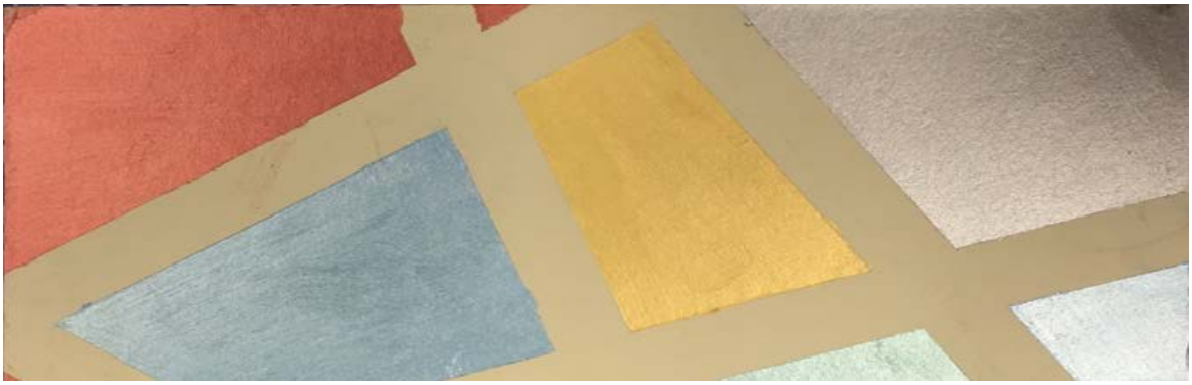
MENTAL HEALTH MATTERS
October 2024 | Issue 144



Welcome to the October 2024 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: what to do where there is no reliable evidence of P's wishes and feelings;

(2) In the Property and Affairs Report: gifts, attorneys and deputies;

(3) In the Practice and Procedure Report: the perfect as the enemy of the good, and what to do when the situation changes;

(4) In the Mental Health Matters Report: the human rights consequences of outsourcing in the mental health context;

(5) In the Wider Context Report: the Law Commission consults on disabled children's social care law and the Grand Chamber of the European Court of Human Rights balances Articles 2 and 8 in the medical treatment context ;

(6) In the Scotland Report: AWI legislative reform on the cards?

There is one plug this month, for a free digital trial of the newly relaunched Court of Protection Law Reports (now published by Butterworths. For a walkthrough of one of the reports, see here.

You can find our past issues, our case summaries, and more on our dedicated sub-site here, where you can also sign up to the Mental Capacity Report.

The picture at the top, "*Colourful*," is by Geoffrey Files, a young autistic man. We are very grateful to him and his family for permission to use his artwork.

Contents

Mental Health Act Statistics, Annual Figures

NHS Digital has published the 2023-2024 Annual Mental Health Act Statistics. The report notes issues with the data provided, including that not all providers submitted information, and there were issues in data quality with some of the providers which did submit information. The report summarises the following 'key facts':

> *52,458 new detentions under the Mental Health Act were recorded, but the overall national totals will be higher. Not all providers submitted data, and some submitted incomplete data* […] *we estimate there was an increase in detentions of 2.5 per cent from last year.* […] *Known detention rates were higher for males (91.4 per 100,000 population) than females (83 per 100,000 population).* [….] *Amongst adults, detention rates tend to decline with age. Known detention rates for the 18 to 34 age group (135.9 detentions per 100,000 population) were around 62% higher than for those aged 65+ (83.8 per 100,000 population).*

Detentions were slightly higher for men than women (91.4 vs 83 detentions per 100,000 population), but there are significant racial disparities in rates of detention per 100,000 population:

White	68.4
Asian or Asian British	82.5
Gypsy or Irish Traveller	93.5
Mixed race	177.1
Black or Black British	242.3

There were also significant disparities in rates of detention for ICB regions, with the NHS Somerset ICB region having rates of detention at 31.2 per 100,000 population, and NHS North Central London ICB having rates of 158.5 per 100,000; this is perhaps unsurprising given the data on rates of detention steadily rising with levels of deprivation in an area:

01 Least deprived	43.4
02 Less deprived	49.9
03 Less deprived	54.9
04 Less deprived	60.0
05 Less deprived	74.4
06 More deprived	84.0
07 More deprived	100.1
08 More deprived	124.2
09 More deprived	137.2
10 Most deprived	151.3

Whilst we wait for further news as to whether and how Mental Health Act reform is to be

progressed, some might find of interest this discussion Alex had with Colleen Simon and John Mitchell about a recently published discussion paper about the ways in which Approved Mental Health Professionals ('AMHPs') undertake their statutory role of 'considering' patient's cases under s.13 MHA 1983, and why it is dangerous to think of an 'MHA assessment' as a single event.

Separately, the Home Office has published data from 43 of the 44 police forces in England and Wales, showing that there were 31,213 instances in the year to 31 March 2024 when the police used their powers under s.136 MHA 1983 to remove someone from a public place to a place of safety. This was a 10% drop from the 34,685 in the year to 31 March 2024. Community Care reports that the National Police Chiefs' Council suggests that the drop in the use of s.136 was partially attributable to the introduction of the Right Care, Right Person policy by forces across England and Wales. However, Community Care also reports that the chairs of the Approved Mental Health Professional Leads Network as saying that "though the decrease in s136 usage may be related to the RCRP, drawing definitive conclusions—beyond anecdotal evidence—is challenging". Michael Brown's post on the topic on the Mental Health Cop website also poses some interesting and challenging questions about the data.

Outsourcing and the Human Rights Act 1998 – the consequences

Sammut v Next Steps Mental Healthcare Ltd [2024] EWHC 2265 (KB) (High Court (KBD) (HHJ Bird sitting as a High Court Judge))

Other proceedings – civil

Summar

Without straying into politics, is a case which demonstrates the consequences of the fact that much state-funded care – including coercive mental health care – is now delivered privately. It concerns a man, Paul Sammut, who had what was described as a chronic, enduring and treatment resistant schizophrenia. For large parts of his adult life, he was detained under s.3 Mental Health Act 1983. As HHJ Bird (sitting as a High Court judge) identified at paragraph 2 of his judgment:

> *[…] On 26th February 2018, following a best interests review, he moved from a secure hospital to facility operated by the first Defendant [a private healthcare company, the care being funded jointly by health bodies and a local authority under s.117 MHA 1983.*[1]
> *2. Whilst resident at the facility, Paul was treated as a person subject to deprivation of liberty safeguards. In fact, although he was deprived of his liberty, save for a very short period when he first moved in, the deprivation was at no time authorised.* [it appears, although the judgment is less than clear on this point, that the provider sought an authorisation but it was not considered in a timely fashion by the relevant local authority].
>
> *3. Paul died on 20th April 2019. The medical cause of death was found, following an inquest, to be broncopneumonia, large intestinal obstruction and faecal impaction related to the side effects of Clozapine (an*

[1] The reference in the judgment to care being funded under s.75 Care Act 2014 is confusing, because s.75 does not relate to funding, but rather to the amendments to s.117 MHA 1983 introduced by the Care Act. It must have been the case that Mr Sammut was only being provided with care funded under s.117 MHA 1983 because, had his case been funded by the local authority under the Care Act 2014, s.73 Care Act 2014 would have been engaged.

atypical anti-psychotic used to deal with the effects of schizophrenia).

Mr Sammut's estate brought a claim against the private healthcare company and the NHS Trust responsible for his care for damages for clinical negligence and for false imprisonment. Each of the claimants brings a claim pursuant to sections 6 and 7 of the Human Rights Act 1998 in respect of each defendant relying on breaches of Article 2, Article 3, Article 5, and Article 8.

The care provider sought to strike out the claim and /or to have summary judgment granted in its favour on the basis that it was not a public authority and so no remedy could be granted under the HRA 1998. Alternatively, it submitted, Article 2 ECHR was not engaged on the facts of Mr Sammut's case.

It was common ground that the private healthcare company was not a core public authority for purposes of the HRA 1998. It was also common ground that he could not benefit from the provisions of s.73 Care Act 2014, as he was not being provided with the care under the 'right' funding arrangements so as to deem the activities of the care provider to be a public function. The key question, therefore, was whether the functions being carried out by it were of a public nature.

In answering this question, HHJ Bird had little truck with the Form 3 completed as part of the DoLS assessment process which had identified that placement was imputable to the State, on the basis (1) that the care was funded under s.117 MHA1983; and (2) that the provider was regulated by the CQC, a state authority. HHJ Bird identified that the question of imputation arose when considering deprivation of liberty, but that this was a different issue to whether the provider's functions were of a public nature.

HHJ Bird therefore directed himself by reference to the decision of the House of Lords in *YL v Birmingham City Council and others* [2007] UKHL 27 and had little hesitation in finding that, applying *YL*:

> *50. In my judgment it is clear that the first Defendant's functions were entirely private and (as in YL) it was simply carrying business (which happened to have – at least in the abstract – some social utility) for a profit.*

In reaching this conclusion, HHJ Bird found that:

> *51. The absence of any special statutory power is an important factor. In order to deal with that absence, the Claimants submitted, in effect, that the court should treat the first Defendant as a body with special statutory powers, in particular powers to deprive Paul of his liberty. The submission was based on the fact that the first Defendant appeared to believe that it had those powers and perhaps on the basis that a knowledgeable observer would know that the only lawful way to do what was being done was through the exercise of such a power.*
>
> *52. I am unable to accept that submission for the following reasons:*
>
> > *a. As a matter of fact, the first Defendant did not have any relevant statutory power. The outcome of the inquiry is binary: there is either a power or there is not.*
> >
> > *b. The estate's claim for false imprisonment relies on the absence of a statutory right to detain (summarised at paragraph 7 of the PAPoC). The assertion that I should treat the first as acting under a statutory authority contradicts that position and would create an*

> *inappropriate internal tension in the PAPoC.*
>
> *c. The argument that the first Defendant (in effect) should not be heard to deny that it was acting under a statutory authority was not directly advanced but is the natural conclusion of the Claimants' position. In my view the argument is untenable for the reasons set out above.*

HHJ Bird therefore struck the claim out, but identified that he would in any event grant the care provider summary judgment. He then went, on in the alternative, to conclude that Article 2 was not engaged on the facts of the present case, basing himself on the decision of the Supreme Court in *R (Maguire) v HM Senior Coroner for Blackpool and Fylde* [2023] UKSC 20. He noted that:

> *66. It is in my judgement clear that the claimants pleaded case in respect of Article 2 is not sufficient to engage Article 2. First, there is no assertion that Paul's life was "knowingly put in danger by denial of access to treatment". There is no sense that the medical practitioners were fully aware that his life was at risk if treatment was not given and, even in the face of such knowledge, denied him that treatment. The "denial" referred to in argument is on its own insufficient to engage Art.2. It is no more than an allegation of (very serious) clinical negligence. It follows that the first type of exceptional circumstance that would justify engagement of Art.2, is absent. Secondly, there is no plea of dysfunction which is "genuinely identifiable as systemic". The pleaded failure to "establish, maintain and apply procedures" is a plain reference to something going wrong or functioning badly not as a result of systemic failures, but as a result of clinical negligence. The remaining particulars simply go to emphasise the seriousness of the clinical negligence claim.*
>
> *67. I am therefore satisfied that, had I not decided the first Defendant was not a public authority, it would have been right to strike out the Article 2 claim pleaded against the first defendant.*
>
> *68. I am satisfied, on the proper application of McGuire, that it would be inappropriate (and wrong in law) to allow the matter to proceed on the basis, as suggested in the skeleton argument, that "recklessness" as to the risk to life as a result of denial of treatment would be sufficient to engage Art.2. It is the need for "full awareness" that elevates the matter above the realm of clinical negligence. It is therefore plainly, a necessary element if the first exceptional circumstance is to be made out.*

Comment

It is important to note that the decision of HHJ Bird did not mean that the estate has no claim against the care provider – the strike out / summary judgment application related solely to the HRA claim against the care provider, not the clinical negligence claim advanced. The decision also did not address the HRA claims against the NHS Trust, pleaded on the basis of breaches of Articles 2, 3, 5 and 8 ECHR.

The judgment does, however, reinforce how limited the HRA is as a tool in respect of 'outsourced' care. Mr Sammut's case was arranged and paid for by the state, and, for purposes of Article 5 ECHR, his confinement was unquestionably attributable to the

State.[2] Staying with deprivation of liberty for a moment, Mr Sammut was, on the face of the judgment, confined in a locked door environment with a secure perimeter fence. Logically, this must have meant that the care provider could not provide him with the care and treatment he required without confining him. To comply with its obligations under Regulation 13 of the Regulated Activities 2008, the care provider could not deprive him of his liberty at the unit "without lawful authority." Some might feel that the difference between a situation where a person has a statutory power to detain and a position where a person cannot carry out a task that they are being commissioned to do without lawful authority is a distinction without an immediately obvious material difference when deciding if they fall within the scope of the HRA.[3]

Had Mr Sammut's care been funded under the Care Act 2014, s.73 of the Care Act 2014 would have applied to deem the care provider a public authority. But the local authority's funding obligation arose under s.117 MHA 1983, so s.73 was not engaged (nor, we note, would it have been engaged had his care been commissioned entirely by the NHS). On the face of the judgment, there is nothing to suggest that the nature of the (coercive) care that he received was any different to that which would have provided had the care been funded under the Care Act. In consequence of that might be thought, by some, to be a funding fluke, Mr Sammut's estate (and, were he still to be alive, Mr Sammut himself) had no direct recourse against the care provider under the HRA. The Law Commission pointed out the anomalous position as regards rights protection to which this gave rise in the context of deprivation of liberty.[4] The Joint Committee on Human Rights has done the same in relation to the ECHR more widely,[5] but to date there has been no appetite to remedy this. In the meantime, the HRA provides a direct remedy in relation to private care providers in respect of far fewer situations than many might anticipate.

[2] HHJ Bird's observations about this were perhaps expressed in rather too tentative terms, given the clear Supreme Court authority in *Re D* (see paragraph 43) as well as *Cheshire West* about the operation of state imputability for confinements being carried out by private persons. For what it is worth, Mr Sammut would also undoubtedly be considered to have been deprived of his liberty for purposes of the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment: see the July 2024 General Comment of the OPCAT Committee on Article 4 of OPCAT.

[3] It so happens that, in this case, the care provider did take steps to seek such authority, albeit that, pending the completion of the DoLS authorisation process, was both breaching its regulatory obligations under the Regulated Activities Regulations and unlawfully depriving him of his liberty.

[4] See paragraphs 15.41 to 15.50 of its report on Mental Capacity and Deprivation of Liberty. Full disclosure, Alex was a consultant to the project.

[5] See paragraphs 85 to 93 of its report on human rights in care settings. Full disclosure, Alex was the specialist adviser to the Committee

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Conferences

Members of the Court of Protection team regularly present at seminars and webinars arranged both by Chambers and by others.

Alex is also doing a regular series of 'shedinars,' including capacity fundamentals and 'in conversation with' those who can bring light to bear upon capacity in practice. They can be found on his website.

Adrian will be speaking at the European Law Institute Annual Conference in Dublin (10 October, details here).

Peter Edwards Law have announced their autumn online courses, including, Becoming a Mental Health Act Administrator – The Basics; Introduction to the Mental Health Act, Code and Tribunals; Introduction – MCA and Deprivation of Liberty; Introduction to using Court of Protection including s. 21A Appeals; Masterclass for Mental Health Act Administrators; Mental Health Act Masterclass; and Court of Protection / MCA Masterclass. For more details and to book, see here.

Advertising conferences and training events

If you would like your conference or training event to be included in this section in a subsequent issue, please contact one of the editors. Save for those conferences or training events that are run by non-profit bodies, we would invite a donation of £200 to be made to the dementia charity My Life Films in return for postings for English and Welsh events. For Scottish events, we are inviting donations to Alzheimer Scotland Action on Dementia.

Our next edition will be out in November. Please email us with any judgments or other news items which you think should be included. If you do not wish to receive this Report in the future please contact: marketing@39essex.com.

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