



Welcome to the July 2022 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: Injunctions against family members; Draft LPS forms published; and serious medical treatment applications.

(2) In the Practice and Procedure Report: Remote observations of hearings and new SRA guidance on vulnerable clients.

(3) In the Wider Context Report: Mental Health Bill Update; Archie Battersbee case in the Court of Appeal; Posthumous use of embryos; and CAMHS gatekeeping.

(4) In the Scotland Report: World Congress and Scott Review Updates; Learning Disabilities and Mental Health legislation; and permanence orders.

You can find our past issues, our case summaries, and more on our dedicated sub-site [here](#), where you can also find updated versions of both our capacity and best interests guides.

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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.

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Draft Mental Health Bill update

We covered the introduction of the draft Bill in the [June Report](#). By way of update since then:

- Alex has produced an unofficial [version of the MHA 1983](#) as it would be if the amendments proposed in the draft Bill were brought into force;
- The [timetable](#) for pre-legislative scrutiny has been announced, with a Joint Committee of Lords and Commons to consider and report by 16 December 2022. For more on what pre-legislative scrutiny means, see [here](#);
- The Government has published an ‘[action plan](#)’: to strengthen community support for

people with a learning disability and autistic people, and reduce reliance on mental health inpatient care. Such a plan is going to be of huge significance if the current intention to remove autism and learning disability entirely from the (civil) longer-term sections of the MHA 1983 is not simply going to lead to a legal transfer of detention mechanism for very many such individuals detained under, or at risk of detention, the MHA 1983 to DoLS.

Amy Holmes appointed as Public Guardian

Amy Holmes has been appointed as the new Public Guardian. A [press release](#) on her appointment states:

Amy Holmes, currently Domestic Affairs Director in the Economic and Domestic Secretariat at the Cabinet Office, will take over the role of Public Guardian and Chief Executive of the Office of the Public Guardian (OPG) in the Autumn.

She was successful in fair and open competition for the role and her appointment has been approved by The Deputy Prime Minister.

Jo Farrar, Second Permanent Secretary, Ministry of Justice and Chief Executive Officer, HM Prison & Probation Service said:

"I am delighted that Amy will be joining us in the vital role of Public Guardian and CEO of the OPG. Amy will bring a wealth of experience from an impressive career in government to lead the OPG's ambitious plans to improve and modernise its services. I look forward to welcoming Amy when she takes up the post later this year."

Stuart Howard will continue in the role of Interim Public Guardian of OPG until Amy joins the agency in the Autumn, after which he will continue in his role as OPG's Head of Legal and Information Assurance.

New podcast from 39 Essex Chambers: Everyone's Business – a safeguarding podcast

'Everyone's Business' is a safeguarding podcast, which explores interesting and unique perspectives in respect of safeguarding children and adults at risk. The series is part of 39 Essex Chambers' Public Law Podcast and features guests who can offer exceptional insights into the subject.

This ambitious mini-series, a project developed by [Ian Brownhill](#), runs for ten episodes over summer 2022. From safeguarding in Esports to the role of the Safeguarding Adults Board, there's something for everyone.

The guests are experts in their field and each episode is chockfull of advice and opinion.

In this first episode, Ian asks, 'Is safeguarding trendy?'. He explores the role that trends have in safeguarding in sport, statutory services and beyond.

You can listen to the first episode [here](#), where you can also subscribe to our Public Law Podcast on iTunes and Spotify. Follow this series on Twitter: [Everyone's Business: A Safeguarding Podcast](#).

Archie Battersbee case: Court of Appeal, second substantive judgment, and return to the Court of Appeal

Barts Health NHS Trust v Dance & Ors [2022] [EWHC 1165 \(Fam\)](#) (13 May 2022) (Arbuthnot J)

Barts Health NHS Trust v Dance & Ors [2022] [EWHC 1435](#) (13 June 2022) (Arbuthnot J)

Barts Health NHS Trust v Dance & Ors (Re Archie Battersbee) [2022] [EWCA Civ 935](#) (06 July 2022) (Master of the Rolls, McFarlane LJ, King LJ)

Barts Health NHS Trust v Dance & Ors (Re Archie Battersbee) [2022] [EWFC 80](#) (15 July 2022) (Hayden J)

Barts Health NHS Trust v Dance & Ors (Re Archie Battersbee) [2022] [EWCA Civ 1055](#) (25 July

2022) (McFarlane LJ, King LJ, Peter Jackson LJ)

Best Interests - Medical Treatment

Summary

These five judgments concern 12 year old Archie Battersbee, who suffered a serious hypoxic brain injury on 7 April 2022 and is being cared for in the paediatric intensive care unit at the Royal London Hospital. The treating clinicians suspected he might be brain stem dead, but could not obtain the parents' permission to carry out the clinical tests required for that diagnosis.

In the first judgment, Arbuthnot J said that the clinical tests should be carried out, noting that they would enable Archie's family and doctors to know whether he was alive or dead. The tests were not in fact carried out, because, as Arbuthnot J said in the second judgment, "*Archie did not react to the peripheral nerve stimulation tests which were a precursor to the brain stem test. Had the brain stem test then been performed the results may have provided a false negative result.*" [24] Nevertheless, Arbuthnot J held that on the balance of probabilities, Archie was brain stem dead.

That decision was overturned by the Court of Appeal in the third judgment, who noted that "*none of the medical witnesses before the judge diagnosed death in this case*" [34] because the clinical tests had not been administered. There was therefore no medical evidence on to support the judge's conclusion. The case was remitted to a different judge for a full best interests analysis.

That resulted in the fourth judgment, in which Hayden J held that it was not in Archie's best interests for life-sustaining treatment to be continued. Hayden J concluded that it was:

46...intrusive, burdensome and intensive. If there were even a possibility that it could achieve some improvement to Archie's condition, it might be both proportionate

and purposeful. Where, as here, the treatment is futile, it compromises Archie's dignity, deprives him of his autonomy, and becomes wholly inimical to his welfare. It serves only to protract his death, whilst being unable to prolong his life.

That decision was then appealed. The Court of Appeal in the fifth judgment upheld Hayden J's decision, noting that the choice was between "*an arranged removal of life sustaining treatment with the inevitability of death a short time later, and [...] the continuation of life-sustaining treatment in the knowledge that in the very near future Archie's bodily functions would collapse in an unplanned manner*". [16] Permission to appeal was refused on all grounds. A short stay has been granted as the parents indicated they would make an urgent application to the ECtHR.

Comment

Despite the Court of Appeal's rejection as unarguable the parents' proposition that "*UK law obliges the withdrawal of life-sustaining treatment where someone is in an irreversible state of unconsciousness with no prospect of recovery*", [26] the eventual outcome of these proceedings felt inevitable. The degree of damage to Archie's brain and his accepted prognosis of death within a matter of weeks even if he continued to receive full treatment in intensive care, made it exceptionally unlikely that a court would find that continued treatment was in his best interests.

The first Court of Appeal decision is an important reminder that courts can only reach conclusions on medical matters where they have the evidence to support them from clinicians. The need to apply the guidance in respect of brain stem death has been strongly reinforced. It seems likely that the guidance will come under further scrutiny in light of the judgment in *Re A* [2022] EWHC 1873 (Fam) where a diagnosis of brain stem death was apparently made in accordance with the guidance but turned out to be incorrect.

Deprivations of liberty of children in unregistered placements and CAMHS gatekeeping

Blackpool Borough Council v HT (A Minor) & Ors [2022] EWHC 1480 (Fam) (17 June 2022) (MacDonald J)

In this latest of a line of such judgments from MacDonald J, he deals with the “depressingly familiar” issue of children, deprived of their liberty in “suboptimal”, unregistered settings¹ and the role played by CAMHS (child and adolescent mental health services) in so-called “gatekeeping”.

The case concerns HT, a 17-year old girl with a history of significant mental health difficulties and a number of recent suicide attempts. The local authority sought the court’s continued authorisation of HT’s deprivation of liberty in an unregistered unit, notwithstanding the local authority’s acceptance that the placement was not ideal and that it had given notice for HT to leave, but in the context of a search of 67 placements, all of whom had refused to offer a bed to HT.

MacDonald J noted that, in common with many other similar cases, the application was made in the context of a dispute between the relevant local authority and NHS CCG (as was) and NHS England as to whether the subject child should be provided with a CAMHS Tier 4 inpatient bed or a placement and services by the local authority under the Children Act 1989 with the associated deprivation of liberty being authorised under the Inherent Jurisdiction of the High Court.

In a helpful exegesis on the law – provided in part by our Tor Butler-Cole QC who, having acted in the case, has not been involved in the writing of this piece – the judgment sets out the law

applicable to deprivations of liberty under the Inherent Jurisdiction of the High Court:

23...in an appropriate case the court may grant a declaration under its inherent jurisdiction authorising the deprivation of the liberty of a child in a children’s home registered with Ofsted pursuant to the provisions of the Care Standards Act 2000 (and, in conditions of imperative necessity, even if not yet registered) or in unregulated placement, i.e. a placement not subject to the regulatory regime requiring registration. Such a declaration may be made if the court is satisfied that the circumstances that will pertain for the child in the placement in question constitute a deprivation of liberty for the purposes of Art 5 of the ECHR and if it considers such an order to be in the subject child’s best interests.

In circumstances where, rather than being accommodated by the local authority in a regulated – or unregulated - placement authorised by the court, a child or young person meets the criteria for detention of the Mental Health Act 1983, a different legal regime applies:

30. Pursuant to the Mental Health Act 1983 a child or young person may be admitted and detained for assessment pursuant to s.2 of the Act or treatment pursuant to s.3 of the Act. This case concerns admission and detention for assessment under s.2 of the Mental Health Act 1983. Under s.2(1) of the Act a person may be admitted to a hospital and detained there for a period not exceeding 28 days in pursuance of an application for admission for assessment made on the basis that, for the purposes of s.2(2), the person is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a

¹ See also, *Wigan Metropolitan Borough Council v W and others* [2022] 1 FLR 1226; *Lancashire CC v G (Unavailability of Secure Accommodation)*

[2020] EWHC 2828; *Tameside Metropolitan Borough Council v C and Others* [2021] EWHC 1814 (Fam)

hospital for assessment (or for assessment followed by medical treatment) for at least a limited period and the person ought to be so detained in the interests of their own health or safety or with a view to the protection of other persons. The application for admission for assessment must be based on the written recommendation of two registered medical practitioners.

The judgment then goes on to set out the relevant provisions of the MHA 1983:

35. Section 11(2) of the Mental Health Act 1983 requires that every application for admission for assessment shall be addressed to the managers of the hospital to which admission is sought. The Mental Health Act Code further emphasises that the application must state a specific hospital. Within this context, Ms Butler-Cole points to the commentary in the Mental Health Act Manual, Jones, R. 23rd Edtn. At 1-025 suggesting that it is arguably unlawful for an AMHP to make an application to detain a patient and convey him or her to hospital where it is known that a bed will not become available at the named hospital and that it is unlawful to convey a patient to hospital on the authority or an application which does not state the name of the potential admitting hospital.

However, as the court then goes on to acknowledge, s.2 MHA 1983 'does not impose a legal obligation on a hospital to admit a patient. Rather, it requires that a bed be identified, and confers authority on a hospital manager to detain the patient at the named hospital.' [36] Yet more significantly, as the court goes on to record, while the admission for assessment may be authorised on the written recommendation of two medical practitioners, pursuant to NHS Service Specification for Tier 4 CAMHS, the acceptance – which is the requirement for actual

admission – must be by way of an access agreement: the so-called gatekeeping process.

As a psychiatrist for the intervening trust described it,

37...“The gatekeeping assessment is required by commissioners and is a safeguard (as supported by NHSE) to help prevent inappropriate / unsafe admissions and ensure that any decisions to admit children and young people (CYP) to hospital are not taken lightly, that the least restrictive principle is adhered to and the decisions are underpinned by an age appropriate assessment conducted by those with CYP experience.”

The court summarised:

38...whilst a detention may be authorised by an application made by two qualified medical practitioners under the Mental Health Act 1983, it is the Access Assessment determines whether in-patient admission to a Tier 4 CAMHS service is appropriate.

MacDonald J held that authorising the deprivation of liberty at the local authority commissioned, unregulated placement for as short a time as possible under the Inherent Jurisdiction in preference to a potential detention in CAMHS placement:

43. It is plain on a proper analysis of the mental health legislation and guidance that, even where an application for admission for assessment is certified by two qualified medical professionals as meeting the criteria under s.2 of the Mental Health Act 1983, the provision of the Tier 4 CAMHS bed remains subject to the outcome of a referral that complies with the National Referral and Access Process, which includes the completion of an Access Assessment undertaken by reference to the criteria contained in the

service specification for the Tier 4 CAMHS Service.

44. *With respect to the role of the court where the Access Assessment has concluded that an admission to a Tier 4 CAMHS Service is not appropriate notwithstanding the certification of an assessment application by two qualified medical professionals, that role is necessarily limited. The court will not ordinarily entertain a claim for judicial review in respect of a decision not to allocate medical resources to a particular case, here the relevant decision being not to admit a child or young person to a Tier 4 CAMHS bed following an Access Assessment (see R v Central Birmingham Health Authority ex parte Collier, Unreported, 6 January 1988 and R v Cambridge Health Authority ex parte B [1995] 1 WLR 898). The court may, and in cases such as this one often does, join NHS England (and sometimes the relevant Clinical Commissioning Group) where the circumstances are such that the court may wish to invite reconsideration by the NHS Trust of the decision not to make Tier 4 inpatient provision for the subject child. By way of example, this step was taken by Sir James Munby in Re X [2017] EWHC 2036 (Fam). Alternatively, the court may consider directing a direct a single joint expert qualified in Tier 4 CAMHS to provide a second opinion, albeit that the efficacy of this approach is likely to be limited by the fact that upon receipt of the report the court's powers to give effect to an expert recommendation contrary to the position taken by NHS England are limited for the reasons I have already described.*

Comment

There is no short-term solution to the terrible dearth of appropriate beds for children and adolescents suffering with mental health difficulties. This judgment is helpful in clarifying some of the routes towards ensuring that any

placements that are found are appropriately authorised and makes clear the rather vexed topic of gate-keeping – a hitherto fairly well-kept secret to those not familiar with the workings National Referral and Access Process.

Posthumous consent to use embryos

R(Jennings) v Human Fertilisation and Embryology Authority [2022] EWHC 1619 (Fam) (22 June 2022) (Theis J)

In this unusual case, the High Court declared it was lawful for a husband to use embryos created with his late wife through IVF for birth by surrogacy, notwithstanding the lack of written consent. The case has some interesting observations about consent, and the need to see it in context.

The applicant (Mr Jennings) and his late wife (Ms Choya) had created the embryo in question in 2018 in the course of fertility treatment. They had married in 2009, and been trying to conceive for some time, with unsuccessful cycles of IVF and pregnancies ending in miscarriage. Ms Choya died unexpectedly following a uterine rupture in 2019 while 18 weeks pregnant with twins. However, there was one remaining embryo from the 2018 fertility treatment.

There was no express written consent for the use of the embryo by Mr Jennings should Ms Choya die, but the applicant contended that in the circumstances the intent was clear and sought a declaration from the court. The Secretary of State for Health and Social Care decided not to participate in proceedings, but the Human Fertilisation and Embryology Authority (HFEA) opposed the declaration being granted on the basis that there was no written consent.

The forms then in use to record consent did not provide any opportunity for a woman to consent to a partner-created embryo being used by her partner if she dies, although the form to record male consent to treatment did contain such provision. The form which would have been

applicable for Ms Choya referred to the need to complete another form (the WSG form) *'if you wish for your eggs or embryos to be used in someone else's treatment if you die or become mentally incapacitated'*.

The court noted that Ms Choya had completed the forms on behalf of both partners and 'notably' had ticked the box on the male consent form to indicate consent to use of a partner-created embryo following death or incapacity.

The applicant filed evidence from a consultant gynecologist at the hospital to the effect that some reference would normally be made to the option of completing additional forms, but take-up was generally low. The applicant's position was that he was sure that had Ms Choya been offered the WSG form, she would have completed it.

The applicant contended that *'the focus on consent as recognition of the individual autonomy of the donor is the cornerstone of the legislative scheme rather than the need for consent to be evidenced in writing'*. [34] The evidence established that Ms Choya wanted to be able to use the embryos in the event of Mr Jennings' death, and the court could infer that she would have wished for him to be able to use the embryos too. She would have consented if given the opportunity, but was not given it.

The court held that:

82. Whilst it is right to acknowledge the issue of consent is the cornerstone of the statutory scheme and that the statutory scheme requires such consent to be in writing that cannot, in my judgment, be considered in a vacuum. It is necessary to consider the circumstances in which such consent is considered, the information that was available and what opportunity was given for that consent to be given.

The statutory scheme requires a suitable opportunity to receive proper counselling, and for a person considering IVF to receive *'such relevant*

information as is proper'. It does not set out what information has to be given or what the counselling should involve, but *'by definition, it has to be meaningful information that will inform the person considering the issue of consent'* [83]. Neither the HFEA Code of Practice nor the HFEA Guide for Clinics set out what consent needs to be provided for a woman to consent to posthumous use of an embryo. The court held that while the women's treatment form did refer to other forms (including the WSG form) *'they are far from clear'*. [88] It could and should have been made clear on the face of the women's treatment form, and accordingly the court held they were not given sufficient opportunity to give consent in writing. [90]

The court accepted that it could infer from the available evidence that Ms Choya would have consented, even in the absence of a direct conversation between Mr Jennings and Ms Choya about the use of the remaining embryo posthumously. They had discussed what should happen in the event of her death when pregnant with the twins, and *'Ms Choya had been adamant that the girls should be saved in the event that there had to be a choice between her and the children.'* [93] The indication on the men's treatment form, and the consistent evidence from her friends and family, all pointed to the same conclusion. The court accepted that previous cases had illustrated that the court had the ability in appropriate cases to look wider than the written consent forms to determine a donor's wishes. [95] This context-sensitive approach to consent, and to determining wishes where they have not been expressly identified, will no doubt be of interest to all those involved in mental capacity law.

Family Court Statistics: Increase in applications to the Court of Protection yet decrease in orders

On 30 June 2022, the Ministry of Justice ("MoJ") [published statistics](#) for the first quarter (January to March 2022) for the family courts of England

and Wales. The statistics include data for the Court of Protection (“CoP”). Interestingly, whilst there was an increase in the number of applications made in relation to both deprivation of liberty and more generally to the CoP (with an increase of 14% and 10% respectively), there was a decrease in the number of orders made when compared to the same period last year (35% decrease for deprivation of liberty and 10% decrease for other applications). The MoJ has provided little analysis of the figures but suggested that the figures generally reflect the reduced capacity throughout the family courts.

The increase in applications relating to deprivation of liberty are part of a wider trend that can (unsurprisingly) be traced back to the Supreme Court’s decision in *P v Cheshire West* [2014] UKSC 19 with a blip in the first quarter of 2020 coinciding with the start of the pandemic. A large proportion of the CoP applications (at 39%) was for an appointment of a property and financial affairs deputy.

The statistics also include the Office of the Public Guardian. During the first quarter, 202,855 lasting powers of attorney (“PoA”) were registered – 57% of PoAs registered from female donors; whilst 42% were from male donors. Altogether, 53% were over 75 years old. The general increase in LPAs is part of a broader upward trajectory since 2015/2016, when there was increasing publicity around LPAs and the new online forms were introduced, which made it simpler and faster to apply.

Deprivations of liberty in educational settings: the Northern Irish courts weigh in

ML v The Special Needs and Disability Tribunal & Ors (Rev1) [2021] NIFam 15 (05 May 2021) (Keegan J)

The Northern Irish High Court Family Division considered an appeal from the SEN Tribunal, in which a child’s mother argued that he should have home tuition rather than education in a specialist school with a bespoke unit to deal with behaviour management. It was agreed between the parties that the proposed placement would result in a deprivation of liberty for the child (ML). The judgment recited ML’s needs and background at [7]:

...the young person is 17 years old and has special educational needs as a result of severe learning difficulties, social, behaviour and emotional wellbeing difficulties and his medical diagnosis of Autistic Spectrum Disorder. The facts also highlight that medical advice is that in addition to his diagnosis of Autistic Spectrum Disorder and severe learning difficulties the young person also has epilepsy, challenging behaviour, fluctuating tic disorder, habitual air swallowing and vomiting and nocturnal enuresis with some daytime incontinence. The young person is reported to have had a Statement of Special Educational Needs since 2008 and has attended a special school since that date until 2018 when following an incident at the school they had to accept that they could no longer meet the young person’s needs without the provision of additional accommodation.

ML’s needs were reported to have increased as he aged and by 2018, he had assaulted a teacher. His school considered it needed more space to provide ML with a room to calm down, and during a period of approximately a year in which ML was receiving home tuition, a bespoke modular unit was built for ML containing ‘a classroom, bathroom facilities, and most importantly, a safe area for the young person to go when experiencing a challenging episode, with facilities for staff to remain in a safe place during such time.’ [8] A Positive Behaviour Support plan was also prepared for ML.

On the construction of the modular unit for ML, his mother raised concerns that 'it resembled "a prison cell" with key fobs/code pads to allow access to and exit from the unit, and that it is also fenced off right around with gates on each side. She felt it would not work for the young person as he would be isolated from peers and the curriculum.' [10] The school clarified at the SEN Tribunal that ML would not always be in this unit, and would also spend time in the main area of the school, but would have the unit for his personal use as needed. ML's mother also argued that he had done well with home tuition, and had developed a good routine at home.

The SEN Tribunal dismissed the appeal brought by ML's mother. It considered that the plan from the school was impressive, and the plan to reintegrate him into school life would be helpful to him as he aged into adult services. It emphasized that ML would not always be in the unit, but that he would have space to de-escalate as needed.

In the appeal heard by the Family Division, ML's mother argued through counsel that

29... the Tribunal has a duty to apply common law and Convention obligations as a public authority and given these obligations the Tribunal could not simply ignore the deprivation of liberty/need for authorisation in this case. He therefore argued that the Tribunal fell into error in its approach as it could not conclude that the placement proposed by the Education Authority was appropriate where it would give rise to a deprivation of liberty and where there was no authorisation in place at the time of the finding by the Tribunal....

Mr McQuitty also argued that in terms of sequencing it was not right to say that the Tribunal should simply decide and then if an authorisation is needed it could go under the Mental Capacity Act. He made an argument that the Statement itself was part of a process and that the Statement is

binding from the point of issue. Mr McQuitty made the point that the process of authorisation of a deprivation of liberty is not an onerous task. He therefore argued that the appeal should either have been allowed before the Tribunal or adjourned for a deprivation of liberty authorisation.

In submissions from a range of statutory bodies, including the Department of Education and Attorney General, it was set out that work is ongoing to update guidance relating to children who are deprived of their liberty in educational settings, or subject to restraint or seclusion.

The Family Division dismissed the appeal, finding:

42...SENDIST is a Specialist Tribunal tasked under law to deal with a particular issue which is whether educational provision is appropriate. It is not tasked to authorise deprivations of liberty. In my view the Tribunal is capable of making a determination on whether educational provision is appropriate otherwise the statutory scheme would be frustrated and also delayed. This also applies to the issue of a Statement itself.

43. In this case the core issue was whether home tuition or educational provision at school was appropriate. That is what parliament has asked the specialist tribunal to decide by virtue of Article 16 of the Education (Northern Ireland) Order 1996. There is some confusion about whether or not the Tribunal actually addressed deprivation of liberty as well. I do not think it is particularly purposeful to dissect this but suffice to say that there is nothing wrong with a Tribunal being alive to the issue and in fact that is preferable. However what it actually has to decide is the appropriateness of the educational provision on offer...

46. *I do not accept the argument that the Tribunal was required to interpret the legislation in such a way as to consider authorisation of deprivation of liberty. In my view that is a different consideration which forms part of a parallel process and it is not the function of SENDIST to deal with it under the relevant legislation. I agree with the Attorney General's arguments on this point and I consider that this approach is Convention compliant.*

47. *This means that there has to be multidisciplinary joined up thinking in relation to these issues. It does appear clear to me that deprivation of liberty may be required in a school setting. It is not the function of SENDIST to determine whether there is a deprivation of liberty on the facts of any case or a restriction of liberty. That would usurp the statutory scheme which Parliament has put in place under the Mental Capacity Act 2016. I am informed by Mr Potter that the legislation in Northern Ireland allows for applications to be made in school settings. There have been some 12 applications of this nature and it appears that training has taken place. If the mental capacity legislation does not so provide there can be recourse to the inherent jurisdiction. Either way authorisation has to be sought to satisfy Article 5...*

49. *As regards sequencing there is no difficulty in SENDIST operating and determining cases whilst this other parallel process occurs. It seems to me that the application for authorisation should be made by the relevant Trust in liaison with the Education Authority.*

Comment

We would note that in the English system, the naming of the school in an EHCP merely sets out the provision which the local authority is

offering. A complete answer to the deprivation of liberty challenge in the English courts may have been that the Tribunal ordering a school to be named in section I does not actually require the child to attend that school, merely allows the child to do so. *CB v LB Merton* [2002] ELR 441.

JCHR Report: 'Protecting Rights in Care Settings'

On 22 July, the Joint Committee on Human Rights published its report, '[Protecting Rights in Care Settings](#).' We reproduce the report's summary below:

This inquiry into protecting human rights in care settings follows a torrid few years for care users: the pandemic caused great suffering and isolated residents from their loved ones. We have sought to shed a light on the human rights most at risk in care settings, and what can be done to better protect them. We have focused on four main issues: the provision of medical and personal care; ongoing concerns about visiting arrangements; the complaints process for when things go wrong; and the coverage of the protections of the Human Rights Act 1998 (HRA) to all those in receipt of regulated care services. As health services are devolved, our inquiry focuses on care settings in England although we draw on experiences elsewhere where useful through this report.

The Government is under a number of domestic and international obligations relating to the provision of medical and personal care services. Together, these require that those in care settings should have access to the highest attainable standard of health, as protected by Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR). They should also have their personal needs met, in light of the

protection against torture and inhuman or degrading treatment (Article 3 of the European Convention on Human Rights (ECHR)) and the principle of human dignity. However, too often these standards are not met, and individuals suffer. The regulator for health and care services, the Care Quality Commission (CQC), must fulfil its duty to monitor providers' compliance with the required standards, and hold providers accountable in a timely way. Where services are commissioned, the commissioning body must ensure that there is sufficient provision for monitoring and accountability by the contracting public authority, to allow it to identify whether human rights obligations are being discharged. Specific training on human rights and its effects on the provision of services must be given by all registered providers to staff with the CQC working with all stakeholders to ensure this is taking place.

Some care users have Do Not Attempt Cardio-Pulmonary Resuscitation Notices (DNACPR) in place. These make recommendations that CPR is not given in instances where a person stops breathing or their heart stops beating. During the pandemic we were hugely concerned to hear that these were being applied to care users without their knowledge, in a blanket fashion, contrary to the right to life under Article 2 ECHR. We were disappointed to hear that concerns remain about the use of such notices, with what is often poor consultation with care users and their families, insufficient record keeping, and inappropriate use. We call on the Government to work with stakeholders to raise awareness about the appropriate use of DNACPR notices.

We were also concerned to hear about ongoing issues with Deprivation of Liberty Safeguards (DoLS), the check that is put in

place to ensure that detention in care settings is within the law and in line with the prohibition of torture and inhuman or degrading treatment under Article 3 ECHR, and the right to liberty and security, under Article 5 ECHR. There are often unacceptable delays in authorisation of DoLS and there is often no access to legal aid if care users wish to challenge their deprivation of liberty in court. Whilst the DoLS system is going to be replaced by a new Liberty Protection Safeguards System (LPS), there is no timetable for this to be rolled out. We ask that the Government must work with the regulator and all stakeholders to ensure that providers fully understand the functioning DoLS and comply with statutory requirements, and that access to legal aid for those who wish to challenge is widened. The Government should also set a timetable for rollout of the LPS system and keep us updated on progress.

We have reported before on the visiting arrangements for those in care settings during the pandemic. Evidence submitted to this inquiry showed that through and beyond the pandemic problems persisted with providers following guidance. We also believe a lesson learnt from the pandemic was the harm caused by blanket bans on visiting. We have called in the past for the Government to legislate and do so again here. The Government must introduce legislation to secure to care users the right to nominate one or more individuals to visit and to provide support or care in all circumstances, subject to the same infection prevention and control rules as care staff. The Government must also legislate to give the CQC the power to require care settings to inform them of any changes to their visiting status, and to report live data on levels of visiting and restrictions. The CQC must make compliance with visiting restrictions a key

consideration when undertaking its regulatory and monitoring roles.

Under the HRA, public authorities must act compatibly with ECHR rights. Those providing care services in care settings, however, are not all public authorities. Unless care legislation, such as the Care Act 2014, contract law, or consumer standards provide equivalent protections, there is no way for privately funded individuals in private care settings to enforce human rights on the same basis as for those in publicly funded care settings. This can mean that two residents in the same care home might have different legally enforceable rights. We recommend that the Government should consult on extending the protections of the HRA to those receiving care and support from all regulated providers, and suggest a way this could be done through an amendment of the Care Act 2014.

When something goes wrong, the users of a service should have access to an effective complaints mechanism that is capable of investigating those complaints, and putting things right, in a way that is transparent, fair, and proportionate. However, the complaints system for care users is confusing, time consuming and too often does not result in effective resolution. The system needs to become easier to navigate. Care users must not be frightened of retribution if they complain. We recommend changes to streamline the process, with the roles of the CQC, the Local Government and Social Care Ombudsman (LGSCO), and the Parliamentary and Health Service Ombudsman (PHSO) clarified and with all three organisations operating a “no wrong door policy”.

MCA, advance decisions and shifting the dial – in conversation with Compassion in Dying

[Alex has recorded a shedinar](#) with two representatives from Compassion in Dying, [Usha Grieve](#) and [Sarah Malik](#), reflecting on the promises and pitfalls of advance decision-making.

Difficult Capacity Cases – The Experience of Liaison Psychiatrists

The most recent publication from the [Mental Health and Justice project](#) is an article published in *Frontiers in Psychiatry* on 11 July 2022 led on by Dr Nuala Kane, digging into ‘difficult’ capacity cases. Called [Difficult Capacity Cases—The Experience of Liaison Psychiatrists. An Interview Study Across Three Jurisdictions](#), they explain the motivation for the article in the introduction:

Assessment of capacity for treatment and discharge decisions is common in the general hospital. Liaison psychiatrists are often asked to support the treating medical or surgical team in difficult capacity assessments. However, empirical research on identification and resolution of difficult capacity cases is limited. Some studies have identified certain patient, decisional, and interpersonal factors which cause difficulty, but no study has explored how these issues are resolved in practice. Our study therefore aimed to describe how experienced liaison psychiatrists identify and resolve difficult capacity cases in a general hospital setting.

Methods: We carried out semi-structured interviews with 26 liaison psychiatrists from England, Scotland, and New Zealand, on their most difficult capacity cases. Thematic analysis was used to examine types of difficulty and how these were resolved in practice. Summaries were prepared and example quotes extracted to illustrate phenomena described.

Results: We identified four types of difficulty in capacity assessment,

spanning both clinical and ethical domains: 1) Difficulty determining whether the decision is the patient's own or driven by illness, 2) Difficulty in applying ethical principles, 3) Difficulty in avoiding personal bias, and 4) Procedural difficulties. The liaison psychiatrists presented as self-reflective and aware of challenges and pitfalls in hard cases. We summarized their creative strategies to resolve difficulty in assessment.

The paper stands alongside the other outputs from the 'contested capacity' workstream of Mental Health & Justice, including:

- [Taking capacity seriously: 10 years of capacity disputes before the Court of Protection](#): an article in the International Journal of Law and Psychiatry, which outlines the history of the functional model in England and Wales, and the development of the Court of Protection. It also presents empirical and case-based study of 40 published cases of capacity disputes presented to the Court of Protection, or to the Court of Appeal on appeal from the Court of Protection, during the first ten years of its existence.
- [Applying decision-making capacity criteria in practice: A content analysis of court judgments](#), published in PLOS ONE in February 2021, looking at the way in which the 'functional test' within the MCA is broken down into 'capacity rationales' in practice. A shedinar about the article with Nuala, the lead author, can be found [here](#).
- [Broad concepts and messy realities: optimising the application of mental capacity criteria](#): an article published in the Journal of Medical Ethics in July

2021, digging into how to make capacity assessments more granular and transparent. An accompanying blog by the lead author, Dr Scott Kim, is [here](#).

And last, but very much not least, the [website](#) established by the team to seek to provide practical, research-based guidance for clinicians and social care professionals on the assessment of capacity.

Alex Ruck Keene

European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment and MHA reform

The Council of Europe's [Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment](#) ('CPT, which nb, as needs saying nowadays, has nothing to do with the European Union) published its [report](#) on its 2021 visit to the United Kingdom² on 7 July 2022. As is conventional, it also published the UK Government's [response](#) to its report. Much of the report is directed towards conditions in prisons, the CPT:

again highlight[ing] the cumulative deleterious effects on the lives of prisoners of chronic overcrowding, poor living conditions and the lack of purposeful regimes. Since 2016, these long-standing problems have been exacerbated by a significant escalation in levels of violence. The Covid-19 pandemic may have resulted in a temporary reduction in overcrowding and in violence levels coming down, but the report notes that the underlying structural causes of overcrowding and

² Note, the CPT appears not to have visited Northern Ireland, Wales or Scotland; neither the report, nor the Government's response, appears to take account the different frameworks in

place in those jurisdictions (even the MHA 1983 operates somewhat differently in Wales): it focuses solely upon the position in England.

violence in prison have not been addressed.

This summary focuses on those sections of its report (and the response) relevant to the process of reform of the Mental Health Act 1983 and extracts the key material parts of the CPT's report and the UK Government's response (removing footnotes):

Consent to treatment

CPT report and recommendation

185. In the report on the 2016 visit, the CPT recommended that consent to treatment safeguards needed to be reinforced during the first three months of detention and that the relevant legislation should be amended so as to require an immediate external psychiatric opinion where a patient does not agree with the treatment proposed by the establishment's doctors. In their response, the United Kingdom authorities stated their keenness to continue to make improvements where possible and that they would take the CPT's comments into account. The White Paper on the reform of the MHA does indeed propose a change in the law, namely, that the current period of three months be reduced to fourteen days in the case of a capable patient objecting to the treatment and two months for those without capacity to decide. While representing a step in the right direction, the CPT considers that the proposed revised time frames are still too long to undergo forced treatment without a second opinion.

The CPT recommends that the relevant legislation should be amended so as to require an immediate external psychiatric opinion in any case where any patient actively or passively objects to the treatment proposed by the establishment's doctors; further, patients should be able to appeal against a

compulsory treatment decision to an independent authority, such as the Mental Health Tribunal, and the patient should be informed both orally and in writing of this right.

Government response

The proposed reforms to the Act introduce new safeguards that give the patient greater control over their care and treatment and ensure that they receive independent scrutiny of their treatment at a much earlier point in their detention. For patients who are not consenting to treatment, clinicians will be subject to more stringent rules around when they can override the patient's refusal. This is to ensure that clinically 59 appropriate alternatives, which might be more in line with the patient's wishes and preferences receive proper consideration. If it is decided that compulsory treatment is necessary, then an external psychiatric opinion provided by a SOAD must be requested by the clinician at this point, rather than after the treatment has been given for a period of three months. Patients are currently able to appeal treatment decisions by way of Judicial Review. The Independent Review of the Act recommended that patients should have a new right of appeal to a single judge of the First Tier Tribunal (Mental Health) (MHT). We consulted on this proposal in the White Paper Reforming the Mental Health Act 1983, and a number of significant concerns were raised with this policy, which we are currently exploring in greater detail to establish if they can be overcome.

Naso-gastric feeding

CPT report and recommendation

186. The CPT has always considered the issue of force feeding to be a very sensitive issue that raises many fundamental

questions, in particular of a legal, medical, deontological and ethical nature. At Cygnet Hospital Sheffield and St Andrew's Healthcare Northampton "treatment" in the form of food was being administered to patients with eating disorders by naso-gastric tube (NGT) under section 63 of the MHA. Treatment administered under this section does not need a SOAD opinion and there is no review of the treatment. The CPT does not contest the necessity for such invasive treatment after all other options have been explored but it nevertheless considers that there ought to be an independent regular review of such treatment. Furthermore, the delegation received several allegations of patients who were subjected to naso-gastric feeding in the presence of other patients.

The CPT recommends that all invasive procedures such as forced feeding via NGT should be subject to regular independent review and should be performed out of sight of other patients to preserve the dignity and safety of the patient concerned. All naso-gastric feeding within Cygnet CAMHS services should be done in a separated area away from the sight of other patients.

Government response

At Cygnet Hospitals Bury and Sheffield, a dedicated area has been established for such packages of care. A similar area has also been identified at Cygnet's Joyce Parker Hospital, in readiness for when they launch their NG feeding programme later in 2022. There is a CAMHS clinical working group that works across all Cygnet CAMHS services. This group has a live action plan regarding the further development of NG feeding programmes within CAMHS. Part of this action plan is ensuring independent reviews.

Recording of consent

CPT report and recommendation

189. In its report on the 2016 periodic visit to the United Kingdom, the CPT was also concerned that not all patients had provided their consent to treatment in writing on a specific form ("T2" form under section 58a MHA). During the 2021 visit, the CPT's delegation found that the T2 forms did not contain the patient's signature consenting to treatment as the forms had been digitalised and it was no longer possible for the patients' signatures to appear. In addition, a written form showing a patient's consent to treatment would not be included in the future statutory care plan as it was reasoned that a patient might change their mind and it would be more difficult to go back on the initial decision if it were in writing. However, even though T2 forms do not expire, they should be regularly reviewed and become invalid if the patient loses capacity or if they withdraw their consent, upon which a T3 form¹³⁰ should be drawn up. There is therefore provision in law for such a situation and the signature is not set in stone. The CPT recommends that the United Kingdom authorities take steps to enable patients to sign T2 forms, even electronically. Further, it recommends that such a form be included in the care and treatment plan that will be placed on a statutory footing.

Government response

The T2 form is already a statutory document (see The Mental Health (Hospital, Guardianship and Treatment) (England) (Amendment) Regulations 2008). Therefore, we do not think that there is a benefit to including in the new statutory Care and Treatment Plan. We note the CPT's recommendations with regards to enabling patients to sign T2 forms, however we are concerned that this could have adverse consequences. For

example, patients may feel that their signature carries a contractual status and therefore cannot be easily withdrawn, should they later change their mind and wish to refuse the treatment in question.

SOADs

CPT report and recommendation

190. Capacity assessments are carried out upon admission and regularly reviewed. In all establishments visited, the delegation found that second opinion appointed doctor (SOAD) assessments were carried out over the telephone. This is a completely unacceptable way for such a procedure to take place and does not provide sufficient safeguards, particularly for the young autistic patients at the Alnwood Unit who had multiple additional diagnoses. The CPT understands that due to restrictions related to the Covid-19 pandemic, it was not always possible for these assessments to take place in person, but they should at the very least take place in a manner that enables the SOAD to gain a better idea of a patient's situation than merely by hearing their voice over the telephone. In fact, the High Court of England and Wales recently ruled in an advisory opinion that "personally seen" (section 11 MHA) and "personally examined" (section 12 MHA) require physical presence. The CPT recommends that the United Kingdom authorities take action to ensure that patients in all mental health facilities are seen in person during a SOAD assessment.

Government response

Remote assessments by the SOAD service using video and telephone communication were adopted at a time when national Covid-19 restrictions were in place and the practical alternative – passed in law (Coronavirus Act 2020) but never

implemented – was the suspension of SOAD assessments and their replacement by self-certification by treating doctors. Following a relaxation of the Covid-19 restrictions, SOAD assessments can now be carried out in person through a visit by the SOAD to the detaining hospital, although CQC allows the option of a remote assessment where this is deemed appropriate by the individual SOAD. The pandemic has broadened the use of telemedicine in many fields of practice, and while the CQC accepts that there are particular sensitivities regarding the issue of treatment without consent under a statutory framework, we do not take the view that this necessarily excludes the use of telemedicine in the procedural safeguards of a SOAD assessment. The CQC supports the continuation of remote assessments as an option as it considers that they can be a practical and effective way to provide the procedural safeguard, especially where it might be decided (on a case-by-case basis) that an assessment in person would cause unnecessary delay without adding value or meeting a patient's express wishes. Any visitors to units are required to follow the appropriate IPC requirements/guidelines which includes those related to COVID.

CPT report and recommendation

191. The CPT's delegation also noted that there were often delays in accessing a SOAD, particularly at St Andrew's Healthcare Northampton where SOADs took six weeks or even longer before they came to carry out the assessment. In the meantime, patients were treated under section 62 MHA which should only be used in emergency situations. This state of affairs is completely inappropriate, as not only are patients treated against their will for longer than the current statutory period of three months, but it also represents a misuse of section 62 and means that there

is no effective legal basis for the involuntary treatment.

The CPT recommends that the United Kingdom authorities take steps to reduce the time limits for SOADs to carry out their assessment to ensure that patients are not subjected to involuntary treatment beyond the current statutory period of three months without a second opinion.

Government response

The cause of patients being treated without certification (under urgent treatment powers) upon the expiry of the three-month rule may be due to undue delays in completing the SOAD procedure but can also be due to late requests for that procedure to start, or inadequate information being provided by the treating hospital. There is currently nothing intrinsic to the current SOAD procedure that extends its duration beyond what is necessary to make physical arrangements for the review of treatment.

As such the key focus on ensuring that there are no gaps between the end of the three-month rule and completion of SOAD assessments is for treating hospitals to ensure that they anticipate and request such assessments in good time before the end of the three-month period. The MHA Code of Practice states that such requests should be made at least four weeks before the end of the three-month period (para 25.15). CQC collates information on late requests and shares this with Providers through its INSIGHT reports to enable them to investigate and audit their practice in this regard, and CQC can follow up with authorities who appear to be making such late requests at an avoidable level.

Data on all second opinion activity for the last two years shows a national average

time from receipt to assessment of 12 days.

For St Andrew's Hospital, specifically mentioned by the CPT, this has been 20 days. However, we do accept that 36 (9%) out of 386 second opinions for St Andrew's took six weeks to completion. St Andrew's is a large site with a relatively long-stay population, and as such submits a high volume of SOAD requests. This does create a challenge in meeting their specific demand with a relatively small pool of SOADs willing or able to visit or carry out the second opinions remotely for this site. This is one of a few hospitals where we agreed to arrange monthly day sessions (pre-scheduled days where the appointed SOAD would carry out multiple second opinions). These have not always worked as expected, due to logistical difficulties (e.g., due to a lack of arrangements on the part of the Provider or when the appointed SOAD is unable to do the day due to ill health), and despite regular SOAD activity at the site, where day sessions have to be cancelled this exacerbates delays.

There are no statutory time limits for the completion of SOAD work, and we do not have plans at present to introduce ones for general requests. If the SOAD assessment is requested with sufficient time before the end of the three-month rule, such a time limit would serve no purpose. We consider it would be better for the assessment to take as long as is required to ensure adequate consultation, etc, than be curtailed by an arbitrary cut-off point. In a similar way, for much of the civil detention procedure under the MHA there are no such time limits, with similar justification.

The CPT notes the UK Government's proposal to reduce the 'three-month period' to no longer than two months in any case, and considerably shorter for some cases. SOAD procedures are under

exploration at present as legislative proposals are being drawn up.

The Mental Health Tribunal

CPT report and recommendation

193. In its report on the 2016 periodic visit to the United Kingdom, the CPT had recommended that patients be able to appeal against a compulsory treatment decision to the Mental Health Tribunal. Although the situation had not evolved at the time of the 2021 visit, the CPT notes that the planned reform of the MHA will make it possible for patients to be able to challenge a specific treatment before a single-judge tribunal (in a “permission to appeal” stage before the case goes to a full MHT hearing). The judge will not be able to make a clinical decision but will be able to make a finding that the responsible clinician should reconsider their treatment decision. **The CPT supports this proposed additional role for the MHT.**

Government response

The Independent Review of the Act recommended that patients should have a new right of appeal to a single judge of the First Tier Tribunal (Mental Health) (MHT). We consulted on this proposal in White Paper Reforming the Mental Health Act 1983 and a number of significant concerns were raised with this policy, which we are currently exploring in greater detail to establish if they can be overcome.

CPT report and recommendation

195. The CPT’s delegation found that in all establishments visited, review procedures appeared to function appropriately. Provision was made for MHTs to take place on the premises, although during the height of the pandemic, the tribunals were held via videoconference. At Bamburgh

Clinic, during the first lockdown, there was no hearing of the person either physically or remotely; reviews were only carried out on paper. Even though a tribunal without a hearing is permitted, particularly during the pandemic, in exceptional circumstances by the First-tier Tribunal (Health, Education and Social Care Chamber) Rules, which the MHT must follow, the CPT considers this not to be a good practice, as the possibility for the patient to attend tribunals preserves their interest in the decision-making process. The CPT recommends that even during public health crises, patients with mental health disorders have an effective right to be heard by the MHT at the very least by audiovisual means when the court reviews the lawfulness of their continued involuntary hospitalisation.

Government response

In response to the COVID-19 outbreak, a series of temporary, emergency rule changes and practice directions were made to alter how proceedings in the tribunals could be conducted. After six months, these practice directions were reviewed and extended until March 2021.

These temporary measures affected the Mental Health Tribunal by:

- allowing cases to be decided by a single judge sitting alone, unless the Chamber, President or Deputy Chamber President considers it to be inappropriate.
- allowing certain cases to be dealt with on the papers, unless the Tribunal considers it to be inappropriate; and
- temporarily removing the requirement for pre-hearing examinations, unless the Chamber President, Deputy Chamber President or an authorised salaried judge deem one necessary due to the exceptional circumstances of the case.

The changes enabled the Tribunal to continue operating during the pandemic period. During a crisis the Tribunal needs to retain the flexibility to respond as is necessary and appropriate in order to deliver justice. This may include being able to prescribe whether certain categories of cases may be more suitable to be dealt with on the papers, and/or allowing patients to be able to choose to have their case dealt with as a hearing by papers. During the pandemic the Tribunal utilised the use of video/ audio hearings where appropriate and the Tribunal continues to utilise this technology today.

- *challenge treatment decisions where they have reason to believe they are not in the patient’s best interests*
- *appeal to the tribunal when patients are too unwell to do so themselves*

High quality advocacy is critical to make sure people get the support they need when detained. We are considering how we can improve the role and we welcome your views on whether this can be achieved by professionalising the service.

As set out in the White Paper Reforming the Mental Health Act 1983, we will take forward legislative changes to extend eligibility of IMHA services to all mental health inpatients, including informal patients, and to add the proposed additional rights and powers relating to supporting service users with advance choice and care planning, and applying to the Tribunal on behalf of the service user. We will also consider the requirements needed for an opt out service.

IMHAs

CPT report and recommendation

198. [...] All patients in mental health units in England have access to independent mental health advocates who help patients express their views and concerns, including when making a complaint. However, not all patients in Priory Hospital Enfield were aware of the existence of these advocates and some said that they had never seen one. The CPT stresses the importance of independent mental health advocates as providing an additional safeguard for patient’s rights and recommends that all patients be informed of their existence and provided greater access to them.

Government response

Independent mental health advocates (IMHAs) provide important safeguards to people detained under the Act. We want to expand the role of IMHAs so that they can also

- *support patients to take part in care planning*
- *support individuals to prepare advance choice documents*

Comment

Editorially, it is noteworthy, one might think, that the CPT appear to proceed on a rather different basis as regards the fundamental validity of a system which allows for compulsory detention and treatment (even including naso-gastric “force” feeding), than does the Committee on the Rights of Persons with Disabilities); likewise the CPT appears to accept concepts such as mental capacity which are contested by the Committee. See further in this regard the [discussion](#) at Appendix B to the report of the independent Review of the MHA 1983.

Alex Ruck Keene

Suicide and the (mis)use of capacity – in conversation with Dr Chloe Beale

In a recent shedinar, Alex talked to [Dr Chloe Beale](#) about the uses and misuses of capacity in the context of responding to suicide risk. Warning, they do get quite deep into the issues involved.

The LPS and care providers

In this video, recorded on 12 July 2022, Alex gives an overview of how the LPS is relevant for care providers (primarily residential care providers), and what steps they need to be taking to ready themselves for LPS implementation.

Reported judgments involving medical treatment of children

In a very helpful development anyone either interested in or involved in cases involving the medical treatment of children, Professor Jo Bridgeman has persuaded her publishers to allow her to put online, and keep updated, a [table of reported judgments](#) which originally appeared as an appendix to her [excellent](#) book, [Medical Treatment of Children and the Law: Beyond Parental Responsibilities](#). The table lists all reported cases concerning the medical treatment of children from the first case of *Re D* in 1976 and is updated monthly. In addition to the case citation and judge, the table includes: age and medical condition of the child, the treatment at issue, the process by which the case was referred to court, the decision of the court and identifies important issues raised by the case.

Book Review: Medical Treatment Decisions and the Law

[Medical Treatment: Decisions and the Law](#) (4th edition) (Edited by Christopher Johnston QC and Sophia Roper QC (Bloomsbury Professional, 2012, paperback and ebook, £110))

I [described](#) the 3rd edition of this work (published in 2016) as the authoritative practitioner text for medical treatment cases. Now co-edited by Christopher Johnston and Sophia Roper QC, and with a further expanded authorial team from Serjeants' Inn Chambers (some 29 in total, including the editors), I am happy to say that the description remains equally apt for the 4th edition. As before, it contains a very helpful overview of general principles in Part 1 (addressing the position both in relation to adults and children), before applying those principles to specific problems in Part 2 (for instance, in a particularly strong chapter, in relation to cases involving pregnancy and childbirth). Throughout, the crisp analysis is supported by extensive footnotes enabling rabbit holes to be followed where relevant (or mined for skeleton arguments, to mix a metaphor).

Since the publication of the last edition, it is perhaps relevant to note the following key developments (all covered in this work):

- The continued working out of the implications of the [Montgomery](#) decision as regards the duties of medical professionals (applying the law of negligence) to provide relevant information to patients. As this new edition notes (although the framing which follows is mine) there is an intriguing, and yet to be resolved, tension between the approach of the MCA 2005 (pushing towards a low threshold for the giving of consent) and the negligence approach (pushing towards ever greater information-provision before such consent can be said to be informed);
- The continued discussion between the courts and clinicians about their respective decision-making authority, seen in the life-sustaining treatment context in [NHS Trust v Y](#) and in the

context of those under 18 in *Bell v Tavistock*;

- Linked, continued discussion about when and why authority must be sought from the courts, including the publication of [guidance](#) (in relation to adults) by the Vice-President of the Court of Protection – an issue covered in exemplary fashion in Chapter 6 ('Going to Court'), likely to be one of the most well-thumbed chapters in the work;
- A simultaneous expansion ([to those aged 16/17](#)) and contraction (through the so-called *Ferreira* carve-out) of the concept of deprivation of liberty in the medical context;
- The placing of conventional understandings of medical decision-making under enormous strain during the pandemic so far, placing an increased focus (amongst other things) on choices and funding in access to healthcare.

pragmatic world of the court room" (in Sir James Munby's rather robust dismissal of such a point in *NHS Trust v X (No 2)*). Nor does it seek to engage with the ethical dilemmas that underpin so many of the decisions in this area (for a contrasting – or perhaps complementary – approach, see the 2nd edition of *Law and Ethics in Intensive Care*). But as an authoritative guide to how the law works, and how to navigate the law in medical treatment decision-making, the guide is unrivalled.

[Full disclosure: I am grateful to the publishers for providing me with a copy of this book. I am always happy to review works in or related to the field of mental capacity (broadly defined)]

Alex Ruck Keene

One other development since the previous edition I am duty-bound to note is the publication of Ben Troke's *A Practical Guide to the Law of Medical Treatment Decisions*, which, at around £100 cheaper, and several hundred pages shorter, might on its face appear somewhat to have stolen the present authors' thunder. However, as I noted in my [review](#) at the time, the two books in fact very happily co-exist: Ben Troke's book for the medical professional who needs an overview, and this book for either the particularly medico-legally enthusiastic clinician or, more likely, the desk of the lawyers within the Trust, Integrated Care Board or Local Health Board (or those they instruct) who need clear and above all sound assistance in providing advice to that clinician/their team.

As with the previous edition, whilst it draws lightly upon academic commentary in places, this book does not dwell upon points which have more "traction amongst the dreaming spires of the Academy than in the robust and ultimately

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Conferences and Seminars

Forthcoming Training Courses

Neil Allen will be running the following series of training courses:

16 September 2022	BIA/DoLS legal update (full-day)
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To book for an organisation or individual, further details are available [here](#) or you can email [Neil](#).

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 September. 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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