MENTAL CAPACITY REPORT: THE WIDER CONTEXT

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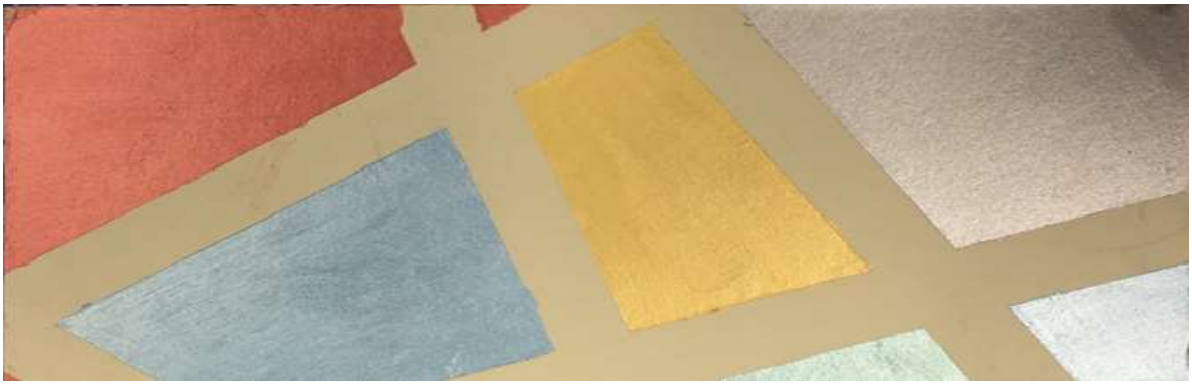

Welcome to the April 2020 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: the DHSC emergency guidance on MCA and DoLS, the Court of Protection on contact and COVID-19, treatment escalation and best interests, and capacity under the microscope in three complex cases;

(2) In the Property and Affairs Report: the Golden Rule in (in)action and the OPG's 'rapid response' search facility for NHS and social care staff to access the register of deputies / attorneys;

(3) In the Practice and Procedure Report: the Court of Protection adapting to COVID-19 and an important decision on the s.48 threshold;

(4) In the Wider Context Report: COVID-19 and the MCA capacity resources, guidance on SEND, social care and the MHA 1983 post the Coronavirus Act 2020, dialysis at the intersection between the MHA and the MCA and an important report on the international protection of adults;

(5) In the Scotland Report: the response of the legal community to AWI law and practice under COVID-19, and an update from the Mental Health Law Review.

You can find our past issues, our case summaries, and more on our dedicated sub-site here. Chambers has also created a dedicated COVID-19 page with resources, seminars, and more, here.

If you want more information on the Convention on the Rights of Persons with Disabilities, which we frequently refer to in this Report, we suggest you go to the Small Places website run by Lucy Series of Cardiff University.

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

Contents

The MCA and COVID-19

Alex has set up a resources page on his website for the MCA and COVID-19, gathering guidance and practical resources. The resources page also includes a link to a recording of the first rapid response webinar held by the National Mental Capacity Forum on 1 April, at which Alex spoke; a second webinar will be held on 28 April 2020.

The impact of the Coronavirus Act 2020

We have produced a guidance note addressing the impact of the Act upon social care and SEND, available here. We have also produced a rapid response guidance note addressing the impact of the changes to the MHA 1983 (which have yet to be brought into force), available here.

Short Note: hospitals, scarce resources and human rights

In a decision handed down on 9 April 2020, Chamberlain J gave some important observations about the lawfulness of the allocation of scarce hospital resources in *University College London Hospitals NHS Foundation Trust v MB* [2020] 882 (QB).

The case arose because the Trust sought possession of a bedroom from a woman called MB in a hospital that it runs (where she had been since February 2019), on an urgent basis: "*because the COVID-19 pandemic meant that the bedroom is urgently needed for other patients; and because in any event it is contrary to MB's interests to remain in the Hospital, where she is at increased risk of contracting COVID-19.*" The Trust, the claimant, contended that the woman could be safely discharged to specially adapted accommodation provided by the local authority, with a care package, which the Trust considered more than adequate to meet her clinical and other needs. Chamberlain J had to decide

whether to grant the Trust an injunction on an interim basis to require MB to leave the hospital.

The facts of the case, and in particular MB's medical history, are complex, and we do not set them out here. For present purposes, it is of importance that MB did not seek to defend the claim on the basis that it was irrational of the Trust to cease to provide her with inpatient care, and hence to require her to leave (and the judge held that any such contention would be unsustainable).

Rather, MB argued that requiring her to leave would breach her rights under Article 3 and Article 8 ECHR (read independently, and together with Article 14), as well as amounting to breaches of the Equality Act 2010. Chamberlain J started with Article 3 ECHR:

> *So far as Article 3 ECHR is concerned, Mr Holland's submissions amount to this: if it can be established that, unless her concerns are addressed, discharge will precipitate suicide, self-harm or extreme distress rising to the level of severity necessary to qualify as inhuman or degrading treatment within the meaning of Article 3 ECHR, the Hospital is legally precluded from discharging her until those concerns are met, even if her concerns are, from an objective clinical point of view, unreasonable and unwarranted. I cannot accept that proposition.*

The reasons Chamberlain J gave for rejecting her contention are important, and merit setting out largely in full:

> *54 It is a tragic feature of MB's complex constellation of mental health difficulties that she frequently suffers from extreme distress, whether she is in hospital or not. But, if the Hospital were precluded from doing anything which might precipitate such distress, it would soon end up in a situation where it was legally precluded from taking any step other than in accordance with MB's wishes. In this case, MB would be entitled to insist on the provision of whatever she considers she needs as a condition of discharge from hospital, even if the result of her doing so were that the needs of others could not be met. That is not the law, because her needs are not the only ones that the law regards as relevant.*
>
> *55 In some circumstances, a hospital may have to decide which of two patients, A or B, has a better claim to a bed, or a better claim to a bed in a particular unit, even ceasing to provide in-patient care to one of them to leave will certainly cause extreme distress or will give rise to significant risks to that patient's health or even life. A hospital which in those circumstances determines rationally, and in accordance with a lawful policy, that A's clinical need is greater than B's, or that A would derive greater clinical benefit from the bed than B, is not precluded by Article 3 ECHR from declining to offer in-patient care to B. This is because in-patient care is a scarce resource and, as Auld LJ put it in R v North West Lancashire Health Authority ex p. A [2000] 1 WLR 977, at 996, "[i]t is plain… that article 3 was not designed for circumstances… where the challenge is as to a health authority's allocation of finite funds between competing demands". Decisions taken by a health authority on the basis of finite funds are, in my judgment, no different in principle from those taken by a hospital on the basis of finite resources of other kinds. In each case a choice has to be made and,*

in making it, it is necessary to consider the needs of more than one person.

56 The present situation does not involve a comparison of the needs of two identified patients. But the decision to withdraw permission for MB to remain in the Hospital is still a decision about the allocation of scarce public resources. Decisions of this kind are a routine feature of the work of hospitals and local authorities, even when there is no public health emergency. The fact that we are now in the midst of the most serious public health emergency for a century is likely to accentuate the need for such decisions. The absence of evidence identifying a specific patient or patients who will be disadvantaged if MB remains where she is does not mean that such patients do not exist. It is important when considering human rights defences in cases of this sort not to lose sight of that. 57 Analytically, the reason why a decision to require a patient to leave a hospital is unlikely to infringe Article 3 ECHR is because it is based on a prior decision not to provide in-patient care. Such a decision engages the state's positive (and limited) obligation to take steps to avoid suffering reaching a level that engages Article 3, rather than its negative (and absolute) obligation not itself to inflict such suffering. Where the decision to discontinue in-patient care involves the allocation of scarce public resources, the positive duty can only be to take reasonable steps to avoid such suffering: cf R (Pretty) v Director of Public Prosecutions [2002] 1 AC 800, [13]-[15] (Lord Bingham). It is difficult to conceive of a case in which it could be appropriate for a court to hold a hospital in breach of that duty by deciding, on the basis of an informed clinical assessment and against the background of a desperate need for beds, to discontinue in-patient care in an individual case and, accordingly, to require the patient to leave the hospital. The present is certainly not one.

In relation to Article 8:

the difficulties facing MB's argument are even more pronounced. In R (McDonald) v Royal Borough of Kensington and Chelsea [2011] UKSC 33, [2011] HRLR 36, Lord Brown said this at [16]:

> *"the clear and consistent jurisprudence of the Strasbourg Court establishes 'the wide margin of appreciation enjoyed by states' in striking 'the fair balance … between the competing interests of the individual and of the community as a whole' and 'in determining the steps to be taken to ensure compliance with the Convention', and indeed that 'this margin of appreciation is even wider when … the issues involve an assessment of the priorities in the context of the allocation of limited state resources'".*

Even though the decisions to cease to provide in-patient care to MB and to require her to leave plainly interfere with MB's right to respect for private and family life, the evidence adduced by the Claimant amply demonstrates that the interference was justified in order to protect the rights of others, namely those who, unlike MB, need in-patient treatment. Bearing in mind the broad discretionary area of judgment applicable to decisions of this kind, there is no

> *prospect that MB will establish the contrary.*

Finally, in relation to Article 14:

> *60 Nor does reliance on Article 14, read with Article 3 or Article 8, take matters any further. The decision to decline in-patient care to MB does not discriminate against her on the ground of her disabilities. The Hospital has treated her in the same way as a patient with different disabilities or with none: it has determined whether to continue to offer her in-patient care on the basis of her clinical need for such care. To the extent that this is itself discrimination against those, like MB, whose disabilities make them perceive a need for things (such as a rainwater canopy outside the front door) for which there is in fact no objective need, the discrimination would be justified even outside the context of a public health emergency. In the context of such an emergency, there is no prospect that a challenge based on Article 14 in these circumstances could possibly succeed.*

MB also relied upon the Equality Act 2010, but to no avail:

> *61. As for MB's arguments under the 2010 Act, these too are without merit. Compliance with the duty in s. 149 of the 2010 Act* [the public sector equality duty] *is a matter of substance, not form. The fact that there has been no express reference to that duty does not matter. What matters is whether the factors required to be considered have been considered, insofar as they are relevant to the function in question. Here, the function is that of deciding whether to cease to provide in-patient care to MB. That decision was taken on the basis of the careful assessment of Dr Christofi and other members of the multi-disciplinary team. The assessment paid the fullest possible attention to the complex needs arising from MB's physical and mental disabilities. The contrary is not arguable. To the extent that it is said that the decision discriminates against MB on the ground of her disabilities contrary to s. 29 of the 2010 Act, any such discrimination is justified for the same reasons as given in relation to Article 14. To the extent that the complaint is one of failure to make reasonable adjustments, the history demonstrates that Dr Christofi and his team have made every possible reasonable adjustment. The further adjustments to the care package now sought are, for the reasons I have given, not reasonable. There is therefore no arguable claim under the 2010 Act.*

It was therefore clear, the judge held, that even on an interim basis, MB had no sustainable public law challenge (and that, had she sought to judicially review the Trust's decision, he would have refused permission and certified her claim totally without merit). He therefore granted the injunction,

Comment

There is, at present, much discussion in relation to the potential for resources within hospitals to become sufficiently stretched that decisions may have to be made that clearly and expressly proceed on utilitarian grounds: i.e. expressly comparing the relative need of one patient with another for (for instance) a bed in intensive care, or a ventilator. A good overview of the ethical issues can be found in this briefing paper prepared by the Essex Autonomy Project, and a

resource for considering issues in detail is this site maintained by the Centre for Law, Medicine and Life Sciences at the University of Cambridge. The legal issues that arise were also discussed in this webinar held by members of Chambers on 7 April 2020, the recording of which is available here.

This judgment is a good reminder that considerations of the allocation of scarce resource are ever-present even absent the current situation. It also lays out clearly both the steps for Trusts would need to take to ensure that utilitarian decisions that may have to be made in future are lawful, and also the hurdles that will lay in the way of those who may seek to challenge such decisions.

It should, finally, be emphasised that to the extent that current concerns about the impact of COVID-19 on clinical resources are leading decisions about advance care planning to be done to, not with people, this is wrong: see Alex's video here.

Dialysis, the MHA 1983 and the MCA 2005

A Healthcare, B NHS Trust v CC [2020] EWHC 574 (Fam) High Court (Queen's Bench Division) (Lieven J)

CoP jurisdiction and powers – interface with inherent jurisdiction – Mental Health Act 1983 – interface with MCA – treatment for mental disorder

Summary

This case concerned a 34-year-old man ('CC') with psychotic depression, mixed personality disorder who was deaf, had diabetes and was detained under s.3 of the Mental Health Act 1983. The main issue was whether haemodialysis was medical treatment for his personality disorder for the purposes of MHA s.63. Lieven J held that the dialysis treatment, use of light physical restraint and chemical restraint (if required), was authorised by s.63.

Medical treatment for mental disorder

The responsible clinician's view was that CC's non-compliance with dialysis treatment was a symptom or manifestation of his mental disorder and that 'at best' his decision-making capacity was fluctuating. Without dialysis he would die and, to be reasonably stable, he needed 4 hours of it, three times a week. The treating team's intention was to commence peritoneal dialysis, which involved the insertion of a catheter, enabling less burdensome overnight dialysis. But, in the meantime, haemodialysis was necessary. His acceptance of the treatment fluctuated, but there were times – including the day before the hearing – when he was clear that he wanted it, did not want to die, and would want to be restrained if necessary to receive it.

Lieven J held that the treatment fell within the scope of MHA s.63:

> *36. In my view this is a clear case of the treatment proposed, the dialysis, treating a manifestation of the mental disorder, namely personality disorder. The need for dialysis stems from CC's self-neglect, including in regard to diet, which has led in whole or in part to his kidney failure. The reason his diabetes has resulted in kidney failure is to a large extent because of that self-neglect, which is itself a consequence of his mental disorder….[I]t seems to me clear that the physical condition CC is now in, by which dialysis*

> *is critical to keep him alive, is properly described as a manifestation of his mental disorder. There is a very real prospect that if he was not mentally ill he would self care in a way that would have not led to the need for dialysis. Further, that CC is refusing dialysis is very obviously a manifestation of his mental disorder. When he is mentally well he agrees to dialysis. His situation is therefore highly analogous with that of the force feeding cases.*

The judge rejected the argument that, to fall within s.63, the "primary purpose" of the treatment must be to treat the mental disorder:

> *37 … I do not think that one can take from the words of section 145(4) a need to analyse a hierarchy of potential purposes of the treatment or causative links. It is in my view sufficient that a purpose of the proposed treatment is to alleviate a manifestation of the mental disorder. There is no suggestion in any of the caselaw that I have referred to above that the Court (or a clinician) has to go through the type of exercise Mr Lock proposes. It is therefore sufficient that the renal failure is a manifestation of the mental disorder.*

Interface between ss.62, 63 and 58

The health bodies submitted that the sedation required to carry out the dialysis fell within MHA s.58 and therefore required either capacitous consent or a second opinion appointed doctor ('SOAD') to certify the sedation as appropriate. Lieven J held that s.58 was excluded because this was emergency treatment for the purposes of s.62:

> *46. In my view, on this second issue under the MHA 1983 Mr Lock's arguments are wrong and section 63 is the appropriate course. There is no doubt that in this case, as in most if not all the previous authorities, the treatment being proposed under section 63 is urgent, and in all those cases life-saving. The proposed dialysis for CC is plainly extremely urgent, and without it he will undoubtedly die. In those circumstances in my view the case plainly falls within section 62(1)(a) (b) and (c) and as such section 58 is excluded. In particular, in urgent treatment cases such as this, treatment is immediately necessary to save CC's life, to prevent a serious deterioration of his condition and to alleviate serious suffering.*
>
> *47. I also accept on the facts that Mr Lock's analysis would make section 63 largely, if not wholly redundant, because in most if not all cases where section 63 is relied upon, the treatment will involve some use of medication, often sedation. It makes no sense of the statute for sedation to be dealt with under one statutory route and other forms of treatment to be dealt with by a wholly different one.*
> *48. I do accept Mr Lock's point that considerable care needs to be taken in the use of section 63 if it is not to become a way of treating detained mental patients, with or without capacity, without their consent. However, the safeguard that is in place is the requirement set out by Baker J in NHS Trust v A at [80] that in cases of uncertainty, the appropriate course is to apply to the Court."*

MCA 2005

The alternative argument of the health bodies was to seek a contingent declaration under MCA s.15(1)(c). The evidence suggested that the day before the hearing, CC had capacity to make the decision but it was fluctuating. The judge would have been prepared to make the declaration but, given that the treatment fell within MHA s.63, it was not necessary to do so:

> *51. … I emphasise that this is not a case of CC simply making a poor decision with which the Court and the health professionals do not agree. Mr Maguire's Attendance Note and Dr H's evidence are both clear, that when well CC does not wish to die and wishes to have dialysis. His change of position is a function of his mental state worsening, and that in turn is a function at least in part of him refusing dialysis. I therefore find that when CC refuses dialysis he does lack capacity*
>
> ...
> *55. In some ways this case is more straightforward. CC currently has capacity and is clear that he wants to have dialysis; that he does not want to die; and that he wishes to continue to have dialysis if he loses capacity. This is therefore in practice akin to an advance decision under section 24 MCA 2005, albeit that he has not gone through the formal processes of an advance decision contained in section 25 MCA 2005 and it is an advance decision to accept treatment not refuse it. It is in those circumstances relatively easy to declare that if CC loses capacity in respect of a decision about dialysis, then it is in his best interests to have dialysis in accordance with the care and treatment plan proposed. Such a declaration undoubtedly accords with CC's wishes and feelings, both because he has said so when he has capacity, but also because he is clear that he wants to live, and if he does not have dialysis then at some point he will die very prematurely."*

Accordingly, it was held that it was for the responsible clinician to decide whether to provide the dialysis treatment under s.63, in consultation with the clinicians attending to his physical health, including the consultant nephrologist, which was subject to the supervisory jurisdiction of the High Court.

Comment

This is an interesting decision for many reasons. First, and as acknowledged at paragraph 9, treatment for end stage renal failure would not normally be seen as treatment for mental disorder. As the MHA Code of Practice recognises at paragraph 16.6:

> [Medical treatment] *includes treatment of physical health problems only to the extent that such treatment is part of, or ancillary to, treatment for mental disorder (eg treating wounds self-inflicted as a result of mental disorder). Otherwise the Act does not regulate medical treatment for physical health problems.*

For mental disorder to result in self-neglect which results in kidney damage and therefore treatment for kidney damage is treatment for mental disorder reflects a very elastic interpretation of s.63. And such elasticity is hugely significant in human rights terms, given that, controversially, s.63 neither requires consent nor a second opinion. This decision can be contrasted with *GJ v Foundation Trust* [2009]

EWHC 2972 (which was not referred to in the judgment) where GJ was forgetting to take his insulin because of dementia. There it was held that diabetic treatment was physical treatment and not treatment for mental disorder.

Secondly, the arguments around s.58 were rather novel. Section 58 is the 3-month psychiatric medication rule and the safeguards apply "*if three months or more have elapsed since the first occasion in that period when medicine was administered to him by any means for his mental disorder*". It is surprising therefore that all parties accepted that sedation for dialysis (namely midazolam) was medicine administered for personality disorder. Moreover, it was not clear whether, even if it was, 3 months had elapsed since it was first administered.

Thirdly, the reference to CC's "advance decision to accept treatment" needs unpacking. An advance decision under MCA s.24 is to refuse healthcare so, in reality, his capacitous desire for treatment was an advance *statement* which has very different legal consequences to an ADRT.

Recall, available treatment and the MHA

PM v Midlands Partnership NHS Foundation Trust [2020] UKUT 69 (AAC) Upper Tribunal (AAC) (Upper Tribunal Judge Church)

Mental Health Act 1983 – treatment for mental disorder

Summary

Whilst detained under MHA s.3 with schizoaffective disorder, PM commenced long-acting depot anti-psychotic medication (Aripiprazole at a dose of 300mgs, to be administered monthly). She received two doses, the first on 17 May 2019 and the second on 21 June 2019, with the plan that she should continue on the depot on the third Friday of each month. On 5 July 2019 she was discharged onto a community treatment order ('CTO') and, to continue the treatment, a second opinion appointed doctor ('SOAD') was required to certify it as appropriate within 3 months of it first being administered; that is, 17 August 2019. The request for a SOAD was made on 15 July 2019 but, owing to a SOAD backlog, such certification would not be made within the statutory deadline.

The tribunal hearing took place on 15 August 2019 where the patient argued that appropriate medical treatment was not available because the depot would be unlawful in two days' time and that, accordingly, PM should be discharged from the CTO. This was rejected by the tribunal which upheld the CTO and this decision was appealed to the Upper Tribunal. The main issue was "*whether the lawfulness of administering medication to a Part 4A patient is relevant to a tribunal's assessment of whether the medical treatment proposed by the responsible authority was appropriate and available, or whether such a consideration, like consent, is something that comes into play only at the later stage of deciding whether to give the treatment*" (paragraph 9.4).

Appropriateness

At first instance, the tribunal had held that the lack of a SOAD opinion was not relevant to appropriateness of medical treatment. The Upper Tribunal held that the SOAD's opinion "*may, but will not always, be relevant to the issue of appropriateness*" and it depends on the facts (paragraph 9.10). If, for example, a SOAD refused to certify, that would likely be evidence for the

tribunal to consider when determining appropriateness.

Availability

In the absence of precedent as to the meaning of 'available', the judge considered the following dictionary definition to be the most suitable in the context of the MHA: "*capable of being employed with advantage or turned to account; hence, capable of being made use of, at one's disposal, within one's reach.*" So, having determined that treatment is clinically appropriate, a tribunal must also be satisfied "*that the treatment proposed is one that can be provided should consent be forthcoming*".

> *10.4. To consider an example, if the appropriate medical treatment relied upon is not one which the responsible authority has the resources to provide, and there is no plan to source the treatment from another provider, then it could not be said to be "available" because there would be no prospect of the treatment actually being given in practice, even were the responsible clinician to decide that the treatment should be given and should valid consent be obtained.*
> ...
> *10.6 … a legal impediment is at least capable of being relevant at the identification and classification stage to the extent that it can be said to take the treatment outside the options at the clinician's disposal or within the clinician's reach.*

The fact that, at the precise moment of the tribunal, SOAD approval was not necessary for another 2 days was not fatal to the argument: the tribunal should not use a 'snapshot' approach but instead look at the whole course of treatment, past, present and future (paragraphs 10.13–10.15). In conclusion:

> *12.1 … While the lawfulness of the administration of treatment is not, per se, relevant to the "appropriateness" of medical treatment it is relevant to its "availability".*

Accordingly, the tribunal erred in law but, as PM had already been discharged from the CTO before the Upper Tribunal's decision, the first instance decision need not be set aside.

Comment

This is a significant decision in the context of the MHA. Appropriate medical treatment is not available if it requires SOAD-certification and has not been so certified. This of course does not mean that a patient would be denied treatment they require as, for example, there may still be a nurse available to administer the depot. But what it does mean is that the patient would not be on the CTO to receive it. The Coronavirus Act 2020 provides a means to not require SOAD certification if getting a second opinion would be impractical or involve undesirable delay. However, that amendment has not yet been implemented.

The linking of legal impediments with the concept of availability may be relevant in relation to other aspects of the MHA. The appropriate medical treatment being available requirement is present in many other aspects of the MHA, so the linking of legal impediments with the concept of availability may have a broader application. The Code already states that "*medical treatment must actually be available to the patient. It is not sufficient that appropriate*

treatment could theoretically be provided" (paragraph 23.14). Introducing the legality of such treatment into the equation, at least insofar as non-compliance with the treatment safeguards are concerned, may therefore give rise to further legal arguments in this area.

The Protection of Adults in International Situations

The European Law Institute has published a report on the protection of international adults (to which both Adrian and Alex contributed).

The ELI project began in 2017, under the leadership of Pietro Franzina and Richard Frimston, and was successfully approved by ELI's Membership in March 2020. The Report encourages the European Union to consider both external action and the enactment of legislation in the field of protection of adults. It provides analysis on the protection of adults in international situations. Where appropriate, it includes proposals regarding such protection as well as further issues surrounding the application of the Hague Convention of 13 January 2000 on the International Protection of Adults. It addresses the following issues: (a) the bases and scope of the Union's competences as regards the protection of adults in international situations; (b) the strategies that the Union should consider following in order to enhance the protection of adults in the relations between Member States; and (c) further improvements that the Union may promote with respect to the Hague Convention of 13 January 2000 on the International Protection of Adults without making use of its external competence or its legislative powers. Finally, the Report sets forth a checklist to encourage the development of private mandates within the ambit of the substantive laws of the Member States.

The Report has been already presented to Members of the European Parliament and brought to the attention of national authorities and relevant stakeholders, and strides will continue to be taken in this regard.

It should also, in this regard, be noted that during the course of the Second Reading of the Private International Law (Implementation of Agreements) Bill in the House of Lords on 17 March 2020, the question of why the 2000 Convention had not been ratified in respect of England & Wales was raised by Lord Wallace of Tankerness. For the Government, Lord Keen responded:

> *The noble and learned Lord, Lord Wallace of Tankerness, raised* [the 2000 Convention]*. Hague, unlike Lugano, for example, can be entered into by a state, but can be ratified and applied in respect of only one jurisdiction within the state. It so happens that* [the 2000 Convention] *was implemented in respect of Scotland, but not of England and Wales, nor, I believe, Northern Ireland. I am not able to explain why it has been in abeyance for a number of years with respect to those other jurisdictions, but I can say that since the noble and learned Lord raised the point with me I have spoken to officials who are addressing that matter. Certainly, our recommendation would be that it should be applied in respect of England and Wales as well.*

We await developments as the Bill progresses through Parliament.

Short note: information disclosure and the rights of others

In *ABC v St George's Healthcare NHS Trust* [2020] EWHC 455 (QB) Yip J dismissed a claim brought by the daughter of a man with Huntington's disease for negligence and Article 8 ECHR in circumstances where the claimant's father had instructed the NHS Trust not to share his diagnosis with his daughter and the NHS Trust complied with his instruction.

The court accepted the claimant's submission that the NHS Trust owed her a duty of care to balance her interest in being alerted to the genetic risk posed by her father's condition against the interest of her father in having his confidentiality protected and the public interest in maintaining confidentiality. However, Yip J stressed that the duty would only rarely give rise to a cause of action because: the standard of care would be measured by reference to professional guidelines where non-disclosure is the default option; decisions supported by a responsible body of medical opinion would not be considered negligent; and, the courts would grant considerable latitude to clinicians making difficulty decisions.

On the facts of the case the duty had not been breached because the clinician in question had considered his patient's safety, taken advice from a geneticist and heard competing arguments before making what was a difficult decision in respect of which there was a reasonable range of professional opinion.

The CQC and Whorlton Hall

On 18 March 2020 the Care Quality Commission ("CQC") published the findings of an independent review into its regulation of Whorlton Hall between 2015 and 2019. The review was undertaken by Professor Glynis Murphy and was tasked with examining whether abuse of patients at Whorlton Hall should have been identified earlier by the CQC. In summary, the review concludes that the CQC followed its procedures but makes six recommendations for the improvement of the CQC's inspection and regulatory approach:

- displaying data for services in a user-friendly way to help inform inspections
- changing inspection methodology to include more unannounced and evening weekend inspections, more regular "Provider Information Requests" (PIRs) and the quicker publication of inspection reports
- improving the response to allegations of abuse, safeguarding alerts and whistleblowing
- prioritising gathering the views and experiences of people using services and their families on inspection
- adopting a more flexible inspection approach when information about a service indicates that it is at risk of failing its service users
- not registering isolated, unsuitable or outdated services or allowing them to expand.

Many of these improvements are presumably going to have to wait until the CQC is able to resume business as normal.

RESEARCH CORNER

We highlight here recent research articles of interest to practitioners. If you want your article highlighted in a future edition, do please let us know – the only criterion is that it must be open access, both because many readers will not have access to material hidden behind paywalls, and on principle.

This month, we highlight the article by Alex on 'Capacity in the time of Coronavirus' now available (in pre-print) in the International Journal of Law and Psychiatry's Special Issue: "Mental health, mental capacity, ethics and the law in the context of Covid-19 (coronavirus)." The article examines the impact of the Coronavirus Act on health and social care outside hospital; public health restrictions; the MCA under strain; the Court of Protection; medical decision-making, the MCA and scarce resource; and mental health law.

It is also available in pre-print via ResearchGate here.

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Adrian is a recognised national and international expert in adult incapacity law. He has been continuously involved in law reform processes. His books include the current standard Scottish texts on the subject. His awards include an MBE for services to the mentally handicapped in Scotland; honorary membership of the Law Society of Scotland; national awards for legal journalism, legal charitable work and legal scholarship; and the lifetime achievement award at the 2014 Scottish Legal Awards.

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Conferences

At present, most externally conferences are being postponed, cancelled, or moved online. Members of the Court of Protection team are regularly presenting at webinars arranged both by Chambers and by others.

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 May. 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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