Psychiatry and the Law: An enduring interest for Lord Rodger

The Lord Rodger Memorial Lecture 2014

Lady Hale

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In many ways I wish I were not here. Had he lived, Alan Rodger would have become the longest serving Law Lord when Lord Hope retired in June of last year, and would no doubt have succeeded him as Deputy President of the Supreme Court had he wished to do so. But had he lived, Alan would have reached the age of 70 last month. He would have had to retire from the Supreme Court then. We would, I hope, have insisted on holding a valedictory for him on the last day of the summer term. He would have had to listen to the President of the Court, the Lord Advocate, the Advocate General, the Dean of Faculty, and no doubt other luminaries, saying all the wonderful and true things about him which have been said since his untimely death. He would, I think, have hated it. But we would all have enjoyed the opportunity, sadly denied to us now, of telling Alan how much we liked and admired him. As Hector MacQueen has summed him up, he was "brilliant, contrarian, serious, funny and above all engaged",[1] or as I would have put it, seriously scary but great good fun. So it is with much

1 *Biographical Memoirs of Fellows of the British Academy XII* (2013).

sorrow, as well as much pleasure, that I am here in his home city of Glasgow, to give a lecture in his memory.[2]

We did not, at least on the surface, have a lot in common. First, it would never have crossed my mind as a child, or even as a law student at Cambridge, that one day I might be any kind of judge, let alone the kind of judge I am today; but apparently before Alan had even become a student, he declared to a neighbour that he wanted to be a Law Lord. Second, I spent much of my life as an academic lawyer, and indeed taught Roman Law in the University of Manchester for many years, but he was a much better scholar than I have ever been (and thoroughly deserved his election as a Fellow of the British Academy long before he became a judge). Who else would take himself off to Oxford to read for a doctorate, when he ought to have been preparing for a career at the Bar, for no better reason than that he was intrigued by a puzzle in Roman Law and wanted to get to the bottom of it? Getting to the bottom of it was just what he did as a judge. Third, after academia, I became a Law Commissioner for England and Wales; but Scottish Law Commissioner is the one important post in the Scottish legal system which Alan never held. Indeed, he strongly disapproved of the sort of law reform, the systematic modernization, simplification and codification of the law, for which both the Law Commissions stand. And finally, I am

[2] With some help from my colleague, Lord Reed, for which I am most grateful.

not at all political, indeed I am fond of shocking American audiences by telling them that I do not know the politics of my fellow Justices. But of course I could not say that about Alan, as he had been both Solicitor General for Scotland and Lord Advocate in a Conservative administration. And he continued to have a certain reverence for tradition in his thinking and his views, both on and off the Bench.

But we did have at least one thing in common.[3] That was a serious interest in mental health law. In Alan's case, this is scarcely surprising, as his father was an eminent psychiatrist – an army psychiatrist during the war, who rose to the rank of Brigadier and consultant in psychiatry to the army in South East Asia and India, then a Commissioner of the General Board of Control in Scotland, then Professor of Psychological Medicine in the University of Glasgow, and a pioneer in the development of general hospital based psychiatry at the Southern General Hospital. Alan himself was a member of the Mental Welfare Commission, the successor to the Board of Control, from 1981 to 1984. In my case, the interest came about because as a baby law lecturer I was "put to" teaching law for social workers and had to teach them mental health law at a time when there was no textbook for any of us

[3] Another common concern may be seen in our speeches in *Ghaidan v Godin-Mendoza* [2004] 2 AC 557.

to use. So I wrote one. And that got me my first judicial appointment as a legal member of mental health review tribunals.

So I thought that it would be interesting tonight to consider Alan's contribution to mental health law through some of the case histories in which he was involved and then to wonder where he would have stood on some of the cases which we have recently considered in the Supreme Court, sadly without the benefit of his views. Together these touch upon every aspect of the law in which mental disorder or disability may lead to different treatment from that which would otherwise be the case – in other words to discrimination.[4] So it is intriguing also to wonder what Alan would have thought of the United Nations Convention on the Rights of Persons with Disabilities. The United Kingdom ratified this Convention without reservation in 2009, despite the obvious difficulty of reconciling some of its provisions with much of our mental health law both north and south of the border.

The Convention clearly covers people with mental disorders and disabilities, at least if these are long term. States Parties undertake to abolish all laws and

[4] I shall not, therefore, discuss Alan's typically rigorous and erudite judgment in *King v Bristow Helicopters Ltd* 2001 SC 54, holding that "bodily injury" under the Warsaw Convention included purely psychological harm, save to say that I found it more persuasive than the House of Lords' decision to the contrary.

practices that constitute discrimination against persons with disabilities (article 4.1(b)) although they are allowed to have laws and practices which are more conducive to the realization of their rights (article 4.4). However, States Parties have to recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life (article 12.2). And States must ensure that persons with disabilities enjoy, on an equal basis with others, the right to liberty and security of person and that "the existence of a disability shall in no case justify a deprivation of liberty" (article 14). Taken at face value, it is difficult to see how these provisions can be reconciled with any of the case histories I am about to describe.

1. Kim Galbraith

Kim Galbraith shot dead her husband, who was a policeman and part time gamekeeper and kept a rifle in the house. She claimed that he had subjected her to violence and sexual abuse over a period of years. She was afraid that he would kill her. She could think of no other way to escape except to kill him. Two psychologists gave evidence that her mental state was consistent with this history and that she was suffering from a form of post-traumatic stress disorder. Rather more hesitantly, a psychiatrist gave evidence that she was suffering from clinical depression sufficient to warrant the prescription

of anti-depressant drugs but not her compulsory admission to hospital under the then Mental Health (Scotland) Act 1984.

Long before the English saw the light, Scots law had recognized that a state of mind falling short of insanity (which is very narrowly defined both sides of the border) might reduce or diminish responsibility so as to turn what would otherwise be murder into culpable homicide. Both sides in the case agreed that the definition given by Lord Hope in *HM Advocate v Connelly*[5] was too narrow and this gave Lord Justice General Rodger, presiding over a five judge court, the opportunity of reviewing and rationalizing the law.[6]

The judgment is full of Alan's characteristic touches. He recounted how both counsel had found it "much easier to tear down the somewhat fragile structure that our predecessors had erected than to suggest what we should raise up in its place". The Solicitor General had suggested that, if they did not like the suggestions of counsel, the court should simply do what they willed. "Wafted on Continental zephyr, the doctrine that the court knows the law had, apparently, reached our shores. So, duly admonished, we set about our task" (para 21). There is then a learned account of the development of the concept, including a reference to the German concept

5 1990 JC 349.

6 *Galbraith v HM Advocate* 2002 JC 1.

of "verminderte Zurechnungsfahigkeit" (not translated) or "verminderte Schuldfahigkeit (which he does translate) (para 24). In order to understand the context of Lord Alness' directions in *HM Advocate v Savage*[7], he researched the facts of the case from the newspapers of the day because they did not appear in the law report (para 34).

He produced a pithy summary, concluding that "In essence, the jury should be told that they must be satisfied that, by reason of the abnormality of mind in question, the ability of the accused, as compared with a normal person, to determine or control his actings, was substantially impaired" (para 54). The abnormality of mind could take a variety of forms, as long as it was not the result of voluntary intoxication by drink or drugs or of a psychopathic personality disorder. Post-traumatic stress disorder, or what would now probably be called "battered wives' syndrome", could clearly be included.

Two comments clearly betray Alan's familiarity with the subject and its practitioners. The abnormality must be one which is recognized by the appropriate science, whether psychiatry or psychology (para 53). Earlier he used a phrase which I have heard psychiatrists use on many occasions, that the individual "is not as normal people are" (para 51). This is, I think, a

7 1923 JC 49.

recognition of the very real difficulties which psychiatrists have in taking a truly scientific approach to a phenomenon which is often easy to recognize but hard to define and explain. Psychiatric diagnosis has sometimes been deeply suspect. There used, I learned the other day, to be a mental illness recognised in the United States, called drapitomania. It was suffered only by slaves and consisted of an irrational desire for freedom and a tendency to escape. But that does not mean that the attempt to recognise and categorise symptoms and to use the resulting diagnosis to determine both the appropriate treatment and the prognosis for the future is in vain.

Kim Galbraith, and no doubt many other women trapped in abusive relationships, have reason to be grateful for Alan's recognition of the wide range of conditions which might amount to an "abnormality of mind". (It may be because he had taken a wide view of the scope of the diminished responsibility defence, he was later able to take a narrower view of the scope of provocation.[8]) At the retrial, Kim Galbraith pleaded guilty to culpable homicide, was sentenced to 10 years imprisonment, later reduced to eight, and released on parole after four.

2. Alexander Reid

8 *Attorney General for Jersey v Holley* [2005] UKPC 23, [2005] 2 AC 580.

Alexander Reid's story is about what may happen to people with mental disorders or disabilities after they have been convicted. In 1967, when aged 17, he pleaded guilty to a charge of culpable homicide and was made subject to a hospital order with restrictions. He was sent to the state hospital at Carstairs. He was first detained under the diagnostic classification then called "mental deficiency". But by 1980 it was considered that he was suffering from a psychopathic or anti-social personality disorder, then defined as a mental disorder which "is a persistent one manifested *only* by abnormally aggressive or seriously irresponsible conduct".[9] How then to draw a distinction between a mentally normal habitual criminal and a mentally disordered one? This matters because the one would usually lead to a determinate but proportionate prison sentence while the other might lead to something very different.

Until *One Flew over the Cuckoo's Nest*, many tended to think that a hospital order was preferable to a prison sentence. But although the surroundings and regime in hospital might (in some respects) be pleasanter than those in prison, the order is unlimited in time. In effect, unless there was some prospect of treatment and cure, it amounts to indefinite preventive detention. The justification for breaching the principle of proportionality in

9 Mental Health (Scotland) Act 1984, section 17(1)(a)(ii).

sentencing was the prospect of cure. But psychiatrists became increasingly pessimistic about their prospects of treating people with anti-social personality disorders. And they did not want to be simple custodians of some very difficult people who were unlikely to get better. In this they had the support of some of their patients, including Alexander Reid, who has battled long and hard to be sent to prison rather than to hospital.

So the Mental Health (Scotland) Act 1984 Act included a "treatability" test. A patient could not be compulsorily admitted to hospital if his diagnostic classification was anti-social personality disorder, unless medical treatment in a hospital was "likely to alleviate or prevent a deterioration" of his condition.[10] But this new test was not expressly incorporated into the criteria for discharge in the newly introduced right of appeal to a sheriff. The sheriff was required to consider only (a) whether the patient was suffering from a mental disorder which made it appropriate for him to be liable to be detained in a hospital for medical treatment, and (b) whether it was necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment.[11]

10 1984 Act, s 17(1)(a)(i).
11 1984 Act, s 64(1).

Alexander Reid began a campaign for his release which took him to the sheriff, to the Lord Ordinary in the person of Lord Rodger, to the Inner House, to the House of Lords, and eventually to Strasbourg. Between the House of Lords and Strasbourg he also took part in the first case to challenge the validity of an Act of the Scottish Parliament, coming before the Inner House presided over by Lord Rodger, who had now become Lord President, and then before the Judicial Committee of the Privy Council.

The appeal which started this ball rolling was heard by the sheriff in June and July 1994, when Alexander Reid had been in hospital for some 27 years. Between 1987 and 1994 he had obtained some 18 reports from six psychiatrists and the Government had obtained 10 reports from eight psychiatrists (just possibly this could be all the forensic psychiatrists in Scotland at the time). They were unanimous that he suffered from a persistent and permanent anti-social personality disorder. The sheriff found that there was a very high risk of his reoffending should he be released. Most of the psychiatric opinions were to the effect that his condition was not curable and that the treatment provided in the hospital was not helping it. But the sheriff found that it was appropriate for him to be detained there. There was evidence that he had benefited educationally and was less physically aggressive in its structured and supervised environment. Of course, no-one really knew how he would cope in the outside world, but the

omens were not good, as by this time he was 44 years old and had been detained in an institution, usually in conditions of maximum security, since the age of 17, and had reoffended as soon as given the opportunity of doing so.

Alan dismissed the petition for judicial review of the sheriff's decision.[12] He analysed the legislation in detail, showing complete mastery of how it all fitted together. He held that treatability was not part of the criteria for discharge, but merely something to be taken into account when deciding whether detention in hospital was appropriate. [13] The protection of the public was also relevant to that criterion. He also analysed the evidence in detail, once again showing his complete grasp of the subject-matter. His decision was characteristic. He followed the letter of the statute and chose the construction which provided the better protection for the public.

The Inner House disagreed.[14] They held that the treatability condition was incorporated into the appropriateness criterion and that it was not met on the factual findings in this case. The House of Lords, by a majority, agreed with the Inner House on the law.[15] For medical treatment to be appropriate,

12 *R v Secretary of State for Scotland* 1997 SLT 555.

13 Finding the English decision in *R v Canon's Park Mental Health Review Tribunal, ex p A* [1995] QB 60, CA "very helpful".

14 1998 SLT 162.

15 *Reid v Secretary of State for Scotland* [1999] 2 AC 512.

it had to be likely to alleviate or prevent a deterioration of the patient's condition.[16] But they allowed the Government's appeal on the facts, because the sheriff had been entitled on the evidence to hold that medical treatment in hospital had done the patient some good in the past and was likely to do so in future.

The Scottish Parliament leapt into action as soon as they could. In August 1999, a sheriff had created a storm by ordering the release of an "untreatable" psychopath.[17] The Scottish Parliament was formally opened on 1 July 1999 and met to conduct business for the first time on 1 September. The Mental Health (Public Safety and Appeals) Bill was introduced on 31 August and passed so swiftly through the Parliament that it received the Royal Assent on 13 September. It was the very first Act of the Scottish Parliament but also the very first to be challenged as "not law" because it was allegedly incompatible with the Convention rights.[18] Among the three challengers was Alexander Reid.[19]

The Act required a sheriff to refuse an appeal if satisfied that the patient was then suffering from a mental disorder "the effect of which is such that it is

16 See note 11 above.
17 *Ruddle v Secretary of State for Scotland* 1999 GWD 29-1395.
18 Under the Scotland Act 1998, s 29(2)(d) and thus not law by virtue of s 29(1).
19 *A v Scottish Ministers* 2001 SC 1, p 12.

necessary, in order to protect the public from serious harm, that the patient continue to be detained in a hospital, whether for medical treatment or not". The challengers argued that it was incompatible with the right to liberty in article 5(1) of the European Convention to require a person to be detained in hospital on account of his mental disorder when there was nothing the hospital could do for him. Alan's answer was that the Strasbourg jurisprudence does not require that the lawful detention of "persons of unsound mind", permitted by article 5(1)(e), be for the purpose of treatment. All that the well-known criteria laid down in *Winterwerp v The Netherlands*[20] require is that the patient be currently suffering from a "true mental disorder . . . of a kind or degree warranting compulsory confinement". Cases discussing the detention of vagrants or alcoholics under article 5(1)(e)[21] showed that the detention could be for social purposes other than the benefit of the person detained. These could include the protection of the public.

Alan prefaced his discussion with some remarks about the general approach which the courts should take to such challenges. The whole Convention was about striking a fair balance between the interests of the community and the fundamental rights of the individual. In deciding whether the Scottish

20 (1979-80) 2 EHRR 387.

21 *Guzzardi v Italy* (1980) 3 EHRR 333, *Litwa v Poland* (2000) 33 EHRR 1267.

Parliament had struck a fair balance between the need to protect the public from serious harm and the patients' right to liberty, "it is right that the court should give due deference to the assessment which the democratically elected legislature has made of the policy issues involved".[22] This was, of course, in June 2000, before the Human Rights Act 1998 had come into force, but I do not think that 11 more years of experience of the Act changed his view on this basic approach to the compatibility of Acts of the UK or devolved Parliaments.

The devolution issue then went to the Privy Council, which reached the same conclusion as the Inner House for essentially the same reasons.[23] Meanwhile, Alexander Reid, after losing his case in the House of Lords, had applied to the Strasbourg court, where eventually he also lost.[24] In the devolution case, Alan had correctly understood the jurisprudence and predicted how they would decide the case.

But Alexander Reid did not give up. In 2012, his sentence was set aside as a miscarriage of justice, on the ground that he had never been suffering from "mental deficiency" and, if this had been appreciated at the time, he would

22 *A v Scottish Ministers* 2001 SC 1, p 21.
23 *Anderson v Scottish Ministers* [2001] UKPC D5, [2003] 2 AC 602.
24 *Reid v United Kingdom* (2003) 37 EHRR 9.

not have been sent to hospital instead of to prison. So a sentence of life imprisonment with a punishment part of ten years was substituted.[25]

Alexander Reid may have got his way and I hope that he is happy with it. But I am puzzled. The psychiatrists were indeed unanimous that he was not mentally disabled but had an untreatable dissocial personality disorder. But if so, would anyone in 1967 (long before *Galbraith*, but even after it) have accepted a plea to culpable homicide instead of murder? On the other hand, the treatability requirement did not exist in 1967, so people with personality disorders of this type were indeed sent to hospital. The issue of principle explored in his story is still a very live one today. What is it about mental disorder which makes indefinite preventive detention in a maximum security institution justifiable if it would not be justifiable in the case of a normal persistent offender?

3. Carol Savage and Melanie Rabone

People with mental disorders can of course be compulsorily detained and treated in hospital even if they have not committed a criminal offence. Alan also understood this area of the law very well. In *K v Craig*,[26] he had rescued

[25] *Reid v HM Advocate* 2012 SLT 65; see also *Reid v HM Advocate* [2012] HCJAC 18.

[26] 1997 SC 327.

the system of community care orders, inserted into the 1984 Act in 1995, from some unfortunate drafting by the sensible use of the doctrine of necessary implication. This time he was upheld in the House of Lords.[27] In the House of Lords, he had also to consider the right to life of detained patients, in the case of Mrs Carol Savage.

Mrs Savage was detained for treatment under section 3 of the English Mental Health Act 1983 in an open acute psychiatric ward in an NHS hospital. She had been there for more than three months when she walked out of the hospital, walked two miles to a railway station and threw herself in front of a train. The inquest jury found that she had killed herself while suffering from paranoid schizophrenia. They also considered that the precautions taken to prevent her leaving the hospital without permission were inadequate. Her husband was too upset to bring proceedings for negligence, either on his own behalf or on behalf of her estate. Instead, her grown-up daughter brought proceedings under the Human Rights Act. [28]

After the hearing in the House of Lords, I was asked to do the lead or "donkey work" judgment. But Alan had always to work things out for himself, especially in a subject which interested him so much. So he too

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[27] 1998 SC (HL) 1.

[28] *Savage v South Essex Partnership NHS Trust* [2008] UKHL 74, [2009] 1 AC 681.

produced a stand-alone judgment, which in my view was much better than mine. I suggested that I might withdraw mine, so as not to confuse anyone who might detect (as clever lawyers so often can) slight differences between us. Characteristically, Alan would have none of this. He was a great supporter of the individual responsibility of each member of the court to reason the case for themselves. But of course his judgment has (rightly) been taken to be the lead judgment ever since.

He draws a careful distinction between the generic duty, which the state owes to everyone, to have laws and effective systems in place to protect life, and the specific operational duty, to protect the lives of those individuals whom it knows or ought to know to be at real and immediate risk. Suicide is not a crime in this country and there is no general duty to prevent everyone from committing suicide. But there is a duty to take general measures to prevent prisoners from committing suicide. This is because of their vulnerable position and because the state has assumed responsibility for them. It is part of the wider duty to take proper care of prisoners. In *Keenan v United Kingdom,*[29] the Strasbourg court had also held that there could also be a specific operational duty towards an individual prisoner, where the authorities knew or ought to have known that he posed a real and immediate risk of suicide. The same applied to conscript soldiers, both at

[29] (2001) 33 EHRR 913.

the systemic level[30] and at the individual level.[31] (Alan quoted the former in the original French, without favouring us with a translation.)

There is of course an obligation to take general steps to protect the lives of patients in hospital. This applies to all patients, whether or not they are suffering from mental illness. But it is one thing to require that there are suitable systems in place, for example, to ensure that competent staff are recruited, high professional standards are maintained and suitable systems of work in place. It is another thing to hold that the specific operational duty arises towards every patient whose life is known (or ought to be known) to be at risk. That would apply to a great many people in hospital. So "casual acts of negligence" by hospital staff will not give rise to a breach of article 2.[32] But there was a distinction between the general or systemic duty to all patients and the particular duty towards individuals known to be at immediate risk.

Alan accepted that the threshold of "real and immediate risk" was high, so that "in these critical circumstances, priority has to be given to saving the patient's life. That is only practical common sense, since nothing else can be done to assist the patient or to promote her recovery unless her life is

30 *Kilinc v Turkey* , App no 40145/98, judgment of 7 June 2005.
31 *Ataman v Turkey,* App no 46252/99, judgment of 27 April 2006.
32 Para 45.

saved".[33] He saw the need to balance the degree of risk presented by the patient against the therapeutic benefits of greater autonomy and a more relaxed environment as aspects of the general obligation to have competent staff and appropriate systems.[34] For him, once they knew of a real and immediate risk, these went out of the window.

In *Savage*, we could be reasonably confident that we had correctly predicted what Strasbourg would decide.[35] It is not difficult to equate detained mental patients with prisoners. But the great majority of patients in hospital for treatment for mental disorders are not detained. I wonder whether Alan would have reached the same conclusion as the Supreme Court in the later case of Melanie Rabone.[36] Aged 24, she was an informal patient in the psychiatric wing of Stepping Hill hospital in Stockport. She had been admitted a week earlier after a serious suicide attempt (her third in a few weeks). She was diagnosed as suffering from a severe depressive episode with psychotic symptoms. A week later, she was allowed to go home on leave for the weekend, with no support other than the care of her parents. The next day, she hanged herself from a tree in Lyme Park.

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33 Para 66.

34 Para 50.

35 In *Eremiasova and Pechova v the Czech Republic,*App no 23944/04, judgment of 16 February 2012, they decided that the police had a duty to take reasonable steps to prevent a prisoner from killing himself by jumping out of a police station window.

36 *Rabone v Pennine Care NHS Foundation Trust* [2012] UKSC 2, [2012] 2 AC 72.

Lord Dyson gave the lead judgment. The differences between informal and detained psychiatric patients were not as great as those between patients with psychiatric and physical disorders, because of the existence of the powers to detain them and the different risks to which psychiatric patients were exposed. The physically ill could give their informed consent to take the risk of either having or not having treatment, whereas the capacity of a mental patient to make a rational decision was likely to be impaired. The very reason that Melanie was in hospital was the risk that she would take her own life. So the operational duty could arise. An "immediate" risk was one which was "present and continuing" rather than one which was "imminent". There was such a risk here. And although the judgment as to what is reasonable included respect for the patient's personal autonomy, in this case the experts had been agreed that no reasonable doctor would have allowed her to go home in the particular circumstances.[37]

In *Rabone*, it was not so easy to be confident that we had correctly anticipated Strasbourg. However, less than a month later, Strasbourg decided that there could indeed be an operational duty under article 2 towards a 36-year-old man who suffered from schizophrenia and was

[37] Applying *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118.

hearing voices ordering him to kill himself. He was taken to a crisis unit because no beds were available in the local psychiatric hospital. His room was on the 6th floor. At around 10.30 pm he broke the window and fell to his death. The Strasbourg court quoted extensively from Alan's judgment in *Savage* in their judgment. [38]

So is it discriminatory to be more tender of the lives of psychiatric patients than of patients suffering from physical disorders?

4. P, and P and Q

But what about people who are so mentally disabled that they do not have the capacity to consent to their living arrangements and are generally compliant with whatever arrangements are made for them? Ever since the modern mental health legislation which came into effect in 1960, it had been assumed that these people could be looked after without any formal procedures subjecting them to compulsion. But then along came the Strasbourg case of *HL v United Kingdom,*[39] in which a severely mentally disabled young man living in foster care had been sedated and informally admitted to hospital after a head-banging episode at his day centre. He was

38 *Reynolds v United Kingdom,* App no 2694/08, judgment of 13 March 2012.
39 (2004) 40 EHRR 761.

not detained under the Mental Health Act but his foster parents were not allowed to see him, in case he wanted to go home with them, and if he had tried to leave he would have been detained. Strasbourg (agreeing with Lord Steyn and Lord Nolan but not with the majority in the House of Lords)[40] held that he had been deprived of his liberty within the meaning of article 5, and for his detention to be "lawful" there had to be safeguards against the arbitrary use of such informal admissions, along with periodic reviews. So what does it mean to be deprived of liberty?

P and P and Q were all severely mentally disabled. P was a 39 year old man with cerebral palsy and Down's syndrome. He lived with two other residents and staff in a spacious bungalow. He was supported to go out to a day centre, socially and to see his mother who lived nearby. But he did have to be restrained from time to time and particularly in order to prevent his getting at and eating his incontinence pads. P and Q were sisters aged 17 and 18 who were removed from their abusive family while still children. P was happily placed with a foster carer, whom she called "mum". She required support with almost every aspect of everyday life. Q was less disabled than her sister and rather less happily placed in a small specialist home for adolescents, where her behaviour was sometimes challenging.

[40] *R v Bournewood Community and Mental Health NHS Trust, ex parte L* [1999] 1 AC 458.

Neither had shown any inclination to leave, but would have been prevented had they done so.

Were these people deprived of their liberty? On the one hand, their living arrangements were as near normal as it was possible to be, consistently with looking after their needs. They appeared to be reasonably happy with the arrangements and had not shown any desire to leave. On the other hand, they were under the complete control of the people looking after them and were certainly not free to go, either for a short time or to go and live somewhere else. Was the fact that the arrangements were for their benefit relevant? Was the fact that they were compliant with those arrangements relevant? Was the fact that the arrangements were "normal" for someone with their disabilities relevant?

We all held that the man had been deprived of his liberty, but three members of the court held that the sisters had not been deprived of their liberty, while the majority held that they had. The acid test was whether they were under the complete control and supervision of the staff and not free to leave. Their situation had to be compared, not with the situation of someone with their disabilities, but with the situation of an ordinary, normal person of their age. This is because the right to liberty is the same for everyone. The whole point about human rights is their universal quality,

based as they are upon the ringing declaration in article 1 of the Universal Declaration of Human Rights, that "All human beings are born free and equal in dignity and rights".

The decision has alarming practical consequences. It means that a great many elderly and mentally disabled people, wherever they are living, must have the benefit of safeguards and reviews, to ensure that their living arrangements are indeed in their best interests. The Scottish Law Commission has very recently made recommendations for a system of approving "significant restrictions" on the liberty of people who lack the capacity to make decisions for themselves.[41] The Law Commission for England and Wales is just embarking on a review of the whole subject.[42]

Alan would have been thoroughly alive to the practical consequences, but I like to think that he would approved of the decision in principle. He may have had a rather traditional view of what psychiatry is for, putting the protection of the health and safety, not only of the patient, but also of other people, above other considerations. But he would surely have agreed that everyone, whatever their disorder or disability, has the same right to liberty as anyone else (although it is never safe to assume what any of my brother

41 Scot Law Com No 240, *Adults with Incapacity* (1 October 2014).

42 Law Com No 354, *Twelfth Programme of Law Reform* (2014), paras 2.17 – 2.19.

Justices think about a particular case until they open their mouths at the post-hearing meeting).

5. Conclusion

That principle of non-discrimination is, of course, entirely consistent with the philosophy of the United Nations Convention on the Rights of Persons with Disabilities. But the other principle, that there are some people who are "not as normal people are" and who may accordingly have to be treated differently from normal people, either for their own good or for the good of others, apparently is not. I think that I can safely guess what Alan would have thought of that.