



Neutral Citation Number: [2021] EWHC 101 (Admin)

Case No: CO/2408/2020

**IN THE HIGH COURT OF JUSTICE**  
**QUEEN'S BENCH DIVISION**  
**DIVISIONAL COURT**

Royal Courts of Justice  
Strand, London, WC2A 2LL

Date: 22/01/2021

**Before:**

**PRESIDENT OF THE QUEEN'S BENCH DIVISION**

**-and-**

**MR JUSTICE CHAMBERLAIN**

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**Between:**

**DEVON PARTNERSHIP NHS TRUST**

**Claimant**

**- and -**

**SECRETARY OF STATE  
FOR HEALTH AND SOCIAL CARE**

**Defendant**

**NHS COMMISSIONING BOARD**

**Interested Party**

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**Fenella Morris QC (instructed by Browne Jacobson LLP) for the Claimant**  
**James Cornwell (instructed by the Government Legal Department) for the Defendant**  
**Jonathan Auburn (instructed by the Government Legal Department) as Advocate to the Court**

Hearing dates: 13 January 2021  
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**Approved Judgment**

**Dame Victoria Sharp, P. and Mr Justice Chamberlain:**

1. This is the judgment of the Court to which both members have contributed.
2. The Devon Partnership NHS Trust (“the Trust”) is the body responsible in its area for the employment and provision of medical practitioners whose recommendations are required by the Mental Health Act 1983 (“MHA”) for the detention or reception into guardianship of patients suffering from mental disorders.
3. Section 2 of the MHA provides for a patient to be admitted to a hospital and detained there for assessment. Section 3 provides for admission and detention for treatment. Section 4 provides for admission for assessment in cases of emergency. Section 7 provides for applications for guardianship. In each case, the application can be made either by the patient’s “nearest relative” or by an approved mental health professional (“AMHP”): see s. 11(1). In the case of detention under ss. 2 and 3 and guardianship, the application is to be “founded on the written recommendations in the prescribed form of two registered medical practitioners”. In the case of emergency admission under s. 4, the application can be founded on one such recommendation.
4. Section 11(5) of the MHA provides that no application for admission for assessment, admission for treatment or guardianship is to be made by any person in respect of a patient “unless that person has personally seen the patient within the period of 14 days ending with the date of the application”. Where an application for admission to hospital is made by an AMHP, s. 13(2) imposes on him or her the obligation to “to interview the patient in a suitable manner”. Section 12 of the MHA provides that the medical recommendations required “shall be given by practitioners who have personally examined the patient”.
5. Until the start of the COVID-19 pandemic in early 2020, these provisions had generally been understood as requiring the person making the application in accordance with s. 11(5) to visit the patient in person and interview them face-to-face and the medical practitioner acting under s. 12(1) to visit the patient in person and examine them face-to-face. The Code of Practice issued by the Secretary of State under s. 118 of the MHA, provides that a medical examination for these purposes must involve “direct personal examination of the patient and their mental state”. Those exercising functions under the MHA are obliged as a matter of public law to follow the Code of Practice absent a cogent reason to depart from it: *R (Munjaz) v Mersey Care NHS Trust* [2005] UKHL 58, [2006] 2 AC 148.
6. Just after the start of the first “lockdown”, on 30 March 2020, NHS England issued a document entitled *Legal guidance for mental health, disability and autism, and specialised commissioning services supporting people of all ages during the coronavirus pandemic* (“the Guidance”). It offered specific advice and guidance on areas which are “posing a particular challenge as a result of the pandemic and where temporary departures from the Code of Practice may be justified in the interests of minimising risk to patients, staff and the public”. The Guidance was revised in May 2020 to include a section, drafted jointly by NHS England and the Secretary of State, headed “Application of digital technology to Mental Health Act assessments”. It said this:

**“This guidance has been prepared for use in the pandemic only.** The MHA makes it a legal requirement that doctors must “personally examine” a person before recommending that they be detained, and that an Approved Mental Health Professional (AMHP) must have “personally seen” the person before applying for a detention.

It is the opinion of NHS England and NHS Improvement and the DHSC that developments in digital technology are now such that staff may be satisfied, on the basis of video assessments, that they have personally seen or examined a person in a “suitable manner”. Bearing in mind the need to prevent infection and to ensure the safety of the person and staff, in some circumstances the pandemic may necessitate the use of such digital technology for MHA assessments. Providers should follow the guidance below to inform this decision. While NHS England and NHS Improvement and DHSC are satisfied that the provisions of the MHA do allow for video assessments to occur, providers should be aware that only courts can provide a definitive interpretation of the law.

...

Even during the COVID-19 pandemic it is always preferable to carry out a Mental Health Act assessment in person. Under specific circumstances where this cannot happen (see below) it is possible for video assessments to occur. Decisions should be made on a case-by-case basis and processes must ensure that a high-quality assessment occurs.”

7 The Guidance then sets out:

- (a) “Situations where a video assessment can be considered” (where there is “significant risk of harm via transmission to the person and/or staff” *and* “significant risk of harm due to the delay of assessment and/or subsequent intervention” *and* “the minimum quality standards and safeguards are met to ensure that a meaningful and high-quality assessment can occur in a safe environment”);
- (b) “Minimum standards and safeguards” (including that, “[t]hroughout the process, staff, as well as the person and their carer (if appropriate), should be confident with the quality of the video assessment and that it meets the requirements of the MHA”); and
- (c) “Specific considerations by setting” (including that it is “likely that the minimum quality standards will be difficult to achieve in a community setting. Therefore, video assessments should only be considered in community (home) settings in exceptional circumstances...”).

8 For the Trust, Ms Fenella Morris QC told us that the Trust had made use of video technology to carry out an examination for the purposes of detention on only one occasion and that, with one exception, other Trusts had taken a similarly cautious approach. At paras 7-8 of her skeleton argument, Ms Morris said this:

“7. Whilst this Guidance approved the use of remote assessments in some circumstances and expresses a view as to their lawfulness, it expressly steps

back from providing certainty on the issue to professionals and the public. Its ambivalence is highlighted by its insistence that it only applies during the COVID-19 pandemic, and upon the very limited circumstances in which it envisages that a remote assessment might be lawful.

8. Medical practitioners, and their employers are concerned about the lack of clarity in the law that governs their roles under the MHA. They perceive that they face a choice of either carrying out a remote assessment and being found to have failed to comply with the MHA so that a patient is wrongly detained and the professional exposed to the risk of allegations are false imprisonment, or, on the other hand, of carrying out an in-person assessment and thereby jeopardising their health and that of their patients and the public....”

- 9 In these circumstances, the Trust has brought this claim under CPR Pt 8 seeking the following declarations from the Court (as modified at the suggestion of the Secretary of State):

“a. The requirement under s.12 MHA that a medical practitioner has ‘personally examined’ a patient before completing a medical recommendation in support of the patient’s detention in hospital may be fulfilled by the medical practitioner examining the patient remotely should that be deemed sufficient to fulfil the requirements of the MHA in the circumstances of that case in the professional judgement of the medical practitioner applying the Guidance.

b. The requirement of s. 11(5) MHA that a person making an application for a patient’s detention in hospital has ‘personally seen’ the patient within the period of 14 days ending with the date of the application may be fulfilled by the person having ‘seen’ the patient remotely should that be deemed sufficient to fulfil the requirements of the MHA in the circumstances of that case in the judgement of the person concerned applying the Guidance.”

The original claim and skeleton argument provided examples of the remote technology envisaged: Skype, Microsoft Teams, Zoom, WhatsApp and FaceTime.

- 10 Ms Morris set out the arguments for the declaration she sought in an appropriately balanced way, drawing proper attention to the possible contrary arguments. The Secretary of State agrees that the declarations sought should be made and, through Mr James Cornwell, made separate submissions as to the proper interpretation of s. 11(5) and 12(1) of the MHA. As the Claimant and Defendant were *ad idem* as to the result, Mr Jonathan Auburn was appointed as Advocate to the Court to ensure that all possible arguments were before us. We are grateful to all counsel for their impressive research, including into the history of the relevant statutory provisions, and for their excellent written and oral submissions.

### **The power to issue a declaration**

- 11 In general, the court does not give advisory opinions on questions of statutory construction. In exceptional cases, however, there is power to issue a declaration as to the construction of an enactment in the abstract where three criteria are satisfied: first,

the declaration sought raises a real question (as opposed to a hypothetical or academic one); second, the party seeking the declaration has a real interest in it; and third, the court has heard proper argument: see *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1, 82 (Lord Goff). Even where these criteria are met, an application for a declaration in the abstract requires “particular justification”: *R (Stamford Chamber of Trade and Commerce) v Secretary of State for Communities and Local Government* [2010] EWCA Civ 992, [13] (Laws LJ).

- 12 In this case, the threshold criteria for the grant of a declaration in the abstract are met: the issue is one of real and pressing concern for those exercising functions under the MHA during the pandemic; the Trust plainly has an interest in the declaration sought as employer of the medical practitioners who will be affected by it; although the Claimant and Defendant are *ad idem*, opposing arguments have been canvassed before us, including in particular by Mr Auburn as Advocate to the Court. There are also compelling reasons for us to decide this issue now. It is in the public interest that those exercising powers under the MHA should have certainty as to what is legally required of them. This will avoid the unlawful detention of patients and clarify the law so that proper consideration can be given to the question whether any amendment is required, whether for the duration of the current pandemic or generally.

### **The Trust’s evidence**

- 13 The Trust’s evidence comes from its medical director Dr David Somerfield, who is a consultant psychiatrist. He has made two witness statements.
- 14 In his first statement, dated 6 July 2020, Dr Somerfield explained (as is now well known) that COVID-19 spreads through respiratory droplets generated by coughing, sneezing and contact with contaminated surfaces. Healthcare workers are particularly vulnerable to COVID-19. The risk they face increases with frequency and length of exposure to patients. Many front-line doctors, nurses, healthcare assistants and care workers in the UK have lost their lives to COVID-19. All healthcare settings, including patients’ homes, are considered high risk areas.
- 15 The Trust is responsible for employing “s. 12 approved clinicians”. These are medical practitioners who have been approved by the Secretary of State under s. 12(2) as having special experience in the diagnosis and treatment of mental disorder. The Trust is also responsible for the health and safety of its staff and patients.
- 16 Public Health England issues guidance setting out the principles for reducing transmission of COVID-19 from patients to staff, staff to patients and staff to staff in clinical settings. These principles apply also to clinical activity in a patient’s home. Six key measures are recommended:
  - (a) reduce face-to-face contacts for clinical assessment and interventions e.g. by use of telephone or virtual (video) consultations;
  - (b) fastidious hand hygiene and cleaning to prevent spread from surface contamination;

- (c) maintaining a distance of at least 2 m from patients to prevent respiratory droplet transmission;
  - (d) the wearing of personal protective equipment (“PPE”) in the form of eye protection, fluid resistant face mask (“FRFM”), plastic apron and surgical gloves if within 2m of the patient and undertaking a non-aerosol generating procedure;
  - (e) the wearing of PPE in the form of eye protection, FFP3 standard facemask, gown and surgical gloves if undertaking an aerosol producing procedure;
  - (f) Patients with possible or confirmed COVID-19 should be asked to wear a FRFM tolerated to prevent dispersal of respiratory droplets to reduce direct transmission and surface contamination.
- 17 In response to this, all mental health secondary and primary care services have urgently remodelled their operating procedures. NHS England are strongly encouraging all NHS trusts to switch to virtual appointments wherever possible. There has been a massive expansion of NHS general practice and hospital virtual outpatient services. These are sophisticated, reliable and high-quality video platforms which allow for personal examinations, for example of skin diseases, and for other clinicians or family members to be invited into the consultation from separate locations as required.
- 18 As a result of guidance from the NHS and in the light of the challenges posed by the pandemic, all mental health services have reduced routine and urgent face-to-face assessment and intervention to limit the risk of viral transmission between patients and staff and have dispersed teams to work remotely to reduce the risk of staff to staff transmission.
- 19 The vast majority of tribunal hearings are now being heard by video. In relation to such hearings, preliminary medical examinations by the medical member of the tribunal have been suspended due to the risks involved.
- 20 Where PPE is worn it reduces the quality and therefore the purpose of the assessment and has a significant negative impact on patient response to clinicians who are in personal attendance (potentially affecting the safety of the clinician and the quality of the assessment). For example, an acutely psychotic patient experiencing paranoid ideation and delusional ideas is likely to react in a very negative way to four strangers in full PPE, thereby significantly increasing the risk of physical violence during the assessment. Feedback from clinicians provides examples of aggressive behaviour from paranoid patients caused by the wearing of PPE.
- 21 During the first spike in COVID-19 cases in early April 2020, significant problems of staff availability were experienced because large numbers of clinical staff, including s. 12 doctors, were isolating or shielding and therefore unable to undertake face-to-face MHA assessments. At the same time, the lockdown gave rise to a surge in in the numbers of people presenting with serious and severe mental health needs and requiring MHA assessments who would not normally present in times of less stress. The decrease in availability of community mental health provision, also linked to the pandemic, may also have contributed to this surge.

- 22 When attending a patient's home to carry out an MHA assessment, it will usually be impossible to comply with the national social distancing guidance, as a very large room would be required if four individuals were to assess a patient simultaneously. The difficulty would be accentuated if the patient was acutely unwell. Even in hospitals, the rooms in which assessments normally take place are often too small for social distancing guidance to be complied with.
- 23 In his second witness statement, dated 26 October 2020, Dr Somerfield noted that the surge in demand for mental health services had not abated. At that time, there remained significant issues regarding the availability of appropriate clinicians to conduct the assessment required by s. 12 of the MHA. The impact of stressors such as unemployment and additional economic difficulties was expected to continue. Mental health issues were increasing across the general population in particular with regard to vulnerable groups such as children. The requirement to wear PPE also continued, as did the difficulties associated with assessing patients where PPE is worn.
- 24 As at 26 October 2020 it was unclear how serious the second wave of COVID-19 would be. If, as anticipated, it was worse than the first wave, the need to conduct MHA assessments remotely would become increasingly important. There was concern that the Trust may well run into capacity problems if face-to-face MHA assessments continue to be required.
- 25 Although we have had no further evidence since 26 October 2020, we can take judicial notice of the fact that, since then, it has become clear that the second wave of the pandemic has indeed proved more serious than the first in terms of the pressure it has placed and is likely to continue to place on the NHS, including its mental health services.

### **The Trust's submissions**

- 26 For the Trust, Ms Morris submitted that the phrase "personally examined" in s. 12(1) MHA means at least that the examination must be carried out by the practitioner himself or herself, rather than by someone else. The same is true of the phrase "personally seen" in s. 11(5). The question is whether these phrases also require that the medical practitioner should examine, or the AMHP should see, the patient face-to-face or whether this may be done remotely in an appropriate case.
- 27 The context is deprivation of liberty, which in the case of a detention under s. 3 might be for up to six months. In those circumstances, and given that a face-to-face examination is likely to be preferable to a virtual one, Ms Morris accepted that it *could* be said that a strict construction is required. However, the words "personally examine" and "personally see" are ordinary English words and do not necessarily rule out the kind of interaction that could take place remotely. When pressed in oral argument, Ms Morris said that there was a strong argument that even an examination conducted by voice over the telephone could qualify as an examination for these purposes. Whilst it involved a little stretching of the language, she submitted that there was an argument that an AMHP who spoke to a patient by telephone could say that he or she had "personally seen" the patient (reading those words purposively and in context).
- 28 Ms Morris noted that different formulations were used in other provisions in the MHA. Section 24(1) provides that, when the nearest relative is considering whether to exercise

his or her powers of discharge in relation to a detained patient or a patient subject to guardianship, a medical practitioner authorised by or on behalf of the nearest relative “may, at any reasonable time, *visit the patient* and examine him in private”. Section 31 applies to the procedure applicable in the county court on applications under s. 29 to displace the nearest relative. It authorises rules of court making provision “for the *visiting* and interviewing of patients in private by or under the directions of the court”. Section 119 applies to practitioners authorised for the purposes of Part IV of the MHA, which deals with consent to treatment, and requires treating clinicians to obtain a second opinion before administering certain kinds of treatment. Medical practitioners appointed for this purpose are known as second opinion appointed doctors or “SOADs”. Section 119(2) authorises a person appointed for this purpose to “*visit* and interview and, in the case of a registered medical practitioner, examine in private” detained patients.

- 29 Ms Morris pointed out that s. 10(1) of and Sch. 8 to the Coronavirus Act 2020 (“the 2020 Act”) contained provisions temporarily modifying certain of the requirements in the MHA. It was not considered necessary to bring these modifications into force and most of them have now expired: see SI 2020/1467. It is, however, instructive to consider the substance of them. Paragraph 3 of Sch. 8 would have allowed applications for admission under ss. 2 or 3 to be founded on the recommendation of a single medical practitioner (rather than two). Paragraphs 6 and 7 of Sch. 8 would have made similar provision for court orders and transfer directions given by the Secretary of State. Paragraph 9 concerned the administration of medicine to persons detained in hospital and would have permitted the approved clinician in charge of treatment to give a certificate authorising treatment without the patient’s consent without obtaining the view of the SOAD. The 2020 Act made no provision, however, for modification of the requirements in subsections 11(5) or 12(1).
- 30 Ms Morris drew our attention to two authorities. She cited *M v South West London and St George’s Mental Health NHS Trust* [2008] EWCA Civ 112, [26], for the proposition that what was required by way of personal examination was a matter for the professional judgment of the clinician concerned. She pointed out, however, that the circumstances of that case were materially different. There, the reason why the examination was cut short was because the patient was being difficult. In any event, in *Re Whitbread (Mental Patient: Habeas Corpus)* (1998) 39 BMLR 94, Phillips LJ noted (*obiter*) that the object of s. 11(5) was “to ensure that the view of an applicant that an application is desirable is informed by recent face-to-face contact with the patient”.
- 31 Ms Morris noted that the Code of Practice provides that the preparation of a recommendation by a medical practitioner “must involve... direct personal examination of the patient and their mental state”. This, says Ms Morris, “does not suggest... any relaxation in the interpretation or application of the requirement of (direct) personal examination of the patient by the medical practitioner, for example, by using a telephone or other remote form of communication”. Whilst the Code of Practice cannot be relied upon to elucidate the meaning of the MHA, it may nonetheless provide important assistance in understanding how it is envisaged a requirement may be fulfilled in practice: *R (CXF) v Central Bedfordshire Council* [2018] EWCA Civ 2852, [23]-[24] (Leggatt LJ).



## The Secretary of State's submissions

- 32 For the Secretary of State, Mr Cornwell submitted that the phrases “personally examined” and “personally seen” should be given their ordinary meanings. The adverb “personally” could mean either “connoting the physical presence of the individual” or “connoting the doing by the individual themselves”. The verb “examine” is defined by the Shorter Oxford English Dictionary as “investigate the nature, condition, or qualities of (something) by close inspection or tests; inspect closely or critically...; scrutinise; ...give (a person) a medical examination”. This, Mr Cornwell submitted, focuses on the intensity of the inspection, rather than whether or not it is carried out face-to-face. Likewise, “see” does not shed any additional illumination on the issue, since a medical practitioner or AMHP could “see” a patient using video-conferencing facilities. This can be contrasted with “visit and interview”, which is used in other provisions of the MHA and which clearly entails physical presence. The fact that Parliament has used this phrase in other contexts may suggest that, where it was not used, physical presence was not required. Similarly, the flexibility inherent in the requirement on the AMHP in s. 13(2) “to interview the patient in a suitable manner” may be considered difficult to square with a reading which requires physical presence, since there is no reason why an interview using video-conferencing facilities would not be capable of being “suitable” in an appropriate case.
- 33 As to the case law, Mr Cornwell placed reliance on *M v South West London & St George's Mental Health NHS Trust* and in particular on Richards LJ's proposition at [26] that “[w]hat is required, as with other aspects of the examination and interview, is a matter for the professional judgment of those concerned”. This, he submitted, was part of the *ratio* of the decision.
- 34 Mr Cornwell referred also to *R v Managers of South Western Hospital ex p. M* [1993] QB 683, 699, in which Laws J held that the duty imposed by s. 11(5) could not be performed through an intermediary. This, he submitted, supports the submission that the word “personally” is intended to prevent delegation rather than to require physical presence.
- 35 Finally, Mr Cornwell submitted that the reference in Phillips LJ's judgment in *Re Whitbread* to “recent face to face contact with the patient” was obiter, because the court was not there dealing with the issue now before us.
- 36 Mr Cornwell set out the history of the provisions now under consideration in some detail. The MHA was a consolidating Act. Sections 11 and 12 are materially identical to the corresponding provisions of the Mental Health Act 1959 (“the 1959 Act”). That Act followed a Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (the Percy Commission). But the phrase “personally examined” dates from the Pauper Lunatics (England) Act 1819 and “personally seen” from the Lunacy Acts Amendment Act 1889 (“the 1889 Act”). At that time, Mr Cornwell points out, the only way of “examining” or “seeing” someone would be face-to-face. This, he argued, shows that “personally” can only have intended to preclude delegation, rather than to require physical presence.
- 37 Mr Cornwell submitted that an analysis of the statutory history shows that the mischief to which the requirement for personal examination was directed was that allegations of

insanity were made to medical practitioners, who then rubber-stamped them without personally examining the patient. The Percy Commission appears to have assumed that any examination would involve the physical presence of the medical practitioner. At para. 275 of its report, it said this:

“It is certainly desirable that every doctor who takes part in these procedures should be personally satisfied that the patient’s medical condition is such as to justify the use of the compulsory powers, and that this opinion should relate to the patient’s condition at the time when the compulsory powers are used and not to his condition some time previously.”

- 38 Various statutes have used the phrase “visit and examine”, which clearly does entail physical attendance on the patient. The Lunatics (England) Act 1828 was the first to use this language, empowering the Secretary of State to require Commissioners to “visit and examine any Person confined as an Insane Person”. The Care and Treatment of Lunatics Act 1853 empowered the Commissioners to “authorize and direct... any competent Person or Persons to visit and examine and report to them upon the mental and bodily State and Condition” of a patient.
- 39 The 1889 Act introduced the concept of an application (then referred to as a petition) for a reception order authorising a patient’s detention. It was a requirement that the petitioner had “personally seen” the patient and the petitioner had in addition to “undertake that he will personally visit the patient once at least in every six months”. Mr Cornwell submits that this “strongly suggests that Parliament was using the word “personally” to indicate that the activity was to be carried out by the petitioner himself or herself, rather than through an intermediary and that the history of the legislation therefore supports an interpretation of “personally seen” and “personally examined” as not involving any requirement for physical attendance on the patient.
- 40 Mr Cornwell pointed out that the case law of the European Court of Human Rights (“the Strasbourg Court”) under Article 5 of the European Convention on Human Rights (“the Convention”) imposes no requirement that detention should follow a face-to-face examination at which the medical practitioner is physically present. The requirements of the Convention are more broadly stated than that: they are simply that the individual to be detained must be “reliably shown to be of unsound mind”, a matter which “calls for objective medical expertise”: *Winterwerp v Netherlands* (1979-80) 2 EHRR 387 at [39]. In *Varbanov v Bulgaria* (App No. 31365/96), on 5 October 2000, the Strasbourg Court held at [47] that “[t]he particular form and procedure [of the medical examination] may vary depending on the circumstances”, but – as the Court made clear in the same paragraph – this was a comment about *when* the examination must take place, not how.

### **Submissions of the Advocate to the Court**

- 41 Mr Auburn began by emphasising that care must be taken not to reason from the convenience of the result sought in present circumstances. If, on proper analysis, it was not Parliament’s intention to provide for the examination of patients by remote means, then the manifest challenges raised by the current situation maybe for Parliament, rather than this Court, to address. The court should guard against construing the MHA by reference to the experience of the current pandemic rather than the intention of Parliament when the relevant provisions were enacted. It should also be borne in mind

that the restrictions on the manner of a medical practitioner's or AMHP's assessment represent an important safeguard of a patient liberty. Any construction of the relevant provisions by this Court will be for all time, not just for the duration of the pandemic.

42 Mr Auburn made five principal points.

43 First, the ordinary meaning of the word “examine” in a medical context is “to perform an examination of (a person or part of the body) for diagnostic purposes esp. by means of visual inspection, palpation, auscultation or percussion”: Oxford English Dictionary. This suggests an activity carried out in the physical presence of the patient. While the word “personally” might have a different meaning on its own, it is important to treat “personally examine” in s. 12(1) as a compound phrase. Read as such, there are reasons to believe that the phrase connotes the physical presence of the medical practitioner. The same goes for “personally see” in s. 11(5). More generally, in psychiatry, there are reasons why a proper examination may require physical presence. Such an examination may require the psychiatrist to read body language, discern non-verbal cues and other diagnostic aids, for example shaking or self-harming scars. Some examinations cannot be carried out remotely, for example taking a patient's blood pressure and temperature, which may be important for ruling out differential diagnoses with a better understanding a patient's mental state. Smell may be an important diagnostic tool, for example because it may suggest use of alcohol or poor personal hygiene. It may also be important to consider and test a patient's proprioception (the brain's understanding of the sense of movement and the positioning of the body in space), which would be difficult or impossible using video-conferencing facilities. Mr Auburn also drew attention to an academic article about the importance of a physical examination to rule out differential diagnoses: see Welch and Carson, ‘When psychiatric symptoms reflect medical conditions’, *Clinical Medicine* vol. 18(1), February 2018.

44 Second, there is no reason to believe that, at the time the 1959 Act or the MHA were enacted, Parliament foresaw the possibility of an examination taking place by video-conference. That being so, the use of the phrase “visit and examine” in other parts of the Act may indicate that Parliament intended there to be a requirement of physical attendance. The 2020 Act shows that, where in Parliament's view the pandemic makes it appropriate to modify the requirements of the MHA, it can and does do so. No such modification has been made in relation to subsections 11(5) or 12(1). The words “suitable manner” in s. 13(2) refer to the way the interview is conducted, not the minimum requirement of physical attendance.

45 Third, the statutory history may in fact tend against the declaration sought. The concerns which led to the use of the words “personally examine” included cases where “certificates of insanity” had been signed in blank for the proprietors of asylums to use: see McCandless, ‘Liberty and Lunacy: The Victorians and Wrongful Confinement’ in A. Scull ed. *Madhouses, Mad-doctors and Madmen: The Social History of Psychiatry in the Victorian Era* (1981), p. 346. An example, which attracted public attention at the time, was the case of *Hall v Semple* (1862) 176 ER 151, where a patient was committed to a “mad house” by a doctor who admitted that his only evidence of the plaintiff's insanity was the testimony of his wife. This suggests that the need for physical attendance may well have been as important in the minds of those who enacted the legislation as the need to avoid delegation.

- 46 Fourth, the interpretation of s. 11(5) and 12(1) must be informed by the common law principle that “a person’s physical liberty should not be curtailed or interfered with except under clear authority of law” and that in consequence “[t]he court may be expected to construe particularly strictly any statutory provision which purports to allow the deprivation of individual liberty by administrative detention”: *Bennion on Statutory Interpretation* (7<sup>th</sup> ed., 2017), §27.3. It is for this reason that “circumstances in which the mentally ill may be detained are very carefully prescribed by statute”: *Re S-C (Mental Patient: Habeas Corpus)* [1996] QB 599. This means that the court should be cautious about applying an “updating construction”. It should be borne in mind that a court “cannot construe a statute as meaning something ‘conceptually different’ from what Parliament must have intended”: *Owens v Owens* [2017] EWCA Civ 182, [2017] 4 WLR 74. He relied also on the observations of Lord Wilberforce in *Royal College of Nursing v Department of Health and Social Security* [1981] AC 800, at 822B-E, which – although part of a dissenting opinion – have subsequently been regarded as authoritative: *R (Quintavalle) v Secretary of State for Health* [2003] UKHL 13, [2005] 2 AC 561, at [10] (Lord Bingham).
- 47 Finally, Mr Auburn submitted that there was a real risk that the construction advanced by the Trust and the Secretary of State could make legitimate a very significant and permanent change in clinical practice which would allow detention in circumstances not envisaged when the MHA was enacted. It could, for example, enable the contracting out of assessments by a mental health trust to UK qualified doctors abroad or in another part of the UK far removed from the physical location of the patient. Resource pressures on the NHS are real. Once the link with the physical presence of a practitioner is broken, the possibilities for making efficiencies in a system under pressure become open-ended.

### Analysis

- 48 We begin with Lord Wilberforce’s famous statement in the *Royal College of Nursing* case of the proper approach to statutory construction in cases where technology has moved on since the date when the statute was enacted: [1981] AC 800, at 822B-E. As Mr Auburn said, this statement has since been regarded as authoritative: see *Quintavalle*, at [10]. Lord Wilberforce was considering the statutory requirements for the termination of pregnancy. He said this:

“In interpreting an Act of Parliament it is proper, and indeed necessary, to have regard to the state of affairs existing, and known by Parliament to be existing, at the time. It is a fair presumption that Parliament’s policy or intention is directed to that state of affairs. Leaving aside cases of omission by inadvertence, this being not such a case, when a new state of affairs, or a fresh set of facts bearing on policy, comes into existence, the courts have to consider whether they fall within the parliamentary intention. They may be held to do so, if they fall within the same genus of facts as those to which the expressed policy has been formulated. They may also be held to do so if there can be detected a clear purpose in the legislation which can only be fulfilled if the extension is made. How liberally these principles may be applied must depend upon the nature of the enactment, and the strictness or otherwise of the words in which it has been expressed. The courts should be less willing to extend expressed meanings if it is clear that the Act in question was designed to be restrictive or circumscribed in its operation rather than liberal

or permissive. They will be much less willing to do so where the subject matter is different in kind or dimension from that for which the legislation was passed. In any event there is one course which the courts cannot take, under the law of this country; they cannot fill gaps; they cannot by asking the question ‘What would Parliament have done in this current case—not being one in contemplation—if the facts had been before it?’ attempt themselves to supply the answer, if the answer is not to be found in the terms of the Act itself.”

- 49 In this case, the MHA was a consolidating statute, so the relevant time for ascertaining “the state of affairs existing, and known by Parliament to be existing” is 1959. It is agreed on all sides that, in 1959, there was no way of conducting a medical examination other than by means of the physical attendance of the doctor. The possibility of doing so using video-conferencing facilities would then have been regarded as the stuff of science fiction. Even in 1983, an “examination” conducted by video-conferencing could not have been contemplated by Parliament. Applying Lord Wilberforce’s test, the question is therefore whether such an “examination” falls within “the same genus of facts” as those to which the policy of the MHA is directed. Another way of putting the same question, using the words adopted by Sir James Munby in *Owens* from Lord Hoffmann’s opinion in *Birmingham City Council v Oakley* [2001] 1 AC 617, 631, is whether such an “examination” is “conceptually different” from that intended by Parliament.
- 50 Mr Cornwell suggested that the fact that subsections 11(5) and 12(1) do not use the word “visit”, whereas other parts of the MHA do use that word, shows that Parliament did not intend “personally seen” and “personally examined” to require the physical attendance of the AMHP/nearest relative or medical practitioner. We do not agree. Sometimes, the fact that Parliament uses one formula in one part of an Act and a different formula in another part shows that a different meaning was intended, but that is not invariably so. In this case, as everyone agrees, video-conferencing was not possible in 1959, or even in 1983. At those times, it would not have been possible to “examine” a patient other than by personal attendance on him or her. The same can be said, *mutatis mutandis*, of the phrase “personally seen” in s. 11(5). Although Ms Morris at one stage suggested that this latter requirement could be fulfilled by a telephone voice call, she did not advance that submission with any great enthusiasm and this was in our judgment understandable: “personally seen” must involve, at minimum, an arrangement in which the patient is visible to the person conducting the interview.
- 51 It follows, then, that the difference in the wording of the statute cannot have been intended to indicate that the interview and examination required by subsections 11(5) and 12(1) need not involve a “visit”. That is not, of itself, conclusive of the question whether they must have been intended to involve physical attendance. Whether they were so intended depends on whether, reading the statute in accordance with established canons of construction, physical attendance was part of the concepts to which the words “personally seen” and “personally examined” refer.
- 52 None of the three cases relied upon as relevant to the construction of the statute in our view assists in answering this question. In *M v South West London & St George’s Mental Health NHS Trust* there was a face-to-face interview and examination, but these took

place while the patient was feeling unwell and it was said that they were too short: see at [21]. Richards LJ said this at [26]:

“There is no set time that must be taken for an examination or interview to qualify under the statute. What is required, as with other aspects of the examination and interview, is a matter for the professional judgment of those concerned; and there is nothing in the evidence in my view to show that there was insufficient time here for a proper examination or interview to have taken place, whether one looks at the period of one-and-a-half hours stated on the form for the whole process of assessment, or the half hour for the interview itself indicated in Mr Kohli's witness statement (if its permissible to look at the statement for this limited purpose), or the shorter period suggested by the description given in the various documents.”

- 53 Thus, the proposition that what is required for a proper examination and interview is a matter for the professional judgment of those concerned related specifically to the duration of the interview and examination and the way they are conducted. Richards LJ was not saying anything, one way or the other, about the question that concerns us: whether the interview and examination can take place remotely.
- 54 Likewise, *R v Managers of South Western Hospital ex p. M* was dealing with a different question: whether the duty in s. 11(4) to consult with the nearest relative could be delegated. The answer was that this particular duty could be delegated, unlike the duty in s. 11(5) personally to see the patient. But Laws J's conclusion that this latter duty “cannot be performed through an intermediary” does not suggest that the *only* purpose of s. 11(5) was to rule out delegation of that duty. His reasoning does not bear on the issue we are now considering. The same is true of *Re Whitbread*, where the reference to the need for “recent face-to-face contact” tells us nothing about whether the contact must involve physical attendance.
- 55 Given that we do not find the case law of assistance in resolving the question of construction before us, there are six considerations which we have found of particular importance. All lead in the same direction.
- 56 **First**, subsections 11(5) and 12(1) set preconditions for the exercise of powers to deprive people of their liberty. In this country, powers to deprive people of their liberty are generally exercised by judges. It is exceptional for such powers to be exercisable by others. Where they are (i.e. where statute authorises administrative detention), the powers are to be construed “particularly strictly”: see the extract from Bennion cited above, which cites the decision of the Privy Council in *Tan Te Lam v Superintendent of Tai A Chau Detention Centre* [1997] AC 97, at 111 (Lord Browne-Wilkinson) and the decision of the Court of Appeal in *R (B) v Secretary of State for the Home Department* [2016] QB 789, at [32] (Lord Dyson MR). The question of construction with which we are now concerned must, in our view, be seen through this lens.
- 57 **Second**, we do not think it appropriate to take the compound phrases “personally seen” and “personally examined”, as used in the 1959 and 1983 Acts, and split them up, asking first what “examined” or “seen” means and then what “personally” was intended to add. We agree with Mr Auburn that this is an artificial approach which fails to capture the

true import of these compound phrases as they would have been understood in 1959 and 1983.

- 58 **Third**, the meaning of the phrases “personally seen” and “personally examined” might no doubt depend on who or what was being examined or seen. In this case, it is a patient. The concept employed by s. 12(1) is that of a medical examination, not merely a consultation. We have no doubt that Parliament in 1959 and 1983 would have understood the medical examination of a patient as necessarily involving the physical presence of the examining doctor. That is confirmed by the use of the word “visit” in other parts of the Act (in circumstances where the difference in language cannot have been intended to connote a difference in meaning). It is also confirmed by the fact that a psychiatric assessment may often depend on much more than simply listening to what the patient says. It may involve a multi-sensory assessment for the purposes summarised at para. 43 above. It may involve a physical examination in order to rule out differential diagnoses. It is no answer to say that it should be up to the examining doctor to decide when physical attendance is necessary, because without the cues that could only be picked up from a face-to-face assessment, the doctor might wrongly conclude that physical attendance was not required.
- 59 **Fourth**, although we accept that it may sometimes be appropriate to apply what has been referred to as an updating construction, we do not think that such a construction would be appropriate here. As Lord Wilberforce said in *Royal College of Nursing* case: “The courts should be less willing to extend expressed meanings if it is clear that the Act in question was designed to be restrictive or circumscribed in its operation rather than liberal or permissive”. In this case, the statutory history unearthed by Mr Cornwell shows that the words we are construing were indeed intended to be restrictive and circumscribed. They were inserted to address a particular problem in which doctors had certified patients as liable to detention without physically attending on them. Whilst it is true that part of the problem was doctors delegating their functions to others, the remedy fixed upon by Parliament was to require the examination to be carried out personally by the person whose recommendation was being relied upon. That would have been understood then, and should be understood now, as connoting the physical presence of the doctor.
- 60 **Fifth**, the fact that the Code of Practice requires physical attendance and that the Secretary of State’s Guidance makes clear that in person examinations are always preferable seem to us to show that, even today, medical examinations should ideally be carried out face-to-face. The fact that the 2020 Act made amendments to other parts of the MHA does not assist one way or the other in construing the provisions we are considering today, because the lack of amendments to subsections 11(5) and 12(1) could suggest either an assumption that those provisions already authorised interviews and examinations by video-conference or an assumption that they did not and an intention not to attenuate the requirement for physical attendance in this context. Either way, however, the 2020 amendments do show that – where Parliament considers that the pandemic necessitated amendments to the safeguards in the MHA – it is willing and able to make such amendments. The decision whether to allow the AMHP/nearest relative to see a patient and/or to allow a medical practitioner to examine a patient by video-conference (contrary to the common understanding of all concerned until the start of the current pandemic) will involve balancing two important public interests: the need to ensure that administrative deprivations of liberty are properly founded on objective

evidence and the need to maintain the system of MHA detention given the exigencies of the pandemic. In our constitution, the weighing up of competing and incommensurable public interests of this sort is for Parliament, even in times of national emergency.

- 61 The **sixth** point is related. We bear firmly in mind that the construction which we are asked by the Trust and the Secretary of State to endorse will be applicable immediately and may remain in force for some time after the end of the current pandemic. The benefit of allowing any modifications to be made by Parliament is that, if they are considered necessary, a judgment might be made not to bring them into force; and Parliament could also consider whether they should be time-limited. Both these things were done in relation to the modifications for which the 2020 Act provided. These techniques offer a tailored way of addressing a time-limited problem. They confirm our view that it is Parliament, and not the courts, that can best address the problems to which the pandemic gives rise in this area.

### **Conclusion**

- 62 For these reasons, we conclude that the phrases “personally seen” in s. 11(5) and “personally examined” in s. 12(1) require the physical attendance of the person in question on the patient. We accordingly refuse the declarations sought.
- 63 We are acutely aware of the difficulties to which the statutory provisions – as we have construed them – give rise for the Trust and for others exercising functions under the MHA. Nothing we have said should be taken as minimising those difficulties. Whether and how to address them will be for Parliament to decide.