for each question stem

1 Declarations made under the inherent jurisdiction of the High Court:
a may be made even when there are statute or rules governing the decision to be made
b may be made about a person's lack of decision-making capacity and best interests
c may apply to any adult with disabilities
d may permit a long-term deprivation of a person's liberty
e must only impose orders that are necessary and proportionate.

2 As regards investigation of safeguarding concerns under the Care Act 2014:
a an assessment cannot be carried out if the person refuses
b the key principles of the Care Act 2014 should be adhered to
c there is no statutory duty for a local authority to make an enquiry about suspected abuse
d clinical teams are responsible for formulation of the adult safeguarding plan
e carers are not recognised as part of the safeguarding processes.

3 As regards assessment of the capacity a person has in relation to contact with others:
a the identity of the person (to whom the contact relates) is unimportant
b a person may have capacity to consent to marriage or sex but lack capacity to maintain contact with the same individual
c if the person lacks capacity in relation to contact with others, a declaration under the inherent jurisdiction may still be made
d the information required to make the decision need not be tailored to the circumstances of the individual
e the information required to make the decision need not include whether the person with whom contact is being considered has previous convictions or poses a risk to the protected party.

4 A person may be considered 'vulnerable':
a because they are able to make a free choice
b because they are subject to coercion or undue influence
c because they are free from constraint
d because any form of disability is present
e only if physical or cognitive disability is present.

5 As regards orders under the inherent jurisdiction:
a they should be directed against the victims of abuse
b they should be made regardless of whether the person who is the subject of the order can understand it
c they need not reflect safeguarding principles under the Care Act 2014
d they cannot impose restrictions on the perpetrator of abuse
e short-term restrictions of the victim of abuse are not permitted.