HOUSE OF LORDS SESSION 2005–06
[2005] UKHL 60

on appeal from:[2004] EWCA Civ 1609

OPINIONS

OF THE LORDS OF APPEAL

FOR JUDGMENT IN THE CAUSE

MH (by her litigation friend, Official Solicitor) (FC) (Respondent)
v.
Secretary of State for the Department of Health (Appellant) and others

Appellate Committee

Lord Bingham of Cornhill
Lord Hope of Craighead
Lord Rodger of Earlsferry
Baroness Hale of Richmond
Lord Brown of Eaton-under-Heywood

Counsel

Appellants:
Philip Sales
Timothy Morshead
(Instructed by Solicitor, Department of Health)

Respondents:
Richard Gordon QC
Paul Bowen
(Instructed by Elliott Bridgman)

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ON
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LORD BINGHAM OF CORNHILL

My Lords,

1. I have had the advantage of reading in draft the opinion of my noble and learned friend Baroness Hale of Richmond. I am in full agreement with it, and for the reasons which she gives would allow the Secretary of State's appeal and make the order which she proposes.

LORD HOPE OF CRAIGHEAD

My Lords,

2. I have had the advantage of reading in draft the speech of my noble and learned friend Baroness Hale of Richmond. I agree with it, and for the reasons she gives I too would allow the appeal and make the order which she proposes.

LORD RODGER OF EARLSFERRY

My Lords,

3. I have had the privilege of reading in draft the speech to be delivered by my noble and learned friend, Baroness Hale of Richmond. I agree with it and, for the reasons she gives, I too would allow the appeal and make the order which she proposes.

BARONESS HALE OF RICHMOND

My Lords,

4. How can a patient who is so severely mentally disordered that she cannot apply to a court or tribunal challenge her detention in hospital? The problem very rarely arises but it may do so more often in future. Most of the patients who are admitted under the formal procedures in the Mental Health Act 1983 do have the very limited capacity required to make an application to a mental health review tribunal or have someone else who can help them to make it. The exceptions may be patients with severe learning disability or severe dementia. It is now unusual for people with those disabilities to be formally admitted to hospital under the 1983 Act. Indeed, these days few patients with severe learning disability are admitted to hospital at all.

5. Most of these patients are much better looked after outside hospital, either at home or in some form of residential care. Those who are admitted to hospital have since the 1950s generally been admitted without legal formalities. It has long been assumed that patients who do not object to being in hospital can be admitted informally even if they lack the capacity to consent. This is merely an extension of the general principle that people who lack the capacity to decide for themselves may be given the care and treatment which they need in their own best interests without specific legal authorisation. The Act's formal procedures were therefore reserved for the very few who actively objected. This assumption was confirmed as a matter of domestic law by the decision of this House in *R v Bournewood Community and Mental Health NHS Trust, Ex p L* [1999] 1 AC 458; but it is now under

reconsideration in the light of the recent decision of the European Court of Human Rights in *HL v United Kingdom* (2004) 40 EHRR 761 that such an informal admission may be a deprivation of liberty for the purpose of article 5 of the Convention. But that is not the issue before us.

The facts and the issues

6. This case is about a young woman, MH, who is severely mentally disabled as a result of Down's syndrome. She was formally admitted to hospital for assessment under section 2 of the 1983 Act. Aged 32 at the time, she lived with her mother, BL, who was deeply distrustful of the health and social services and often rejected the help they offered. As a result, MH was denied the therapy and social contacts which might have helped her to develop her skills and lead a fuller life. It was also feared that if her mother felt unable to cope she might harm her daughter rather than turn to the authorities for help. Matters came to a head in January 2003, when the mother became ill and MH increasingly disturbed in her behaviour. The mother having refused entry to the home so that MH's mental health could be assessed, a warrant under section 135 of the 1983 Act was obtained and executed on 31 January 2003. MH was then admitted to hospital for assessment under section 2. The application for her to be admitted to the hospital was made by an approved social worker and supported by the recommendations of two doctors, one of them Dr Langton, a consultant psychiatrist specialising in adult learning disability who had known MH since 1994.

7. The grounds for admission set out in section 2(2) are that the patient:

> "(a) . . . is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and
>
> (b) he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons."

If the hospital managers to whom the application is made agree to admit the patient, she may then be detained in the hospital for up to 28 days: see section 2(4). However, she can be discharged at any time on the

order of the responsible medical officer (the RMO, who is the consultant in charge of her treatment), or the hospital managers, or her nearest relative: see section 23(2)(a). She may also apply to a Mental Health Review Tribunal within 14 days of her admission: see section 66(1)(a) and (i), (2)(a). The tribunal must hear her case within seven days of receiving the application: see Mental Health Review Tribunal Rules 1983, r 31.

8. No application was made to the tribunal within 14 days of MH's admission. However, MH's mother, as nearest relative, did try to discharge her. The nearest relative has to give 72 hours' notice in writing to the managers of the hospital of her intention to discharge the patient; if the RMO then reports that if discharged the patient would be likely to act in a manner dangerous to others or to herself, the discharge is of no effect: see section 25(1). Dr Langton made such a report in this case and the hospital managers confirmed it. Hence MH was not discharged.

9. Once she had become calmer and her needs assessed in hospital, the plan was to find a suitable residential placement for her. As it was known that her mother would not agree to this, it was also planned to arrange for MH to be received into guardianship under section 7 of the 1983 Act. This is a long term alternative to detention and treatment in hospital. The guardian may be a private individual but is usually the local social services authority. The guardian has power to decide where the patient is to live and to require her to attend at specified places for medical treatment, occupation, education or training: see section 8(1). The grounds set out in section 7(2) are that the patient:

> "(a) . . . is suffering from mental disorder, being mental illness, severe mental impairment, psychopathic disorder or mental impairment and his mental disorder is of a nature or degree which warrants his reception into guardianship . . . ; and
>
> (b) it is necessary in the interests of the welfare of the patient or for the protection of other persons that the patient should be so received."

As with an application for admission to hospital, the application for reception into guardianship may be made either by an approved social worker or by the patient's nearest relative: see section 11(1). However, as with an application for longer term admission to hospital for

treatment under section 3 of the 1983 Act, an approved social worker cannot make the application if the patient's nearest relative has lodged an objection to it: see section 11(4). Furthermore, the nearest relative can discharge the patient from guardianship at any time under section 23(2)(b) and there is no equivalent of the RMO's power in section 25(1) to bar a discharge from hospital. Hence there is no point in making a guardianship application to which the nearest relative objects. In this case, as expected, MH's mother did object to the proposed guardianship application.

10. Where the nearest relative objects to an application either for admission for treatment or for reception into guardianship, the authorities may invoke the procedure for appointing an "acting nearest relative" under section 29 of the 1983 Act. An application may be made to the local county court, usually by an approved social worker, on the grounds set out in section 29(3), *inter alia*:

> "(c) that the nearest relative of the patient unreasonably objects to the making of an application for admission for treatment or a guardianship application in respect of the patient; or
>
> (d) that the nearest relative of the patient has exercised without due regard to the welfare of the patient or the interests of the public his power to discharge the patient from hospital or guardianship . . . or is likely to do so."

In this case an application was made to the local county court the day before MH's 28 day admission to hospital for assessment was due to expire. If an application on ground (c) or (d) is pending immediately before the 28 day period runs out, that period is automatically extended until the application has been finally disposed of and, if it is successful, for a further seven days to enable the formalities for admission for treatment or for guardianship to be completed: see section 29(4).

11. It must originally have been contemplated that county courts would deal with these cases very quickly. In practice, however, they may drag on for a considerable time: the county court order in this case was made after a three day trial in July 2004 and the application not "finally disposed of" until the Court of Appeal dismissed the mother's appeal in May 2005, more than two years after the proceedings had begun: see *Lewis v Gibson* [2005] EWCA Civ 587. County courts have, however, a general power under section 38 of the County Courts Act

1984 to make interim orders and the hospital managers or local social services authority may rely upon an interim order appointing an acting nearest relative in order to admit or receive the patient: see *R v Central London County Court, Ex p London* [1999] QB 1260, CA. An interim order was made on 1 August 2003 and on 7 August 2003 an application was made for MH to be received into guardianship under section 7 of the 1983 Act. By then her condition had much improved in hospital and a suitable placement for her had been found in Liverpool. She had, in fact, already been transferred to that placement in July, presumably on leave of absence from the hospital where she was still technically liable to be detained. She is still under the guardianship of the local authority and was moved to a placement nearer her family in December 2004.

12. Section 29(4) of the 1983 Act places the patient in a most unsatisfactory legal position. She has been compulsorily admitted to hospital under a power which is meant to last for 28 days at most before either lapsing or being replaced with a longer term power for which the procedure and criteria are more stringent. She has the right to apply to a mental health review tribunal within the first 14 days, but may very well not do so: we have been told that there were 21,639 uses of section 2 in England in 2003-4 but only 6,108 applications by section 2 patients to a tribunal. Thus some 70% of admissions do not lead to an application, although it is not known whether this is because the patient is quickly discharged from the section (though not necessarily from the hospital), or has consciously decided not to apply, or is incapable of doing so.

13. If further treatment or care under compulsory powers were still thought necessary after the 28 days had elapsed, the patient would normally expect to be the subject of an application for admission for treatment under section 3 or a guardianship application. If accepted, this would give her a new right to apply to a tribunal once within the six months for which that admission or reception initially lasts: see section 66(1)(b) or (c) and (i) and (2)(b) and (c). If it is renewed at the end of that period, she can apply once within each period of renewal: the first renewal is for a further six months and thereafter renewals are at yearly intervals: see section 66(1)(f) and (i) and (2)(f). Moreover, if a hospital patient does not exercise her right to apply within six months of admission (or of transfer from guardianship) the hospital managers *must* refer the case to a tribunal (unless it has come before a tribunal for some other reason): see section 68(1). When a long term detention is renewed, the managers must also refer the case if three years have gone by since the case was last considered by a tribunal: see section 68(2). These duties were introduced in order to ensure that patients who had

not exercised their rights to apply, perhaps because they lacked the capacity or had become institutionalised, were not "lost" in the system.

14. None of these rights to a review arises if the patient is kept waiting under section 29(4). Yet the timetable for proceedings under section 29 has nothing to do with the patient's needs and is not under her control. Indeed, until the rules were changed in April 2005, the patient could not even be a party to the county court proceedings: see CCR Ord 49, rule 12(3)(b), amended by Civil Procedure (Amendment) Rules 2005 (SI 2005/352). Nor does the nearest relative have any right to apply to a tribunal instead. The normal principle is that a nearest relative who cannot discharge the patient has a right of application to a tribunal. Thus, for example, there is a right to apply within 28 days of an order barring her from discharging the patient: see section 66(1)(g) and (ii) and (2)(d). But this only exists where the patient is detained for treatment, not where the patient is detained for assessment, no doubt because it was thought that there was little point in providing such a right when the detention would only last for 28 days or a short time thereafter. A nearest relative who is displaced under section 29 also has a right to apply once within each year after the court's order: see section 66(1)(h) and (ii) and (2)(g).

15. There is, however, a discretionary power in the Secretary of State for Health at any time to refer the case of any patient who is liable to be detained (whether or not she is actually in hospital) or is subject to guardianship: see section 67(1). In this case, solicitors instructed by the mother wrote in early March 2003 asking the Secretary of State to refer the case. This he promptly did and a tribunal hearing took place on 26 March. The tribunal decided not to discharge the patient.

16. These judicial review proceedings were launched in May 2003, while MH was still in hospital. They were nominally brought by MH, but in reality by her mother acting as her litigation friend. In July, the mother was replaced as litigation friend by the Official Solicitor, who has maintained this action on MH's behalf. At its height, there were challenges to the decisions of the mental health review tribunal, the local social services authority, and the local county court, as well as to the legislation itself. Only the last is live before us. The issue is whether the current law is compatible with the patient's rights under article 5(4) of the ECHR in two respects.

17. Article 5(4) reads as follows:

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

Under article 5(1), "no-one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law". Among the cases listed is "(e) the lawful detention . . . of persons of unsound mind, . . . " As the European Court of Human Rights held in *Winterwerp v The Netherlands* (1979) 2 EHRR 387, 402, para 39, this requires three things:

> "In the Court's opinion, except in emergency cases, the individual concerned should not be deprived of his liberty unless he has been reliably shown to be of 'unsound mind'. The very nature of what has to be established before the competent national authority – that is, a true mental disorder - calls for objective medical expertise. Further, the mental disorder must be of a kind or degree warranting compulsory confinement. What is more, the validity of continued confinement depends upon the persistence of such a disorder."

Thus, given the inherent changeability of mental disorders, article 5(4) requires, not only an initial right of access to a court or tribunal to discover whether the criteria for detention have been met, but also "a review of lawfulness to be available at reasonable intervals" thereafter: see *Winterwerp*, 408, para 55. That review need not always be attended by the same guarantees as are required under article 6, see *Winterwerp*, 409, para 60, but:

> "it is essential that the person concerned should have access to a court and the opportunity to be heard either in person or, where necessary, through some form of representation . . . Mental illness may entail restricting or modifying the manner of the exercise of such a right, but it cannot justify impairing the very essence of the right. Indeed, special procedural safeguards may prove called for in order to protect the interests of persons who, on account

> of their mental disabilities, are not fully capable of acting for themselves."

18. It is argued, therefore, that the present law fails to comply with article 5(4) in two respects. First, it does not provide a practical and effective right of access to a court for a patient detained under section 2 who lacks the capacity to apply to a tribunal by herself. The only way to do this, it is argued, is automatically to refer every such detention to a tribunal. Secondly, the present law does not provide a right of review at reasonable intervals for a patient who finds herself detained by virtue of section 29(4) and is thus deprived of the right which a patient newly detained under section 3 would have.

19. Silber J declined to hold that the present law was incompatible in either respect. The Court of Appeal at [2004] EWCA Civ 1609, [2005] 1 WLR 1209, however, made two declarations of incompatibility:

> "(i) section 2 of the Mental Health Act 1983 is incompatible with article 5(4) of the Convention in that it is not attended by adequate provision for the reference to a court of the case of a patient detained pursuant to section 2 in circumstances where a patient has a right to make application to a mental health review tribunal but the patient is incapable of exercising that right on his own initiative;
>
> (ii) section 29(4) of the 1983 Act is incompatible with article 5(4) of the Convention in that it is not attended by provision for the reference to a court of the case of a patient detained pursuant to section 2 of the Act whose period of detention is extended by the operation of section 29(4)."

The Secretary of State now appeals against both declarations.

Is section 2 incompatible?

20. The question is not whether section 2 is incompatible with article 5(1)(e). Indeed it would be difficult to argue that it was. Its object is to limit compulsory admission to hospital to cases where the *Winterwerp* criteria are met. The requirement of objective medical expertise is met

by the recommendations of two medical practitioners, who must be independent of one another, one of whom must be a specialist and at least one of whom must be independent of the admitting hospital: see section 12. The grounds for admission, set out in para 7 above, are fully in line with the *Winterwerp* requirements. An admission to hospital which complies with the procedural requirements of the Act, and where the substantive grounds for admission do in fact exist, would appear fully to comply with the article 5(1)(e) of the Convention. If the procedural requirements or grounds are not in fact met, the patient will have a right of redress either under the ordinary law or under the Human Rights Act. Even in the most compliant of legal systems, it sometimes happens that people's rights are violated: see, for example, *Storck v Germany* (Application No 61603/00), 16 June 2005.

21. The question, therefore, is whether section 2 is incompatible with the additional procedural protection given by article 5(4), which is designed to procure the speedy release of someone who should not in fact have been detained in the first place or should not be detained any longer.

22. The short answer to this question is that article 5(4) does not require that every case be considered by a court. It requires that the person detained should have the right to "take proceedings". The wording is different from article 5(3), which deals with the rights of a person who has been arrested on suspicion of having committed a criminal offence or to prevent his committing an offence or fleeing after having done so:

> "Everyone arrested or detained in accordance with the provisions of paragraph 1(c) of this article shall be brought promptly before a judge or other officer authorised by law to exercise judicial power and shall be entitled to trial within a reasonable time or to release pending trial. . . ."

The difference between a right to "take proceedings" and a right to "be brought promptly before a [court]" must be deliberate. It stops short of requiring judicial authorisation in every case. It leaves to the person detained the choice of whether or not to put the matter before a court. Understandably, therefore, the respondent abandoned the argument that article 5(4) required that *all* section 2 admissions should be referred to a tribunal and concentrated only on those patients who lack the capacity to exercise their article 5(4) rights. Logically, of course, this argument

would also apply to a patient detained under section 3, for the automatic reference after six months under section 68(1) would not be regarded as "speedy".

23. For them, the argument is that a right "to take proceedings" is ineffective if the patient lacks the ability to do so. Given that the Convention is there to secure rights that are "practical and effective" rather than "theoretical and illusory" this is a powerful argument. But it does not lead to the conclusion that section 2 is in itself incompatible with the Convention or that the solution is to require a reference in every case. Rather, it leads to the conclusion that every sensible effort should be made to enable the patient to exercise that right if there is reason to think that she would wish to do so.

24. There is no Strasbourg case which implies into article 5(4) the requirement of a judicial review in every case where the patient is unable to make her own application, nor is this suggested in authoritative texts such as *Karen Reid, A Practitioner's Guide to the European Convention on Human Rights* (2nd ed 2004). Indeed, in *Rakevich v Russia* (Application No 58973/00), 28 October 2003, it was held that even the judicial review of every admission on the initiative of the detaining authorities is not enough if the patient does not herself have the direct right to apply for her release. In the recent case of *Storck v Germany* (Application No 61603/00), 16 June 2005, there was in principle a procedure available to protect the patient's interests, but the applicant had been unable to secure outside help during her confinement in a private clinic to enable her to institute such proceedings, so it was "questionable whether there had been sufficient safeguards to guarantee the applicant's effective access to court": see para 118. This was not because of lack of capacity but because of the lack of practical machinery for contacting the court. This illustrates only too well how there may be many other obstacles than lack of capacity to the effective exercise of the right to take proceedings. Singling out lack of capacity for special treatment would raise a host of problems of definition and assessment for which there is no warrant either in the Convention or in the Act.

25. That is why our system tries hard to give patients and their relatives easy access to the tribunal which is itself designed to meet their needs. The managers of the hospital have a statutory duty, under section 132 of the Act, to take such steps as are practicable to ensure that the patient understands the effect of the provisions under which she is detained and the rights of applying to a mental health review tribunal

which are available to her. This has to be done as soon as practicable after the patient is detained. Unless the patient wishes otherwise, this information is also to be given to the patient's nearest relative. Under the Code of Practice (published March 1999 pursuant to section 118 of the Act by the Department of Health and Welsh Office), section 14, information should be given to the patient "in a suitable manner and at a suitable time" by a person who "has received sufficient training and guidance". Patients and nearest relatives have to be told how to apply to a tribunal, how to contact a suitably qualified solicitor, that free legal aid may be available, and how to contact any other organisation which may be able to help them make an application. In other words, the hospital managers have to do the best they can to make the patient's rights practical and effective.

26. Mental health review tribunals were also designed with that object in mind. Before they were created, in the Mental Health Act 1959, compulsory detentions were authorised by a judicial officer, who was widely regarded as a 'rubber stamp' of little practical value in challenging the decision to detain. Tribunals are composed of a legally qualified presider, a medical member with expertise in the diagnosis and treatment of mental disorder, and a third member with other suitable experience, for example in the social services. Although the procedures have become more formal since the advent of legal assistance for patients, they are designed to be user-friendly and to enable the patient and her relative to communicate directly with the tribunal. A reference to the tribunal must be considered in the same way as if there had been an application by the patient: see r 29. Hence although the initiative is taken by someone else, the patient's rights are the same. Although an application has to be made in writing, it can be signed by any person authorised by the patient to do so on her behalf: see r 3(1). This could be any relative, a social worker, an advocate, or a nurse, provided of course that the patient has sufficient capacity to authorise that person to act for her. The common law presumes that every person has capacity until the contrary is shown and the threshold for capacity is not a demanding one. These principles have recently been confirmed by Parliament in the Mental Capacity Act 2005.

27. Even if the patient's nearest relative has no independent right of application, there is much that she, or other concerned members of the family, friends or professionals, can do to help put the patient's case before a judicial authority. The history of this case is a good illustration. The patient's mother was able to challenge every important decision affecting her daughter. Most helpfully, she stimulated the Secretary of State's reference to the tribunal very quickly after it became clear that

her daughter was to be kept in hospital longer than 28 days. Had MH been discharged once the 28 days were up there would, in my view, have been no violation of her rights under article 5(4). It follows that section 2 of the Act is not incompatible with article 5(4). Section 29(4), however, is another matter.

Is section 29(4) incompatible?

28. Section 29(4) raises a very different question, which applies to all patients affected by it, irrespective of their mental capacity. The system is obviously *capable* of being operated compatibly. The patient is entitled to make an application during the initial 14 days of the section 2 admission, thus complying with her right, should she choose to exercise it, to a speedy initial judicial determination of the lawfulness of her detention. The county court proceedings may produce a swift displacement order, whether interim or final, after which the patient is admitted under section 3. The patient then has a fresh right to apply to a tribunal, which will arise at a "reasonable interval" after the first. Alternatively, a displacement order may be refused, in which case the patient can no longer be detained unless the relative has been persuaded to withdraw her objection to the section 3 admission. But in that event a fresh right to apply to a tribunal will also arise.

29. The problem arises when the county court proceedings drag on and the patient is detained indefinitely without recourse to a tribunal. Indeed, it may be difficult for the county court to proceed too quickly, without endangering the rights of the parties under article 6 and the rights of both the patient and her relative under article 8. Hence there may well come a time when her article 5(4) rights will be violated unless some means of taking proceedings is available to her. That time may come earlier if she has not made an initial application, so that the lawfulness of her detention has never been subject to judicial determination, than it would do if there had been an early tribunal hearing. But here again the means are available, within the existing law, of securing that she does have that right.

30. The preferable means is what happened in this case: that the Secretary of State uses her power under section 67(1) to refer the case to a tribunal. This is preferable because mental health review tribunals are much better suited to determining the merits of a patient's detention and doing so in a way which is convenient to the patient, readily accessible, and comparatively speedy. As already seen, a reference is treated as if

the patient had made an application, so that the patient has the same rights within it as she would if she herself had initiated the proceedings. It can, of course, be objected that this solution depends upon the Secretary of State being willing to exercise her discretion to refer. But the Secretary of State is under a duty to act compatibly with the patient's Convention rights and would be well advised to make such a reference as soon as the position is drawn to her attention. In this case this happened at the request of the patient's own lawyers. Should the Secretary of State decline to exercise this power, judicial review would be swiftly available to oblige her to do so. It would also be possible for the hospital managers or the local social services authority to notify the Secretary of State whenever an application is made under section 29 so that she can consider the position. These applications are not common: they no longer feature in the annual published *Judicial Statistics*, but when they did feature they tended just to make double figures every year. So the burden on the authorities, the Secretary of State and the tribunals would not be high.

31. Judicial review and/or habeas corpus would, of course, also be available to challenge the lawfulness of the patient's detention. Any person with sufficient standing could invoke them. Before the Human Rights Act 1998, the European Court of Human Rights held that these were not a sufficiently rigorous review of the merits, as opposed to the formal legality, of the patient's detention to comply with article 5(4): see *X v United Kingdom* (1981) 4 EHRR 188. It may well be that, as the Administrative Court must now itself act compatibly with the patient's rights, it would be obliged to conduct a sufficient review of the merits to satisfy itself that the requirements of article 5(1)(e) were indeed made out. But it is not well equipped to do so. First, it is not used to hearing oral evidence and cross examination. It will therefore take some persuading that this is necessary: cf *R (Wilkinson) v Broadmoor Special Hospital Authority* [2002] 1 WLR 419 and *R (N) v M* [2003] 1 WLR 562. Second, it is not readily accessible to the patient, who is the one person whose participation in the proceedings must be assured. It sits in London, whereas tribunals sit in the hospital. How would the patient's transport to London be arranged? Third, it is not itself an expert tribunal and will therefore need more argument and evidence than a mental health review tribunal will need to decide exactly the same case. All of this takes time, thus increasing the risk that the determination will not be as speedy as article 5(4) requires.

32. Hence, while judicial review and/or habeas corpus may be one way of securing compliance with the patient's article 5(4) rights, this would be much more satisfactorily achieved either by a speedy

determination of the county court proceedings or by a Secretary of State's reference under section 67. Either way, however, the means exist of operating section 29(4) in a way which is compatible with the patient's rights. It follows that the section itself cannot be incompatible, although the action or inaction of the authorities under it may be so.

Conclusion

33. For these reasons, my Lords, I would decline to hold that either section 2 or section 29(4) is incompatible with article 5(4) of the Convention in the respects identified by the Court of Appeal. I would therefore allow this appeal and set aside the declarations.

LORD BROWN OF EATON-UNDER-HEYWOOD

My Lords,

34. I have had the advantage of reading in draft the speech of my noble and learned friend Baroness Hale of Richmond. I agree with it, and for the reasons she gives I too would allow the appeal and make the order which she proposes.