

Nearest Relative Consultation and the Avoidant Approved Mental Health Professional

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This article examines three recent cases involving *habeas corpus ad subjiciendum* applications arising out of alleged failures to comply with the provisions relating to nearest relatives within the Mental Health Act 1983 ('MHA'). One of these cases assists with the establishment of the identity of a nearest relative, and the two others consider the requirements of the consultation process to be carried out by an Approved Mental Health Professional ('AMHP') (formerly Approved Social Worker 'ASW'). The important implications of these decisions for patients, nearest relatives and hospitals are discussed in detail.

A patient's nearest relative (as defined under section 26 of the MHA) performs crucial functions which are intended to help safeguard a patient's rights. An AMHP has a duty to consult a person's nearest relative prior to recommending their detention for treatment under section 3 of the MHA (unless such consultation is not reasonably practicable or would involve unreasonable delay)². If the nearest relative objects, the detention cannot take place unless the nearest relative is first displaced under the provisions of section 29 of the Act.

The first step, therefore, is the identification of the person's nearest relative prior to an application for admission under section 3. A list of various possible nearest relatives is to be found in section 26(1) of the MHA, with whole blood relatives and the elder or eldest of relatives of the same description being preferred (section 26(3)). To qualify as the nearest relative, the person must be over eighteen years of age (if not the patient's husband, wife, father or mother) (section 29(5)(b)) and if the patient is so resident, "ordinarily resident in the United Kingdom, the Channel Islands or the Isle of Man" (section 29(5)). Section 26(4) states that "where the patient ordinarily resides with or is cared for by one or more of his relatives", that relative (or the oldest carer relative) will be the person's nearest relative.³ A husband or wife "permanently separated from the patient, either by agreement or under an order of a court", or who "has deserted or been deserted by the patient for a period which has not come to an end" will not qualify (section 26(5)(b)). For the purposes of this article, section 26(6) is of particular significance:

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2 Section 11(4)(b) MHA (as amended).

3 Where the person is an in-patient in a hospital, this means the relative with whom he last resided or by whom he was cared for prior to his admission (s.29(4)).

“...“husband”, “wife” and “civil partner” include a person who is living with the patient as the patient’s husband or wife or as if they were civil partners, as the case may be (or, if the patient is for the time being an in-patient in a hospital, was so living until the patient was admitted), and **has been or had been so living for a period of not less than six months**; but a person shall not be treated by virtue of this subsection as the nearest relative of a married patient or a patient in a civil partnership unless the husband or wife or civil partner of the patient is disregarded by virtue of paragraph (b) of subsection (5) above.”⁴

By way of section 11(4) of the MHA, a nearest relative may prevent a detention from taking place. There is no need for the objection to be reasonable, but it must be conveyed to an AMHP. A detention which proceeds despite a nearest relative’s objection and without that nearest relative being first displaced under the provisions of section 29 of the MHA will be unlawful, and if brought, *habeas corpus* proceedings will succeed. This procedure has been incorporated into the Act for several reasons. The assumption within the relevant blocking provision is that a nearest relative is likely to know the patient well and to have an informed view as to whether or not their mental health has deteriorated sufficiently to warrant a hospital admission. For that reason, a nearest relative may object to such admission, even though experienced mental health professionals think otherwise. This power to say ‘no’ clearly is intended to reflect the importance of the right to liberty and the need for caution when subjecting someone to compulsory detention in order to avoid arbitrary denial of liberty.

R v The Hospital Managers of the Park Royal Hospital, ex parte Robinson, Queen’s Bench Division (Administrative Court), 26th November 2007

There is no requirement for an AMHP to make enquiries as to the identity of a nearest relative, unless not to do so would have been unreasonable in the sense that no competent and careful social worker would have failed to have made them (see *Re D: Mental Patient (Habeas Corpus)* Lawtel 4/12/99, subsequently upheld in the Court of Appeal ((2000) 2 FLR 848)). In *Re D* (at 16) it was held that “the court cannot and should not inquire into the reasonableness of...[the ASW’s] decision, only into the honesty of his assertion that it appeared that [the person consulted]...was the nearest relative”. This was in part what the court was concerned with in *R v The Hospital Managers of the Park Royal Hospital, ex parte Robinson*, (26th November 2007). The facts of the case were complex, but the background was key to the court’s final decision. The essence of the challenge was that the Claimant’s nearest relative was his common law partner, rather than his aunt who had been his nearest relative by way of section 26(1)(g) prior to the couple’s cohabitation of the requisite six month period. The case is important for a number of reasons, not least the comments of Bennett J (albeit strictly *obiter*) in relation to the calculation of the six month cohabitation period necessary for section 26(6) of the MHA to apply.

The Claimant R brought judicial review and *habeas corpus* proceedings in respect of his detention under section 3 of the MHA. He had a lengthy psychiatric inpatient history, both as a formal and an informal patient. In early January 2007 he rekindled a relationship with M, moving most of his belongings into her home in mid-January. R was then imprisoned for breach of a harassment order against his ex-wife in mid-February for a period of approximately two months. On his release from prison, he moved the last of his belongings into M’s flat and the couple became engaged. In July 2007, R was detained in hospital under section during a brief period of relapse. Irrespective of these periods apart, the Claimant’s case was that by mid-June, M had become his nearest relative under section 26(6) by way of six month cohabitation.

Unfortunately, R’s relationship with M’s family was stormy. On 22nd September 2007 R had an argument

4 *Emphasis added.*

with M's mother who was staying with the couple at the time, which resulted in the police being called. R agreed to move out temporarily, and he then spent six days sleeping either in his car or in friends' accommodation. On 28th September 2007, R presented himself to the Accident and Emergency department at his local hospital hoping to be admitted in order to obtain a roof over his head. He was found not to be exhibiting any symptoms of mental disorder and admission was refused. Later the same day however, the Defendant hospital admitted R under section 3 of the MHA, his aunt having been consulted as nearest relative, and having raised no objection to the admission.

Once admitted to hospital, R telephoned his partner, M, who immediately cut short a visit to the north of England in order to see him in hospital. During the course of the admission it was abundantly clear that the relationship was ongoing. On 2nd October 2007, M, considering herself to be R's nearest relative on the basis of cohabitation in excess of six months in accordance with section 26(6) of the MHA, made a written request for his discharge from hospital⁵. The discharge was not barred by R's Responsible Medical Officer ('RMO')⁶. R remained detained, however, and a letter to M informed her that she was not the nearest relative. The Defendant argued that M could not be his nearest relative for three reasons: firstly, he had been engaged to someone else the previous year; secondly, the Defendant's records indicated that his aunt was his nearest relative; and finally, when the ASW had assessed him, he had been of no fixed abode. The Claimant argued that the first two reasons had become irrelevant, and the latter was untrue, or alternatively, had been only a temporary state of affairs due to a short-lived argument.

On 12th November 2007, R made urgent judicial review and *habeas corpus* applications against the detaining authority. He also claimed damages, alleging that in refusing to release him, the hospital had violated his rights under Article 5(1) and Article 8 of the European Convention on Human Rights. He contended that as his nearest relative, M was entitled to order his discharge. It was submitted that since his RMO had not provided a barring report, his continued detention was unlawful.

The Defendant's case was that M was not R's nearest relative, either because the relationship had ended, or because various periods of enforced detention had interrupted the requisite six month period. On behalf of R it was submitted that in calculating that period it would be unfair, impractical, and contrary to Parliament's intention to take into account any periods of compulsory detention in prison or hospital; and further, that it would be unfeasible to expect an ASW or a hospital to have to make such calculations for every patient admitted under section.

Whilst it was the Claimant's view that the *habeas corpus* application could be decided on the papers, Mr. Justice Bennett agreed to the Defendant's application for an urgent *Wilkinson*-style⁷ hearing with oral evidence taken three days later. At that substantive hearing, both R (on leave from hospital) and M gave evidence, in addition to the recommending ASW and R's social worker. R had made it clear to the ASW at the time of admission that due to the argument with his partner he was concerned that their relationship might be over. It was common ground, therefore, that the initial detention had not been unlawful since the ASW had been entitled to consult R's aunt as nearest relative; all that was required by section 11(3) was a reasonable belief on the part of the ASW that the appropriate person was being consulted. It was noteworthy, however, that even though their relationship was strained at the time, M said that if she had been consulted as nearest relative at the time of R's admission, she would have objected to it.

Mr. Justice Stanley Burnton, however, dismissed the Claimant's applications, finding that at the time of

5 S.23(2)(a).

6 S.25(1). Since 3/11/08 the 'RMO' has been succeeded for most MHA purposes by the term 'Responsible Clinician' (s.34(1)).

7 *R(on the application of Wilkinson) v Broadmoor Hospital* [2001]EWCA Civ 1545.

his admission to hospital on 28th September 2007, R had not considered his relationship with M to be ongoing. The fact that the relationship had in fact survived and was continuing was irrelevant. In the learned Judge's view, the relationship was not as settled and permanent as the statute envisaged. He found that M was not R's nearest relative, as the 'clock' measuring the requisite six month period under section 26(6) of the MHA had stopped when R was asked to leave the couple's flat in September 2007. Thus, at the time of his admission he was not living with M as if she was his wife.

The Judge also made comments which were strictly *obiter*, but which may have serious ramifications for the cohabitantes of those with mental health difficulties in the future. He found that even if the relationship had not been interrupted in September 2007, R and M would not have cohabited for the requisite six month period. This was because in calculating that period for the purposes of section 26(6) of the MHA, a hospital should take into account periods apart, including, for example, any time spent abroad, and/or detention in hospital or prison (notwithstanding that such absences are under compulsion). The submissions made on behalf of the Claimant – that it would be impractical for a hospital to have to make such calculations, particularly in a situation where there was time pressure – were rejected by the court. The Judge found that such periods of detention would be recorded and easily ascertainable. Although the learned Judge acknowledged that it might be difficult to identify when a period of cohabitation began, a hospital was obliged to try, as it had a duty to investigate whether a six month cohabitation period had altered the identity of a patient's nearest relative.

According to Stanley Burnton J, whether or not a period apart would bring a cohabitation period to an end for the purposes of section 26(6) would depend on the nature and duration of the relationship when the interruption took place. Whilst not making a specific finding about when the cohabitation had begun, the Judge observed that R and M had been together for a relatively short period of time, and that R had kept some of his clothes at his previous accommodation until he left prison. The period of detention in prison would have interrupted the cohabitation. Whilst it could be argued that, but for the periods of compulsory detention, a couple would have continued to cohabit (and so to use enforced separation to reduce the requisite six month period would be unfair), the Judge found that to be a matter of speculation. Indeed, in this case the court found the cohabitation to have ceased in September 2007 due to an argument, and it was by no means certain that had R not been detained at various points during the year, the relationship would have been maintained.

In retrospect, it was clear that the cohabitation of R and M had not 'ceased' in September 2007, but rather a quarrel had caused a short-term separation. The temporary nature of that separation became abundantly clear only ten days after the couple's argument, when M returned immediately from her trip to the north of England to support her partner, and sought his discharge. However, it is quite right that an AMHP must judge the identity of the nearest relative according to the facts as they appear at the time, and it was open to the ASW in the case of R to conclude that his aunt was the appropriate consultee. The author submits that just as a husband and wife must be "*permanently separated*" for one to cease to be the other's nearest relative (section 26(5)(b)), any separation between a cohabiting couple must also be permanent for there to be a break in the chain of cohabitation. After all, the Judge set much store by the fact that Parliament must have intended a degree of permanency in a relationship to set the requisite period of cohabitation at six months, and yet he did not also consider that there must be a corresponding permanency of separation. The true position was ascertained shortly after admission; in fact the relationship had suffered no more than brief breakdown – a common feature of many relationships including marital ones. It was then that the detaining authority became aware of the identity of the correct nearest relative and, arguably, it should have acted on M's application for R's discharge.

It is clear from section 26(6) of the MHA that where cohabitation has not yet reached the six month stage prior to a hospital admission, the requisite period cannot be added to whilst the patient is in hospital: “or, if the patient is for the time being an in-patient in a hospital, *was so living* [as a spouse] *until the patient was admitted*, and has been or had been so living for a period of not less than six months...”⁸ Presumably, however, where the cohabitation resumes on discharge, the six months period does not begin afresh.

In the event, R did not wish to appeal the decision, which is unfortunate because its consequences are potentially very serious for future patients. It is common for those afflicted with mental health problems to have a transient lifestyle, with difficulties in holding down permanent occupation, and often forensic histories. Those with mental health difficulties are more likely to develop friendships and relationships with other service-users, who may also have periodic admissions. Relapsing patients may well quarrel with those who come into contact with them. The ‘revolving door’ pattern of admission for those who suffer from mental disorder also means that any such six month period of cohabitation may be interrupted by further admissions. Yet, *ex parte Robinson* suggests that even short or informal admissions are to be taken into account. Whilst cohabitation is on the increase, relationships not cemented by marriage will provide less protection for such patients than their married counterparts. That said, now that the provisions for compulsory treatment orders are in force⁹ the frequency of many patients’ admissions to hospital is liable to reduce.

Furthermore, it is difficult to see how a busy AMHP is to calculate a period of cohabitation. The date upon which cohabitation begins may be uncertain, with information presumably coming from a patient. Again, information about periods of imprisonment or hospitalisation is likely to come primarily from a patient – the same patient who is considered to be sufficiently mentally disordered for admission. Contrary to the view of Stanley Burnton J, it is unlikely to be possible to make the appropriate enquiries of the prison service and/or hospitals within the necessary timeframe, particularly where there is thought to be a degree of urgency. In consequence, where cohabitation is less than for the period of a year or so, and an AMHP is aware that the patient being assessed has had other admissions to hospital (or prison) during the course of the same year, the consultation of a cohabitee is unlikely to occur; an AMHP will be liable to consult the person who would be the patient’s nearest relative but for section 26(6). The temptation to ignore the cohabitee may be difficult to resist because an objection from them is, perhaps, more likely, given that they may feel more able to provide support to the person with whom they reside than another relative.

***BB v Cygnet Health Care and London Borough of Lewisham* [2008] EWHC 1259 (Admin)**

In *BB v Cygnet Health Care and London Borough of Lewisham*, 4th March 2008, there was, in the end, no dispute about the identity of the correct nearest relative. Instead, the dispute centred upon whether there had been either an effective consultation of the nearest relative, or indeed any consultation at all. Although in the end the case turned upon the credibility of the witnesses, several findings may be of future application. The facts were these.

The Claimant BB had a diagnosis of paranoid schizophrenia and an extensive forensic history. He was detained in hospital between July and December 2007, but in receipt of extensive leave. Following discharge, he was detained again in hospital on 6th January 2008 and subsequently transferred to the

8 *Emphasis added.*

9 Ss17A – G MHA

private hospital run by the Defendant. Apparently due to the realisation that his detention up until then was unlawful, the Defendant hospital detained him under section 5(2) of the MHA (the doctor's holding power). An ASW employed by the local authority (the Interested Party) sought to assess the Claimant for admission under section 3. As required by section 11(4) of the MHA, the ASW contacted the Claimant's nearest relative, who at that time was his father. His nearest relative could neither speak nor understand English, and he mentioned a name which the ASW ascertained belonged to the Claimant's sister. Consequently the ASW contacted the sister (HB) by telephone. No attempt was made by the ASW himself to contact the Claimant's nearest relative again. The Claimant was subsequently detained under section 3 of the MHA. He applied to the court for a writ of *habeas corpus* on the basis that the requisite consultation of his nearest relative had not taken place and his detention at the hospital was consequently unlawful.

At an initial hearing on 11th February 2008 before Mr. Justice Forbes ([2008] EWHC 954 (Admin)), the Defendant hospital requested an adjournment in order (amongst other things) to obtain its telephone records because there was a dispute about the length of the telephone conversation between the ASW and HB. However, Forbes J. agreed to hear submissions on a preliminary issue, which (had he found for the Claimant) might have been the end of the matter. The Defendant's evidence on paper was that HB did not object to the admission either herself, or on behalf of her family or her father (the patient's nearest relative), despite the family being 'unhappy' about another admission. The ASW's evidence was that HB's only complaint had concerned the distance of the hospital in question from the family home. He claimed to have told her that she should inform her father as to what was proposed, and telephone him back if he objected. He also indicated that HB had told him to 'go ahead' with his assessment and use his professional judgement in respect of the admission (a suggestion strongly contested by HB). This was relevant not to whether the section 11 requirements had been fulfilled, but to the ASW's credibility. It was the Defendant's case that the ASW had then said that he would delay the assessment for 40 minutes to an hour to give HB the opportunity to consult her father and get back to him if need be. It was accepted that HB then telephoned her brother, and that the ASW visited him in hospital while that telephone call was taking place, but he had not asked to speak to HB.

It was submitted on behalf of the Claimant that it must have been obvious that HB and the rest of her family objected to an admission. The failure to use the word 'object' was irrelevant; this must flow from *Re GM (Patient: Consultation)* [2000] MHLR 41¹⁰ (reaffirmed more recently in *R v East London NHS Foundation Trust and the London Borough of Hackney ex parte M*, QBD (Admin) 11th February 2009) which held that it was not necessary for an ASW to ask a nearest relative the specific question as to whether there was an objection to the application being made. As a nearest relative is likely to express an objection in layman's terms, it is difficult to see how unhappiness about the proposed course could be interpreted in any other way. This was accepted in *R v The Hospital Managers of the Edgware Community Hospital and Another, ex parte GD*, 27th June 2008 (a decision heard subsequently and discussed below), where it was acknowledged that "objection was something that might be gleaned from the totality of what was said, including the way in which it was said". Having been put on notice of an objection or a likely objection by the nearest relative, the ASW either avoided undertaking the consultation or made insufficient efforts to do so.¹¹

¹⁰ See para. 1–123, p.84 of *Mental Health Act Manual* by Richard Jones (Sweet and Maxwell, 11th ed.).

¹¹ This was the situation in *R v The Hospital Managers of the Edgware Community Hospital and Another, ex parte GD*, 27th June 2008.

Whilst the case law confirmed that consultation via a third party could be lawful (see *R v Managers of South Western Hospital, ex parte M* [1993] QB 683; [1994] 1 All ER 161), it was pointed out to the Judge that this was confined to circumstances where a *professional* was acting as the consulting person. It was further submitted that effective consultation – “the communication of a genuine invitation to give advice and a genuine consideration of that advice” (see *R v Secretary of State for Social Services, ex parte Association of Metropolitan Authorities* [1986] 1 All ER 164 at 167 (approved in *Re Briscoe* [1998] COD 402)) – could not take place via delegation to a third party if the ASW did not know whether that consultation had taken place or not, or indeed what the result of the consultation had been. Without telephoning HB back (or indeed on the facts asking BB if he could speak to her when she was on the telephone to him), the ASW did not know whether she had relayed the information to her father, or whether he objected to his son’s admission. To fail to make these checks meant that effective consultation could not have taken place.

Furthermore, whilst it was the Claimant’s case that HB did *not* tell the ASW that the decision as to the ‘sectioning’ of her brother should be left to the professionals, it was in any event irrelevant in relation to whether there had been a consultation with the Claimant’s *nearest relative* (who was not at that time HB). It was the ASW’s duty under section 11(4) to consult the nearest relative, and it was submitted that even had he asked HB to contact her father as alleged, this would not have sufficed. Even on the ASW’s version of events, no attempt was made to contact HB a second time prior to sectioning the Claimant in order to ascertain whether or not her father had objected. The ASW knew not whether she had managed to contact her father or to reiterate their conversation. He knew not whether her father objected. Having failed to check the views of the nearest relative, they could not have been given “genuine consideration”.

However, Mr. Justice Forbes held that the Defendant’s evidence taken at its highest (*i.e.*, if true), *could* amount to the requisite consultation of the nearest relative under the Act. Consequently the matter was adjourned for a week for a full *Wilkinson*-style oral hearing, by which time the telephone evidence would be available. An order of disclosure with respect to HB’s mobile telephone records was also made which showed that the relevant telephone call had lasted some forty minutes. At the reconvened hearing, the court heard oral evidence from HB, a nurse at the hospital and the ASW. As expected, HB’s version of events was quite different from that of the ASW. She emphasised her dissatisfaction with the Slough Community Mental Health Team, in particular for failing to provide her brother with the aftercare to which he was entitled, and about which she had previously written several letters of complaint. Her evidence was that she had stated in no uncertain terms that it would be unacceptable to her family were the Claimant to be sectioned again. When the ASW had telephoned her she had protested at length, not only about the unit (which she felt was unsuitable), but also about the need for her brother to be sectioned.

Mr. Justice King allowed the Claimant’s application and a writ of *habeas corpus* was granted, with his release ordered forthwith. The court found that whilst the law permitted the consultation of a nearest relative to take place through an intermediary (*R v Managers of South Western Hospital, ex parte M* [1993] QB 683 applied) and the consultation required by section 11(4) of the MHA could be satisfied by such means, the burden to show that proper consultation had taken place must fall upon the relevant ASW. On the evidence, the ASW had failed to discharge that burden. Whilst both witnesses had been wrong in their respective recollections as to the length of the telephone call, the Judge considered that the ASW’s evidence as to the *content* of the telephone call was unreliable. Contrary to paragraph 11.13 of the Code of Practice to the MHA, the ASW had failed to complete an outline report at the hospital – something that gave the court little confidence about his overall ability properly to discharge his statutory

responsibilities. It was “highly unlikely” that HB had ever said she would rely upon his professional judgement as alleged, given the history of the case and HB’s opinion about the past treatment of her brother by the mental health services. Further, the nurse gave evidence that following his telephone call to HB, the ASW had told her that he would try to make further contact with the nearest relative later. This was inconsistent with his evidence that the requisite contact had already been made, albeit through the intermediary of the Claimant’s sister.

If what the ASW had said about relaying information to the nearest relative had been true, King J. considered that on discovering that HB was on the telephone to her brother when he visited BB to assess him, it would have been “incredible” not to have made an effort to talk to HB to ascertain whether she had spoken to her father and whether or not he objected. The ASW’s reliability having been called into question, the Judge doubted that he had told HB to communicate the content of the conversation to her father, or indeed that he had requested that she call him back if the nearest relative objected to his son’s detention.

By contrast, HB had sought legal advice and telephoned the ward to enquire whether or not her brother had been sectioned, and who had been noted as his nearest relative. She made it clear to the nurse on the telephone that neither she nor her father had consented to the detention. It was also significant that the letter before action in the matter was sent the very next day. Such behaviour was consistent with HB’s insistence under cross-examination that she had repeatedly asserted to the ASW in no uncertain terms that her family did not wish the Claimant to be sectioned. Knowing that the Claimant had been in receipt of extensive section 17 leave since July 2007 and that a CPA meeting had already taken place, Mr. Justice King was satisfied that there were no public policy reasons to stay the writ (see *Re Briscoe* [1998] COD 402), which was granted. The Claimant was discharged from hospital with immediate effect.

Although *BB* was to a certain degree confined to its own facts, it is significant in the mental health law field for several reasons. Firstly, local authorities should be aware that if an AMHP either fails to complete the requisite paperwork or completes it inadequately, this might have an adverse impact upon his or her credibility where there is a dispute on the facts. Secondly, where an AMHP chooses to delegate to a third party the important task of consultation of the nearest relative, it must be borne in mind that the responsibility for consultation remains with him or her. The AMHP must ensure that the consultation did in fact occur, and that it was effective – and he or she must ascertain its result.

GD v The Managers of the Dennis Scott Unit at Edgware Community Hospital and The London Borough of Barnet, Queen’s Bench Division (Administrative Court) 27th June 2008

A third case involving a nearest relative consultation recently before the courts was that of *GD v The Managers of the Dennis Scott Unit at Edgware Community Hospital and The London Borough of Barnet*, 27th June 2008. The Claimant GD suffered from schizophrenia. He was 29 years old and highly intelligent. He had been admitted to hospital frequently since the age of 15. In February 2008, GD began screaming at neighbours because he believed (wrongly) that they were making a noise. By way of section 26(1)(b), GD’s father was his nearest relative. He strongly believed his son’s illness should be treated with natural remedies. The Claimant’s mother became concerned that her son’s mental health was deteriorating. A team meeting was held on 12th June 2008, and his Community Psychiatric Nurse visited the house the next day, but GD would not let her in. A warrant under section 135 of the MHA was then obtained, although it was not executed by the police because, at his mother’s behest, GD cooperated with the assessment at the family home. His admission to hospital resulted. Subsequently he challenged the

lawfulness of his detention in Edgware Community Hospital by way of *habeas corpus* proceedings on the basis that the ASW had failed to consult his nearest relative, who objected to his admission. The ASW's oral evidence was that no objection had been made at the time of the assessment by the nearest relative, and further, that any such objection (if made) was made too late.

At the time of the Claimant's assessment, his father and nearest relative was renovating a cottage in Wales. The ASW admitted that no attempt had been made to contact him prior to the assessment because he was concerned that should his father be alerted to the possible admission of his son to hospital, the Claimant might be removed from the home and taken elsewhere (as in the past).¹² Having obtained the nearest relative's telephone number from GD's mother on 14th June, the ASW left a message telling him that his son was being assessed under the MHA and that he would telephone again. He also telephoned a cottage nearby to ask the residents to try to contact the Claimant's father.

Despite poor reception at the remote location in Wales, GD's father picked up the ASW's message on his mobile telephone on 14th June 2008 and called the hospital only twenty minutes after it had been left. By that stage, the paperwork for the section 3 admission had already been completed. GD's father spoke to the ASW and strongly expressed his anger. His evidence was that he objected to his son's admission in no uncertain terms, calling the plan to admit his son to hospital "violent and evil and generally dreadful", although in oral evidence he was unable to recollect his precise words. The reception was poor, and the ASW was speaking from the kitchen in his family home which was noisy, but he acknowledged that the Claimant's father had been extremely negative about the plan to admit his son, that he had used the words, "how dare you?", and that it had been more of a monologue than a conversation. Although the ASW "accepted that the question of objection was something that might be gleaned from the totality of what was said, including the way in which it was said", he insisted that whilst the Claimant's father had been angry and upset, he had not heard an objection to the admission expressed. The Judge accepted the truthfulness of that assertion. However, somewhat contrary to the ASW's oral evidence, he had ticked a box on the statutory form 9 stating that it was not reasonably practicable to consult the Claimant's nearest relative or would involve unreasonable delay. In the ASW's written summary he completed a section entitled, "Consultation with Nearest Relative and Process for Finding Nearest Relative", where he recorded that an hour after their telephone call, the Claimant's father had telephoned again to object to the admission, but GD had already been admitted and his father was told of his right to discharge him.

The Defendant submitted that even if there had been an objection, it would have come too late as the requisite forms had already been completed. It had not been reasonably practicable to make contact with the Claimant's nearest relative until the morning of the assessment, and the consultation was not possible prior to the application being made. However, the Judge held (*obiter*) that the language of section 6 and the statutory forms made it plain that an application was not 'made' until handed in and Form 14 was signed. As Otton LJ held in *Re D (Mental Patient: Habeas Corpus)* [2000] 2 FLR 848 (at para.15), section 11 "has to be construed strictly. It involves the liberty or loss of liberty of a person".

The Defendant also submitted that where there is a subjective test (as in section 11(4) which requires consultation with whoever "appears" to the ASW to be the nearest relative), the court should not interfere absent dishonesty; *i.e.*, where the decision-maker was "plainly wrong" (*Re D: Mental Patient (Habeas Corpus)* Lawtel 4/12/99). The Judge accepted that "the court will inevitably be sensitive to the difficulties faced by those who have to make difficult decisions, sometimes in fast-moving and tense

¹² The Claimant's father sought his discharge under s.23 which was blocked by a barring report. At the time of writing, the local authority was taking steps to displace the Claimant's father as nearest relative under s.29 of the MHA.

circumstances”. However, he held that the Defendant’s submission that the court should not interfere absent dishonesty was too narrow an approach, as a failure to comply with the statute was reviewable on normal public law grounds. A decision would be flawed not only where there was bad faith or dishonesty, but also if there had been a misuse of power or an application of the wrong legal test (*R v South London & Maudsley NHS Trust, ex parte WC* [2001] EWHC Admin 1025, [2001] 1 MHLR 187 applied).

The Claimant contended that there had been no proper attempt to engage in consultation at all, but rather an avoidance of it. The ASW had admitted that he had delayed attempts to contact GD’s father, by which time he could have had no effective input. Further, there had been no reason for the assessment to take place immediately at the family home, given that the section 135 warrant obtained could have been executed and the Claimant removed to the hospital as a place of safety, providing ample time for consultation. Instead, the ASW and the professionals liaised with the Claimant’s mother – no doubt because she supported the admission – apparently as a means of avoiding the requirements of the statute.

Whilst Mr. Justice Burnett found that those involved in GD’s care were motivated only by GD’s best interests, he found the Claimant to have been unlawfully detained. The Judge held,

“The duty to consult is one which exists to enable there to be a dialogue about the action proposed in respect of a mentally ill individual. The person consulted is entitled to have his views taken into account and, importantly, the consultation process should enable the nearest relative to object to the proposed course if he wishes. The consultation must be a real exercise and not a token one. If an objection is raised, it does not have to be a reasonable one. It does not have to be one which judged objectively is sensible.”

The Judge considered that the chances of involving GD’s nearest relative in the process from the beginning had been intentionally limited because the professionals involved feared that the admission would be blocked. “[O]rdinarily there is no need to search uphill and down dale” for the nearest relative, but “in seeking to protect the best interests of GD they calculated that they should do no more than nod in the direction of consultation as contemplated by section 11(4). They set in motion a course of events which was designed to leave consultation with GD’s father to the very last moment, and thus seriously inhibit the chances of his having any effective input into the process and the chances of his having an opportunity to make an objection.”¹³ Thus, what had occurred “could not properly be considered consultation at all”. In essence, whilst not stated in terms, Mr. Justice Burnett found that any difficulties involved in contacting the nearest relative had been caused by the ASW himself because he had left the consultation to the eleventh hour, and so he could not hide behind the terms of section 11(4) by suggesting that consultation was “not reasonably practicable” or would have involved “unreasonable delay”.

It is clear that the nearest relative’s “significant role in the protection of the patient or otherwise acting in his or her interests” is “not lightly to be removed by invoking impracticability” (observations in *R v Bristol City Council, ex parte E* [2005] EWHC 74 (Admin) at para. 29, *per* Bennett J. (relying on *R v Secretary of State for Health, ex parte M* (2003) EWHC 1094)). It is worth commenting that in *BB v Cygnet Health Care and London Borough of Lewisham*, one possible defence might have been that it had not been reasonably practicable to consult BB’s father about his son’s admission, given that he did not speak English. On previous occasions a telephone translator had been arranged, which the court might have

¹³ Arguably, the consultation that, on the written evidence, took place in *BB v Cygnet Health Care and London Borough of Lewisham* [2008] EWHC 1259 (Admin), 4th March 2008, was also merely a “nod in the direction of consultation”, but Mr. Justice Forbes found it to be sufficient.

accepted would have involved unreasonable delay¹⁴ or would have been impractical at the time. Admittedly, when the ASW telephoned HB, his detention under section 5(2) still had 24 hours to run, which would have made such an argument more difficult.

Returning to *ex parte GD*, the deliberate failure to consult at a stage that would have permitted effective consultation had amounted to a misuse of power which “infected the application process from beginning to end”. Accordingly, the application was allowed, and an order for the Claimant’s immediate release was made by way of a writ of *habeas corpus*.

Conclusion

It is clear that the nearest relative continues to have a very important role, despite the somewhat arbitrary way in which a person may find themselves holding the position in law. It is likely that following the amendments made to section 29 MHA by the *Mental Health Act 2007*, which have (a) empowered the patient to seek displacement of the nearest relative¹⁵ and (b) added the new ground of ‘unsuitability’¹⁶, some patients may acquire nearest relatives more in tune with their own thinking. Consequently AMHPs may find an increase in the raising of objections to detention under section 3. However, in view of *ex parte BB* and *ex parte GD*, AMHPs will have to make real attempts to consult such nearest relatives no matter how obstructive they may be considered. The author expects an increase in the number of applications to displace the nearest relative.

14 However, see the observation of Richard Jones in his *Mental Health Act Manual* (11th ed.) on p.86 that “it is unlikely that this situation would often obtain”.

15 s.29(2)(2a).

16 s.29(3)(e)