The nurses’ power to detain informal psychiatric patients: a review of the statutory and common law provisions in England and Wales

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This paper explores the extent to which nurses can use statutory and common law provisions as lawful authority to detain informal psychiatric patients. The power of a nurse to detain informal psychiatric patients received statutory recognition for the first time in the Mental Health Act 1983. Section 5(4) of this Act, the ‘Nurses Holding Power’, provides for nurses of the ‘prescribed class’ to detain informal psychiatric patients for up to 6 hours. Further statutory authority that may be invoked with respect to the detention of patients is laid out in the Criminal Law Act (1967) and the Police and Criminal Evidence Act (1984). These statutes set out the circumstances whereby a nurse can use reasonable force to detain a patient. One of the most confusing areas in law is the extent to which common law powers can be used by nurses to detain or restrain informal psychiatric patients, including those who lack mental capacity. The detention of those patients who lack the mental capacity to express an informed desire to leave hospital has caused uncertainty and difficulties for nurses caring for them. These difficulties relate to whether it is lawful to detain and give treatment to informal patients who lack the capacity to express a choice. The principles derived from the case law are discussed in relation to detention, clinical practice and patients rights.

Keywords: nurse, law, detention, informal patients, psychiatry, mental health

STATUTORY POWERS

The Mental Health Act (1983)

The Statutory provisions for the compulsory care and treatment of mentally disordered patients in the United Kingdom are contained within the Mental Health Act (1983). Aligned with the 1983 Act is the Department of Health and Welsh Office (1999) Code of Practice in which guidelines for good practice are set out. Although these guidelines are not legally binding, failure to comply with them can be used in evidence for any legal proceedings. The 1983 Act builds on and extends the provisions of the Mental Health Act (1959), with the main objective of improving the rights of patients. This is especially the case with respect to consent to treatment and the care of mentally disordered offenders (Bluglass 1985). Although the basic structure and philosophy of the 1959 Act remains unchanged, the 1983 Act saw the introduction for the first time specific reference to the powers and duties of nurses.

The 1983 Act seeks to provide appropriate care for the mentally disordered and to safeguard those who are not mentally disordered against wrongful detention (Fennell 1996). Those people who are mentally disordered should be cared for in the least restrictive alternative setting, and informal admission to hospital, should wherever possible, be the guiding principle (Gostin 1983). No one may be detained under the Act unless he is suffering from mental disorder. Recent statistics
indicate that over 90% of patients admitted to psychiatric hospitals have an informal status (Department of Health 1998), and are this admitted without any legal formality.

The statutory provisions for informal admissions are set out in section 131 of the 1983 Act. This section states that:

“nothing in this Act shall be construed as preventing a patient who requires treatment for mental disorder from being admitted to any hospital or mental nursing home in pursuance of arrangements made in that behalf and without any application, order or direction rendering him liable to be detained under this Act, or from remaining in any hospital or mental nursing home in pursuance of such arrangements after he has ceased to be so liable to be detained.”

Patients who are admitted informally to psychiatric hospitals are not therefore subject to the statutory restrictions, which apply to detained patients, they are equivalent in law to those patients admitted to nonpsychiatric hospitals (Sugarman et al. 1995). These informal patients have two basic rights under common law which detained patients do not. They may leave hospital whenever they like, and they may refuse to accept any form of treatment which they do not want (Hoggett 1996). However, in practice should an informal patient decide to exercise this right he may well be detained by a nurse or doctor under either statutory of common law powers. This in practice the notion of informal status may be no more than a legal fiction.

**Section 5(4) of the Mental Health Act (1983) ‘Nurses Holding Power’**

The 1959 Act contained no statutory mechanism whereby a nurse could restrain an informal patient from leaving hospital in circumstances where the nurse’s clinical judgement indicated that the patient should be so detained (Fennell 1984). Hence, section 5(4) of the 1983 Act saw the introduction for the first time in law statutory powers for nurses of the ‘prescribed class’ to detain, for up to 6 hours, a patient who is receiving treatment for mental disorder as a hospital in-patient (The Mental Health (Nurses) Order 1983). For the purposes of section 5(4) of the 1983 Act a nurse of the prescribed class shall be a nurse registered in any part of the register maintained under section 7 of the Nurses, Midwives and Health Visitors Act (1997). These parts of the register are:

- part 3 (first level nurses trained in the nursing of persons suffering from mental illness);
- part 4 (second level nurses trained in the nursing of persons suffering from mental illness [England and Wales]);
- part 5 (first level nurses trained in the nursing of persons suffering from learning disabilities);
- part 6 (second level nurses trained in the nursing of persons suffering from learning disabilities [England and Wales]);
- part 13 (nurses qualified following a course of preparation in mental health nursing);
- part 14 (nurses qualified following a course of preparation in learning disabilities nursing).

This Order has extended the categories of nurse who are prescribed for the purposes of section 5(4) of 1983 Act.

**The power**

Section 5(4) of the 1983 Act, the ‘Nurses Holding Power’, provides that if in the case of a patient who is receiving treatment for mental disorder as an in patient in a hospital, it appears to a nurse of the prescribed class that the patient is suffering from a mental disorder to such a degree that it is necessary for his health or safety or for the protection of others for him to be immediately restrained from leaving hospital.
It must also appear to the nurse that it is not practicable to secure the immediate attendance of a medical practitioner who has the power to detain the patient for up to 72 hours under section 5(2) of the 1983 Act (‘Doctors Holding Power’). The nurse who invokes section 5(4) of the Act should furnish a written report to the hospital managers and in that event the patient may be detained in the hospital for a period of 6 hours or until the earlier arrival of the patients Responsible Medical Officer or his nominee who will decide whether to convert section 5(4) to section 5(2).

The Code of Practice offers guidance and sets out the circumstances in which a nurse of the prescribed class may lawfully prevent an informal in-patient, receiving medical treatment for mental disorder, from leaving hospital. It recommends that before using the power the nurse should assess the likely arrival time of the doctor as against the likely intention of the patient to leave. It suggests that most patients who express a wish to leave hospital can be persuaded to wait until a doctor arrives to discuss it further; but where this is not possible the nurse must try to predict the impact of any delay upon the patient. The Code of Practice states that the nurse should also assess the consequences of a patient leaving hospital immediately with respect to the harm that might occur to the patient or others. The assessment should precede any action, however, in acute emergencies the nurse may invoke the power without carrying out the proper assessment.

Fennell (1984) points out that section 5(4) does not apply to the situation where the patient is not intending to leave hospital but the ward staff believe his behaviour is such that seclusion from the rest of the patients is appropriate. He argues that use of seclusion in this situation would amount to detention of the patient for the period of seclusion. Therefore nursing staff need to be sure that they are acting lawfully if a charge of false imprisonment is to be avoided. There is also no right under section 5(4) to give any treatment to the patient without his consent. The power is concerned solely with restraining the patient from leaving hospital. This might give the nursing staff practical problems of patient management during the 6 hours if the patient is grossly disturbed and aggressive. However, Jones (1999) suggests that depending on the severity of the patient’s behaviour it might be possible under the doctrine of necessity to seclude or administer a short-acting sedative. This would require that the patients mental disorder precluded any rational communication with him, and a reasonable person would conclude that such action would be in the patient’s best interests (Jones 1999). In practice it is doubtful whether nurses would be prepared to administer treatment under the doctrine of necessity for fear of subsequent litigation.

The use of section 5(4) should only be an emergency measure and the nurse in charge of the ward has a duty to explain to the patient the reason section 5(4) has been used. If the patient continues to attempt to leave hospital then the nurse invoking section 5(4) may use the minimum force necessary to prevent the patient from leaving.

The provision of section 5(4) was included in the 1983 Act largely as a response to the anxieties and uncertainties experienced by nursing staff when they were required to deal with uncooperative and often aggressive informal patients in the absence of the Responsible Medical Officer. These legal uncertainties were highlighted by the trade union, the Confederation of Health Service Employees (1977); which stated that whilst the law probably permitted staff to restrain informal patients in an emergency their power to deal with potential emergencies was not clear. Section 5(4) of the 1983 Act could therefore be viewed as an attempt to clarify the legal position of nurses when dealing with a psychiatric emergency.

Nolan (1996) offers an alternative view stating that the Government’s apparent recognition of the authority and status of the mental health nurse by the introduction of this statutory power has been resource driven. He argues that the introduction of the ‘Nurses Holding Power’ was at least partly due to a cost-cutting initiative; in that the 1983 Act under Section 5(4) devolved power to a professional group within the mental health service who were less highly paid and therefore more
cost effective than doctors. Bean (1986) suggests that this new power was not really necessary, arguing that existing medical powers and common law provides for the physical restraint of patients. He goes further by suggesting that this particular holding power has created a dangerous precedent which may adversely affect the therapeutic relationship between the nurse and patient. He views the effect of this power as an unjustified addition of yet another occupational group to those already given the powers of detention.

Although the Code of Practice recommends that a suitably qualified nurse should be on all wards where there is a possibility of section 5(4) being invoked this is not necessarily the case in practice. Furthermore, while the Code of Practice states that it is desirable that a nurse who invokes the power should be qualified in the speciality relevant to the patient’s condition it points out that the legislation does not require this. Thus, nurses from other wards and specialities may be called upon to invoke section 5(4) for patients they do not know and where the clinical details are unfamiliar. Where this may be the case the Code of Practice suggests that employers arrange suitable post-basic education and training, especially in the use of section 5(4). Again in practice this is seldom provided.

Risk assessment
Both the 1983 Act and the Code of Practice emphasize the importance of effective risk assessment of the patient by the nurse before invoking section 5(4). The Department of Health (1988) statistics indicate that the number of times section 5(4) has been used in National Health Service and private facilities in England is relatively small. The ‘Nurses Holding Power’ was invoked 1526 times from 1996 to 1997 compared to 10 545 times for section 5(2) ‘Doctors Holding Power’ for the same period.

Harrison (1997) has suggested that these data may reflect reluctance on the part of nurses to use section 5(4); and that this could be a result of inadequate knowledge with respect to the power and limited risk assessment skills on the part of nurses. Ward (1991) in a study of nurses knowledge levels found that some nurses believed they should be instructed by a doctor to invoke the section, others were unaware of how long the section lasted or when it commences and terminates. Brown (1991) also suggests that nurses knowledge of section 5(4) is patchy and inconsistent.

Bowler and Cooper (1993) in an audit of the use of section 5(4) in a psychiatric unit found that nurses felt uncomfortable with the power, and preferred still to use the powers of persuasion and common law for detention until the arrival of the doctor. This concurred with findings by Allen and Johnstone (1992) who report that over a quarter of nurses questioned admitted using restraint to detain a patient without implementing section 5(4). Notwithstanding this Bowler and Cooper (1993) report that when section 5(4) was used the conversion rate to section 5(2) was 85%. This suggests that when nurses did use section 5(4) this was the appropriate course of action in the vast majority of cases. The audit stresses that the assessment of risk at the time of the emergency is of paramount importance. It is therefore vital that both pre- and postregistered nurses receive adequate training in the assessment of risk.

Although section 5(4) provides a statutory basis for restricting a patient’s liberty, nurses are accountable for their own actions as practitioners and as such must justify formally any detention of a patient. Nurses are bound by their duty of care at act in the best interests of the patient, this is especially important as a patient detained under section 5(4) has no legal right to appeal against that decision.

The decision of when to invoke section 5(4) relies on the professional judgement of the nurse who cannot be instructed to exercise this power by anyone else. However, these powers under the 1983
Act appear to be discretionary. The law has left the decision as to when to invoke section 5(4) up to individual nurses whose knowledge and risk assessment skills may vary. This creates the possibility for a wide range of circumstances in which section 5(4) may be applied depending on the approach taken by the individual nurse. In addition to the powers of detention contained in within the provisions of the 1983 Act nurses can also find statutory authority to detain informal patients under the Criminal Law Act (1967) and the Police and Criminal Evidence Act (1984).

Criminal Law Act (1967)
Under section 3(1) of the Criminal Law Act (1967) a person may use such force as is reasonable in the circumstances in the prevention of crime, or in affecting or assisting the lawful arrest of offenders or suspected offenders or persons unlawfully at large. This provision enables a member of the nursing staff to use reasonable force in an attempt to prevent a patient from committing an assault or any other criminal offence (Dimond 1998). This may include physical restraint or seclusion of the patient (Fennell 1984). Both these authors note that this power does not apply where the patient is insane within the mean of the rules laid out in R v. McNaghten (1843), because in theory at least, such a patient is not capable of committing a crime. The McNaghten rules apply where, at the time of the act, the patient was labouring under such a defect of reason, from disease of the mind, so as not to know it was wrong. Importantly, nursing staff are not required to make this assessment at the time of the incident by virtue of the fact that reasonable force can be used in self-defence or for the defence of others (Fennell 1984).

The Police and Criminal Evidence Act (1984)
Under the Police and Criminal Evidence Act (1984) section 24(4) a person, which would include a nurse, has the power to arrest without warrant anyone who is in the act of committing an arrestable offence or anyone who has reasonable grounds for suspecting someone to be committing such an offence. The Police and Criminal Evidence Act (1984) section 24(5) enables a person to arrest without warrant, where an arrestable offence has been committed, any person who is guilty or whom he has reasonable grounds for suspecting is guilty. Dimond (1998) suggests that there statutory provisions would cover most situations where nurses are required to take action to prevent harm arising.

COMMON LAW POWERS OF DETENTION
Perhaps one of the most confusing areas in law is the extent to which common law powers can be used by nurses to detain or restrain informal psychiatric patients including those who lack mental capacity. The main legislative provision covering the care of mentally disordered people remains the 1983 Act. However, patients informally admitted to psychiatric facilities in England and Wales are not subject to the statutory restrictions which apply to detained patients. These informal patients have two basic rights: to refuse some or all of their treatment and to leave hospital if they wish (Hoggett 1996). They are equivalent in law, to those patients admitted to nonpsychiatric hospitals (Sugarman et al. 1995). These rights are not set out in statute but have taken root in the common law and stem from the ethical principles of an individuals right of personal autonomy and self determination [Shloendorff v. New York Hospitals (1914); Re T (1992); Airedale National Health Service Trust v. Bland (1993)]. However, should an informal patient try to exercise these rights he may well be liable to be detained under the common law in a situation where the nurse considers there are justifiable grounds to do so.

In Poutney v. Griffiths (1975) it was established that staff in psychiatric hospitals have a general ‘right of control’ over mentally disordered patients in their care. However, because there is no case law that deals specifically with this issue, the extent to which this ‘right of control’ may be applied
remains unclear. Although it is implied in this case that the right of control would be much less extensive where the patient is informal.

A nurse may also detain an informal patient where there is a risk of a breach of the peace. The common law authority to detain an informal patient until a risk of a breach of the peace has passed is laid out in the case of Albert v. Lavin (1982). In this case the House of Lords held that:

“every citizen in whose presence a breach of the peace is being, or reasonably appears to be about to be committed has the right to take reasonable steps to make the person who is breaking or threatening to break the peace refrain from doing so; and these reasonable steps in an appropriate case include detaining him against his will.”

A breach of the peace occurs not only when harm is actually or likely to be done but also where a person is in fear of being harmed. Thus, where a nurse has reasonable grounds to believe that a breach of the peace is likely, and where it is reasonable to do so, the patient may be detained without arrest until the risk has passed (Fennell 1984).

The Scottish courts in Black v. Forsey (1987), a case under the Mental Health (Scotland) Act (1984), took a fully confirmatory view. It was held in this case that the common law confers upon a private individual power to detain, in a situation of necessity, a person of unsound mind who is a danger to himself or others. Should a nurse exercise this power he must be able to justify the action, which would require proving the mental disorder of the detained patient and the necessity of the detention (Jones 1999). Lord Griffiths stated that the power:

“is confined to imposing temporary restraint on a lunatic who has run amok and is a manifest danger either to himself or to others. Such a common law power is confined to the short period of confinement necessary before the lunatic can be handed over to a proper authority.”

**De facto detention of informal patients**

Fennell (1992) argues that the rights these informal patients have may not exist in reality for certain patients. He suggests that ‘for many, especially confused elderly or profoundly learning disabled people, these rights remains purely theoretical since there is nowhere else for them to go and because they lack the capacity to express and informed desire to leave hospital’ (Fennell 1992 p.314). This aspect of practice has caused uncertainty and difficulties for nurses caring for these patients with respect to whether it is lawful to detain and give treatment to informal patients who lack the capacity to express a choice. It is not uncommon for these patients to be nursed on a locked ward and to be given medication without their informed consent. While the Code of Practice suggests caution in the use of combination locks and double-handled doors to prevent elderly mentally disordered patients from wandering; it also states that patients who are not deliberately trying to leave the ward, but who may wander out accidentally may legitimately be deterred from leaving the ward by those devices. Therefore these patients while not detained in law are detained in fact. Tingle and Cribb (1995) suggest the extent to which this advice falls within the existing law is a matter of debate. Restricting a person’s freedom is false imprisonment, but certain restrictions are permissible. As the nurse owes a patient in these instances a duty of care, it would be appropriate for the nurse to determine that there is no false imprisonment where the patient is unthinkingly trying to leave. But where the patient is making a purposeful desire to leave the ward prevention without statutory authority may not be lawful (Tingle & Cribb 1995).

Jones (1999) states that the Mental Health Act Commission are frequently asked whether elderly patients who lack capacity to make reasoned judgements should be detained for care and treatment under the 1983 Act or can they be admitted and cared for informally. He goes on to suggest that there is no hard and fast rule and that each case should be considered on its own merits.
The confusion in this difficult area has recently been highlighted in the judgement by the Court of Appeal in R v. Bournewood Mental Health NHS Trust ex parte L (1998a) (which was subsequently overruled by the House of Lords). The facts of this case are that L is 48 years old and suffers from autism. This has caused him to be unable to speak and to have complex needs requiring 24-hour care. On one occasion at the day centre which he attended, L became agitated. His family could not be contacted so the general practitioner attended and prescribed a sedative for L. The Social Services care staff recommended admission to the accident and emergency department at Bournewood Hospital. At the accident and emergency department L became increasingly agitated and was admitted informally to the Mental Health Behavioural Unit at the hospital where he remained. L had no ability to communicate assent or dissent to treatment and was denied contact with the family who were caring for him. He was unable to express preference to residing at one place or another and unable to express assent or dissent to detention. L sought judicial review of the decisions of the Trust to admit him informally and to detain him in hospital, a declaration that the Trusts detention was unlawful and mandamus requiring the Trust to release him forthwith. Damages for false imprisonment and assault were also claimed.

At first instance Owen J dismissed the application for judicial review on the grounds that L was not detained. The view was taken that he could be admitted as an informal patient and that he did not need to be detained under the 1983 Act. The Clinical Director of Learning Disabilities confirmed that if he had resisted admission, he would certainly have detained him under the 1983 Act but he did not consider this necessary. L co-operated with treatment, and where he showed any signs of distress in relation to particular assessments, then these assessments were postponed and reviewed. He could not communicate distress to particular forms of treatment.

This decision was overruled by the Court of Appeal which considered several issues. These were whether L was detained, and if so, could his detention be justified by the common law doctrine of necessity, and if not what was the appropriate relief that the court should grant. Central to the issue was the contention of the hospital that the 1983 Act left untouched the hospitals entitlement to admit and treat patients in accordance with common law.

In deciding the status of the L the Court of Appeal agreed that he was one of those severely disabled patients, who were unable to exercise any genuine choice, but do not exhibit active dissent which provokes professionals to invoke the compulsory procedures.

The findings of the Court of Appeal were that they considered that a person is detained in law if those who have control over the premises in which he is have the intention that he shall not be permitted to leave those premises and have the ability to prevent him from leaving.

The Court of Appeal stated that the right of a hospital to detain a patient for treatment for a mental disorder is to be found in, and only in, the Mental Health Act (1983), whose provisions apply to the exclusion of the common law doctrine of necessity. However, Fennell (1998) points out that section 131 of the 1983 Act, which preserved the right to admit a patient informally, addresses only the position of a patient who is admitted and treated with consent. It was held that the Trust had admitted L and was detaining him for treatment for a mental disorder without his consent and without the formalities required by the 1983 Act. It was a false premise of the Trust to believe they were entitled to treat L as an inpatient without his consent as long as he did not dissent. The Court concluded that it followed that the Trust had acted and were acting unlawfully.

The Court clarified that the common law powers of necessity can be extended by an individual to protect someone who is ill, whether his illness is due to physical or mental causes. But, where the 1983 Act covers the situation, no necessity to act outside statute can arise. The Trust’s powers to
act under the common law doctrine of necessity can arise only in relation to situations not catered for by the 1983 Act.

In summary, if a Trust wished to treat a patient, who lacks capacity, for a mental disorder then it must apply the provisions of the 1983 Act and give the patient the various protections which arise under this Act. The effect of the Court of Appeals judgement would have been that large numbers of psychiatric patients who would formerly not have to be compulsory detained under the 1983 Act would have to be so detained.

The House of Lords in R v Bournewood Community & Mental Health NHS Trust ex parte L (1998b) in overruling of the Court of appeals ruling held that, whether or not L had been detained, his admission and retention by the trust was justified at the common law on grounds of necessity. It was held that the Court of Appeal had erred in finding that L was detained as he had made no attempt to leave and had been accommodated on an unlocked ward. It could not therefore be said that he had actually been deprived of his liberty (cited in Fennell 1998). Thus, it has been established that patients admitted informally who lack the capacity to consent or dissent can be detained and treated in hospital, and that the treatment can be justified on the basis of the common law doctrine of necessity.

CONCLUSION
The statutory powers by which a nurse can detain informal psychiatric patients are reasonably well defined in the appropriate legislation. However, the circumstances in which these powers would be invoked remains open to interpretation.

The more difficult area concerning the extent to which common law provisions can be invoked has been resolved, for the time being at least, by the landmark ruling in the Bournewood case (the case may go to appeal at the European Court of Human Rights). As a result of the decision in R v Bournewood Community and Mental Health NHS Trust ex parte L (1998b), common law powers can be used by nurses to detain and provide care, without consent, for patients who lack mental capacity. Thus, in common law a nurse is entitled to apprehend and restrain a person who is mentally disordered where there is a serious risk to the health or safety of the patient or to the safety of others. Also, incapacitated patients can be admitted outside the Act where the requirements of the common law principles of necessity are satisfied. The degree of medical or physical intervention used should be the minimum necessary to bring the emergency to an end. The requirements of these principles are identified by Dimond (1998) as: (i) where there is a necessity to act when it is not practicable to communicate with the patient; and (ii) the action taken must be such as a reasonable person would in all the circumstances take, acting in the best interests of the patient.

Nevertheless, the Mental Health Act Commission continues to express concerns about the lack of statutory rights that these patients have. The Mental Health Act Commission has in the past suggested that their remit should be extended to include the review of informal patients. In addressing these concerns the House of Lords in the Bournewood case stated that under section 121(4) of the 1983 Act the Mental Health Act Commissioners have the power to review the care and treatment of these patients.

The implementation of this power is currently under review by the Secretary of State.

Dimond (1998) argues that the situation remains extremely unsatisfactory and that the use of common law powers to detain patients should only be seen as a temporary measure. She suggests that to rely on a decision of the House of Lords rather than have an act of parliament which sets out the parameters of the law is unacceptable. Sugarman et al. (1995) concur with this view stating that
the situation of informal psychiatric patients in England and Wales is cause for concern. They stress that the basic right to treatment and detention by consent should be set out in statute.

Hopes that the Governments recent ‘root and branch’ review of the current mental health legislation may have taken cognisance of these concerns are fading. Whilst the Department of Health’s (1999) Richardson committee addressed this issue and made some recommendations for an appropriate framework, the Department of Health’s (1999) subsequent Green Paper has not. The Green Paper makes no commitment to introduce the essential statutory framework to resolve the Bournewood problem (Peay 2000). Furthermore, the Green Paper seeks to broaden the definition of mental disorder, increase the length of time a patient may be detained under the ‘Nurses Holding Power’, and introduce more extensive powers of compulsory treatment in the community than was recommended by the Richardson committee. These changes if enacted in a new mental health act may well be considered a further erosion of patient autonomy and serve to reinforce the view that the psychiatric nurses role is becoming primarily concerned with risk assessment at the expense of therapeutic interventions and relationships.

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