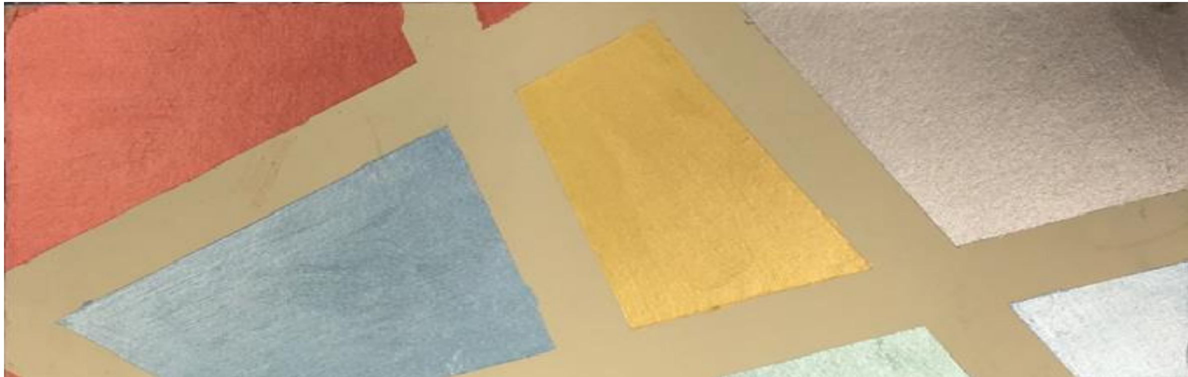

Welcome to the June 2019 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: an update on the Mental Capacity (Amendment) Act; the Court of Appeal on sex and social media; life-sustaining treatment in a 'pro-life' care home; an important Strasbourg case on deprivation of liberty; and the former Vice-President of the Court of Protection on the MHA 1983/MCA 2005 interface in the community; .

(2) In the Practice and Procedure Report: a richly deserved award for District Judge Eldergill; and civil restraint orders in the presence of impaired litigation capacity;

(3) In the Wider Context Report: a summary of the recent developments relating to learning disability, seclusion and restraint; inquests, DoLS and Article 2 ECHR; and international developments including a ground-breaking report on the right to independent living;

(4) In the Scotland Report: the Chair of the newly established review of the Mental Health (Care and Treatment) Act 2003 provides his initial thoughts; and the Stage 1 report of the Independent review of learning disability and autism in the Mental Health Act.

For lack of sufficient relevant material, we have no Property and Affairs Report this month.

You can find all our past issues, our case summaries, and more on our dedicated sub-site here.

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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

HEALTH, WELFARE AND DEPRIVATION OF LIBERTY 3
Medical treatment seminar 3
LPS update 3
Sex, social media and 'silos' 3
Life-sustaining treatment – what would P have done? And does it make a difference that she is in a 'pro-life' nursing home? 8
Testing the faith 11
Deprivation of liberty – appropriate places and appropriate treatment 12
Does the Court of Protection have a role in respect of conditionally discharged restricted or detained patients whose living arrangements amount to a deprivation of liberty? 15
PRACTICE AND PROCEDURE 25
District Judge Eldergill 25
Short note: permission test for appeals 25
Short note: litigation capacity and civil restraint orders 25
THE WIDER CONTEXT 27
ENGLAND, WALES AND NORTHERN IRELAND 27
Learning Disabilities Mortality Review 27
Restraint, seclusion and abuse: the CQC and Whorlton Hall 28
Detained children 29
Inquests, detention and DOLS 31
Short note: litigation friends, settlement and costs 34
Deprivation of liberty – the limits of the inherent jurisdiction 34
Deprivation of liberty – the Northern Irish perspective 36
Short note: when can the police use force to respond to a person in mental health crisis? 37
The financial cost of unlawful psychiatric detention 38
Short note: unincorporated international conventions and treaty bodies 39
Mental ill-health and appeals from the Employment Tribunal 40
INTERNATIONAL DEVELOPMENTS 41
Irish Law Commission: a statutory framework for safeguarding 41
Independent living across Europe 42
Deprivation of liberty and disability – good practices 42
RESEARCH CORNER 43
SCOTLAND 45
Scottish Government extended review 45
Review of the Mental Health (Care and Treatment) Act 2003: the Chair's perspective 46
Independent review of learning disability and autism in the Mental Health Act: Stage 1 report 47
More on anonymisation – the *MH* case again 47
Visiting team from Singapore 48
The Independent Inquiry into Mental Health Services in Tayside: Interim Report – Inquiry update and Emergent Key Themes 49

HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

Medical treatment seminar

We are holding a half-day seminar in Chambers on medical treatment on 26 June, covering such topics as fluctuating capacity, diabetes and amputation, when applications have to be made, and urgent applications. For more details, and to book, see here.

LPS update

The Government has confirmed its intention is that the Liberty Protection Safeguards system will to come into force on 1 October 2020, subject to ongoing implementation planning with delivery partners and the Welsh Government and progress of the work on developing the Code of Practice and regulations for this reform.

The DHSC update circulated on 12 June 2020 continues

> *The Government is currently working closely with stakeholders across the sector in England and Wales on developing draft chapters for the Code of Practice. The Code of Practice will be a vital document for practitioners, the people who rely on these protections and their families. The Government's priority is to ensure the Code of Practice delivers on providing detailed and easy to understand guidance which will ensure the successful implementation of the new system. The focus must be on getting this right.*
>
> *Good progress is being made and initial outputs from the working groups contributing to this work can be expected by summer 2019. The Government plans to do further work with expert groups and those with lived experience over the coming months and following this there will be a full public consultation. The final draft of the Code is expected to be laid before Parliament in spring 2020. The Department of Health and Social Care is working closely with the Ministry of Justice to align this work with the review of the Mental Capacity Act Code of Practice.*
>
> *The Government is also in the process of drafting the regulations brought forward by the Act. These will set out important detail regarding the reform. There will be engagement with the sector on the development of the regulations and we expect that these will also be laid before Parliament in spring 2020.*
>
> *Alongside the work on the Code of Practice and the regulations, the Government is taking forward a range of activity to prepare for implementation of the Liberty Protection Safeguards, working closely with key delivery partners and stakeholders. Some initial materials will be published shortly which will be publicly available and they can be used by the sector as a starting point in the preparations for the new system. The Government is also in the process of developing training both to support staff in the sector with the change to the new system, and to approve people to become Approved Mental Capacity Professionals.*

For more details of the LPS scheme, see Alex's website here.

Sex, social media and 'silos'

B v A Local Authority [2019] EWCA Civ 913 (Court of Appeal (Sir Terence Etherton MR, King and Leggatt LJJ))

Mental capacity – assessing capacity – residence – sexual relations – social media

Summary

The Court of Appeal has made both general and specific observations about the assessment of mental capacity in determining the appeal/cross-appeal against the decision of Cobb J in *Re B (Capacity: Social Media: Care and Contact)* [2019] EWCOP 3. As it noted at the outset of its judgment:

> *5. The important questions on these appeals are as to the factors relevant to making the determinations of capacity which are under challenge and as to the approach to assessment of capacity when the absence of capacity to make a particular decision would conflict with a conclusion that there is capacity to make some other decision.*

In *Re B*, handed down at the same time as *Re A* [2019] EWCOP 2, Cobb J took the test that he had drawn up in *Re A* for capacity to decide to use social media for purpose of developing or maintaining connections with others, and applied them to a 31 year old woman, B, to make an interim declaration that she lacked that capacity. He also made interim declarations about B's capacity to decide as to residence, care, contact and sexual relations.

The Official Solicitor, as B's litigation friend, appealed against those parts of Cobb J's order relating to social media and sexual relations. The local authority cross-appealed against Cobb J's determination that B had capacity to decide upon residence.

By way of general observation, the Court of Appeal noted that:

> *35. Cases, like the present, which concern whether or not a person has the mental capacity to make the decision which the person would like to make involve two broad principles of social policy which, depending on the facts, may not always be easy to reconcile. On the one hand, there is a recognition of the right of every individual to dignity and self-determination and, on the other hand, there is a need to protect individuals and safeguard their interests where their individual qualities or situation place them in a particularly vulnerable situation: comp. A.M.V v Finland (23.3.2017) ECrtHR Application No.53251/13.*
>
> […]
>
> *36. As has frequently been said, in applying those provisions the court must always be careful not to discriminate against persons suffering from a mental disability by imposing too high a test of capacity: see, for example, PH v A Local Authority [2011] EWHC 1704 (Fam) at [16xi].*

Social media

The Court of Appeal had little hesitation in dismissing the Official Solicitor's appeal, because the Official Solicitor did not challenge the finding in the order that B lacked capacity in this domain, but rather the reasoning that underpinned that finding. However, "[i]*t is a basic principle […] that an appeal is against an order and*

not merely the reasoning of the judge in support of his or her order to which no objection is made."

The Court of Appeal limited itself to observing that there was no particular advantage to the alternative formulation that the Official Solicitor advanced for the formulation of the relevant information, and that:

> *44.* […] *Whether the list or guideline of relevant information is shorter or longer, it is to be treated and applied as no more than guidance to be adapted to the facts of the particular case.*

Sexual relations

The Official Solicitor objected to the following aspects of Cobb J's formulation of the relevant information:

> *(iii) the opportunity to say no; i.e. to choose whether or not to engage in it and the capacity to decide whether to give or withhold consent to sexual intercourse.*
> *(iv) that there are health risks involved, particularly the acquisition of sexually transmitted and transmissible infections;*
> *(v) that the risks of sexually transmitted infection can be reduced by the taking of precautions such as the use of a condom.*

In dismissing the Official Solicitor's appeal, the Court of Appeal confirmed (paragraph 51) that the awareness of the ability to consent or refuse sexual relations is more than just an item of relevant information (but is one), but is fundamental to having capacity. It then went on to confirm that:

> 57. *In accordance with the MCA s.3(1)-(4), the ability to understand and retain [the risk of catching a sexually transmitted infection through unprotected sexual intercourse, and the protection against infection provided by the use of a condom, satisfy that requirement] at least for a period of time and to use or weigh them as part of the decision whether to engage in sexual intercourse are essential to capacity to make a decision whether to have sexual intercourse. What is critical is not that a person, whose capacity is being assessed, is permanently aware of how sexually transmitted infections may be caught and that protection may be provided by a condom. The assessment is not a general knowledge test. Rather it is an assessment of whether the person being assessed has the ability to understand those matters when explained to him or her and to retain the information for a period of time and to use or weigh it in deciding whether or not to consent to sexual relations.*
>
> *58. We are not bound by any of the authorities cited to us to reach a different conclusion. None of them state expressly that capacity is sufficiently demonstrated by a mere awareness that some kind of ill health may result from sexual relations even if that awareness is no more than a wholly misguided notion of how or why the ill health is caused and has nothing to do with what are in fact sexually transmitted infections or how they may be caused. We respectfully disagree with Parker J in London Borough of Southwark v KA at [72] that it is not necessary to understand condom use. The only practical purpose of understanding that sexually transmitted infections can be caused through sexual intercourse is to know how to reduce the risk of infection since the purpose cannot be to encourage abstinence from intercourse completely.*

As the Court of Appeal noted:

> *59. There are those who would object that many capacitous persons have unprotected sexual intercourse. Indeed, the MCA s.1(4) provides that a person is not to be treated as unable to make a decision merely because he makes an unwise decision. As Peter Jackson J said in Heart of England NHS Foundation Trust v JB [2014] EWHC 342 (COP) at [7], the temptation to base a judgement of a person's capacity upon whether they seem to have made a good or bad decision, and in particular upon whether they have accepted or rejected medical advice, is absolutely to be avoided "as it would allow the tail of welfare to wag the dog of capacity". It is important always to bear in mind, however, as stated in paragraph 4.40 of Chapter 4 of the Code of Practice, that there is a fundamental and principled distinction between an unwise decision, which a person has the right to make, and decisions based on a lack of ability to understand and weigh up information relevant to a decision, including the foreseeable consequences of a decision. As the Code of Practice says, information about decisions the person has made based on a lack of understanding of risks or inability to weigh up the information can form part of a capacity assessment, particularly if someone repeatedly makes decisions that put themselves at risk or result in harm to them.*

The Court of Appeal, by way of "brief postscript," noted that B had been previously assessed on a number of occasions as having capacity to consent to sexual relations:

> *61. [...] the MCA s.1(3) provides that a person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success. In her oral evidence Dr Rippon accepted that she had not asked B about condoms. At one point in his oral submissions Mr Lock appeared to admit that there had been a breach of the MCA s.1(3) because Dr Rippon had not reminded B how sexually transmitted infections were passed and the role of condoms in reducing the risk of infection. We make no observations and no findings in relation to that aspect because it does not form a ground of appeal and only arose in the course of exchanges between Mr Lock and ourselves in the course of the hearing. Further work on whether B has sufficient understanding of sexually transmitted infections and how to reduce the risk of them will no doubt form part of the continuing engagement with B prior to a final decision on capacity to consent to sexual relations under the MCA s.15.*

Residence

The local authority cross-appealed Cobb J's decision that B had capacity to decide on residence, criticising his use of the list of relevant information set out in the decision of Theis J in Re LBX. The Court of Appeal observed that:

> 62. *So far as concerns the appropriateness of the list, as in the case of the list specified by Cobb J in relation to a decision to use social media, we see no principled problem with the list provided that it is treated and applied as no more than guidance to be expanded or contracted or otherwise adapted to the facts of the particular case.*

At the heart of the local authority's appeal was the argument that Cobb J's conclusion on B's

capacity to make decisions on residence, in particular whether to move to Mr C's property or to remain at her parents' home or to move into residential care, was fundamentally flawed in:

> *(1) failing to take into account relevant information relating to the consequences of each of those decisions, and (2) producing a situation in which there was an irreconcilable conflict with his conclusion on B's incapacity to make other decisions, and so (3) making the Local Authority's care for and treatment of B practically impossible. Mr Lock submitted that the Judge's flawed conclusion followed from his approach in analysing B's capacity in respect of different decisions as self-contained "silos" without regard to the overlap between them.*

The Court of Appeal agreed.

Comment

This appeal/cross-appeal, which was both heard and determined at commendable speed, is of importance both for the Court of Appeal's specific observations about capacity to consent to sexual relations – in particular in endorsing the fundamental nature of the need to understand that it is a consensual act – and also for its general observations about how to determine relevant information. It is helpful for confirming – in principle – the use of lists of/guidelines as to information drawn up by courts in different cases (and set out in our Guide to the assessment of capacity), whilst calibrating this with the obvious point that they are guidance to be applied to the facts of any given case. It is also helpful for confirming, in essence, the need to ensure that being too narrowly focused decision-specificity (which, in fairness Cobb J observed did pose its own problems) did not lead to conclusions that are mutually incompatible.

Finally, it will be extremely interesting to see whether Hayden J follows the rather broad hint given by the Court of Appeal that a flexible approach would be acceptable to enable him to resolve the conundrum in the case before him concerning capacity to consent to sexual relations in the context of marriage:

> *49.* […] *it is not in dispute on this appeal that the test for capacity to consent to sexual relationships is general and issue specific, rather than person or event specific. The application of that test in other cases is, however, a live matter as it is currently under consideration by Hayden J in London Borough of Tower Hamlets v NB [2019] EWCOP 17. In that case the judge observed in his interim judgment (at [12]) that there was only one individual with whom it was really contemplated that NB was likely to have a sexual relationship, her husband of 27 years; and it therefore seemed to the judge entirely artificial to be assessing her capacity in general terms when the reality was entirely specific. He added (at [13]) that it might be that NB's lack of understanding of sexually transmitted disease and pregnancy might not serve to vitiate her consent to have sex with her husband. There was no reason to suggest that her husband had had sexual relations outside the marriage and there was no history of sexually transmitted disease. Hayden J has reserved his judgment on the issue. Another example would be a post-menopausal woman, for whom the risk of pregnancy is irrelevant. In IM (at [[75]-[79] the Court of Appeal held that, by contrast with the criminal law*

> *where the focus, in the context of sexual offences, will always be upon a particular specific past event, in the context of mental capacity to enter into sexual relations the test is general and issue specific. The argument before Hayden J in London Borough of Tower Hamlets v NB was presumably that the conclusion in IM does not preclude the tailoring of relevant information to accommodate the individual characteristics of the person being assessed. We heard no argument on these points and do not need to decide them on the present appeals since it was not contended by the OS that anything in Cobb J's guideline was inapplicable because of B's personal characteristics.*

Life-sustaining treatment – what would P have done? And does it make a difference that she is in a 'pro-life' nursing home?

A Clinical Commissioning Group v P (Withdrawal of CANH) [2019] EWCOP 18 (MacDonald J)

Best interests – medical treatment

Summary

In this case MacDonald J gave a detailed judgment to explain why he endorsed an agreed position that he would not consent on behalf of a woman to the continuation of Clinically Assisted Nutrition and Hydration ('CANH'). It is of some importance as the paradigm example of a case that still has to come to court following *An NHS Trust v Y* [2018] UKSC 46, in which the Supreme Court had made clear that where there is a disagreement as to a proposed course of action, or where the approach is finely balanced, "an application to the court can and should be made."

Given the intense focus on P's wishes and feelings in medical treatment cases, the judgment contains a considerable amount of very personal information about the person at the centre of this case, a woman who took an overdose of heroin, went into cardiorespiratory arrest, and suffered a severe hypoxic brain injury. For present purposes, one feature is key, namely that she had had a relationship with a man who had suffered a traumatic brain injury that required him to be placed on life support. P was involved in the decision to terminate his life support. She told her mother that she would not want to be left in such condition if anything happened to her.

After P had suffered the hypoxic brain injury in April 2014 after a heroin overdose, best interests meetings were held. At what appears to have been the first formal one, in June 2014, P's mother had made clear that she did not consider P would wish to live in the circumstances she found herself in.

Following initial treatment in hospital, P was discharged to a nursing home in August 2014. As MacDonald J noted, the nursing home ('the Unit'):

> *is committed to rehabilitation work with those who suffer from neurological impairment. The home endeavours to improve the quality of life for all its residents, each of whom have very severe neurological disabilities. It is clear from the evidence before this court that the ethos of the Unit is about making the most of the lives of each individual labouring under neurological disability and endeavouring to maximise their potential. Within this context, a number of the staff at the Unit have made clear*

> *within the context of these proceedings that they have a strong 'pro-life' (their term) ethos.*

P's diagnosis was the subject of some variation; she was initially considered to be in a vegetative state, and then, some months later, to be in a minimally conscious state. Importantly, there was a difference of opinion between the views of the Unit caring for her and of her family as to her level of awareness, those caring for her at the Unit taking a much more optimistic view than that of the family.

The consultant in neurological rehabilitation medicine, Dr H, and Dr N, P's GP, declined to act as decision-makers in relation to withdrawal of CANH. Dr N did not explain why this was; Dr H explained that he was one of two Consultants in Neurological Rehabilitation in the area assessing patients at different stages of recovery from brain injury. He therefore "*adopted a blanket policy of maintaining a neutral position and not expressing a view as to best interests, in order not to be categorised as someone who was either pushing for withdrawal or not*."

The Unit was opposed to any discontinuation of CANH for two linked reasons:

> *First, because the staff at the Unit considered that P felt pain, laughed, grimaced, and reacted, despite her all-encompassing dependence. Second, staff felt that any decision to discontinue CANH in relation to P could apply equally to all patients at the Unit. More generally, Ms PL (Clinical Lead at the Unit) told Dr Pinder* [the independent expert] *that in stating that both she and her staff would not want CANH withdrawn, she stated that this was not particularly because they felt it was against the best interests, but because "… they are all 'pro-life' in general and do not agree with actively doing anything that is likely to shorten someone's life." Amongst the staff more widely, opposition to any withdrawal of CANH from P tended to involve general objections in principle to withdrawing CANH from a patient like P, a desire to continue caring for her and reluctance to be involved personally in the withdrawal, but also included opposition on the basis of the quality of P's life.*

Ultimately and given the "*consistent and firmly expressed opinion of P's eldest daughter, TD, half-sister, LD, and former partner, NG in favour of the withdrawal of CANH*," the CCG funding her care agreed to take the lead in considering invoking the legal process to obtain a decision on whether it was in P's best interests for CANH to be withdrawn. As part of doing so, and prior to bringing proceedings, they instructed an independent expert, before convening a further best interests meeting in January 2019, at which the Unit maintained its expressed reservations with respect to the removal of CANH, and P's family maintained their position that P would not have wanted to live as she was. The CCG then made the application to the Court of Protection.

Although there was no formal dispute before the court (the CCG being neutral, and the Official Solicitor on P's behalf agreeing with P's family that it was not in her best interests for CANH to be continued), MacDonald J gave a detailed judgment. He agreed that with the Official Solicitor that (following Briggs) "*P's past wishes and feelings on such an intensely personal issue as whether her CANH should be withdrawn can be ascertained with sufficient certainty and, on the particular facts of this application, should prevail over the very strong presumption in favour of*

preserving her life where those wishes were clearly against being kept alive in her current situation."

MacDonald J gave:

> *careful consideration to the views of the staff of the home in which P is cared for. They have the advantage of regular contact with P and are in a position to develop a detailed picture of her current presentation. Against this, they have not had the benefit that the family have had of knowing P when she was capacitous and of seeing and experiencing all of the many varied facets of her character, what she thought, what was dear to her, what she wished for the future and, importantly, what she believed about the situation in which she now finds herself. Whilst the 'pro-life' approach (as they themselves describe it) taken by a number of the members of staff in the current situation is a valid point of view, in the circumstances of this case I am satisfied that it is contrary to the clearly expressed view of P before she lost capacity.*

However, having conducted a detailed analysis of relevant parts of P's life, including, in particular, what had happened around the time of the death of her former partner, MacDonald J expressed himself:

> *sufficiently certain that P would not in her current situation have consented to ongoing life sustaining treatment, a position that is consistent with all that the court understands about her beliefs, her outlook and her personality, and with the clearly and consistently expressed views of her loving family, borne of their direct experience of her views and wishes and of who she was. In all the circumstances, I am satisfied that the sanctity of P's life should now give way to what I am satisfied was her settled view on the decision before the court prior to the fateful day of her overdose in April 2014.*

Comment

The CCG in this case undoubtedly did the right thing in terms of bringing the case to court; the fact that it had also 'front-loaded' the application by obtaining independent expert evidence in advance also meant that it was possible for the proceedings to be resolved much more quickly than would otherwise have been the case.

However, it is very problematic that it took over four years to address the fact that there was a clear disagreement as to whether continuing CANH was in P's best interests. It is sincerely to be hoped that with the publication of the BMA/RCP Guidance on CANH, which featured briefly in the decision (see paragraph 25), the nettle will be grasped very much earlier in other cases. In this context, it is perhaps to be regretted that MacDonald J did not highlight the discussion in the Guidance about conscientious objection, including that:

> *Provider organisations, including care homes, that carry religious or other convictions that would prevent them from making and implementing particular decisions about CANH should be open about that fact when a best interests decision is needed. All such organisations have a duty, however, to comply with the law, including ensuring that best interests assessments are carried out on a regular basis. These*

> *assessments should specifically consider the question of whether CANH continues to be in the patient's best interests as part of the care plan review. Where necessary, organisations should make arrangements for these assessments to be carried out in, or by staff from, another establishment.*

In relation to the BMA/RCP Guidance, we also note that training materials and case studies to accompany the Guidance have now been published and can be found here.

In terms of the substance of the decision, it is the model of a post-*Aintree* approach to best interests, with a clear eye to the gravity of the decision and of the principles in play. In its intense focus on seeking to reconstruct what P would have done, we would suggest that it also represents the implementation of the 'best interpretation of the will and preferences' of the person that the Committee on the Rights of Persons with Disabilities have to date held must govern steps being taken to secure the exercise of legal capacity where the person concerned is unable to express any views. In the case of Vincent Lambert (see the May Mental Capacity Report[1]), the Committee are being invited to adopt, in effect, a blanket position that life-sustaining treatment can never be withdrawn from a person in a prolonged disorder of consciousness. It will be of huge importance to see whether the Committee maintains its previous position in the face of this invitation.

Finally, and rather bathetically, a very small point in relation to the title of the judgment. Whilst the anonymisation by way of initials means that it will be difficult easily to refer to it in future, it is very helpful to give (as MacDonald J has done in other cases) a 'sub-heading' to flag what the case is about.

Testing the faith

Manchester University NHS Foundation Trust v DE [2019] EWCOP 19 (Lieven J)

Best interests – medical treatment

Summary

This was an urgent out of hours telephone application made by the applicant Trust for an order enabling it to provide a blood transfusion to DE in the event that it should become clinically necessary.

DE was a 49 year old woman who suffers from autism and mild learning difficulties. She and her mother were Jehovah's Witnesses. On 11 April 2019 DE suffered a serious break to her left femur and tibia. She required surgical fixation of the femur and possibly the tibia. There was said to be a risk that during the operation DE would require a blood transfusion or blood products.

The Trust had assessed DE as lacking capacity to make decisions about whether to accept a blood transfusion or blood products.

The court heard oral evidence and submissions over the telephone, but adjourned the application overnight so as to allow the Official Solicitor lawyer to visit DE and seek her views.

The Official Solicitor lawyer's attendance note of that visit recorded that he had visited DE and met her with her mother and brother. DE said that she

[1] Since that Report was published, the French courts have ordered that life-sustaining treatment be continued pending the outcome of the Committee's deliberations.

was a Jehovah's Witness but made it very clear that she wanted the operation to happen as soon as possible. She could not explain why blood transfusions were prohibited under the religion. She did not appear too concerned about having a transfusion.

Having met with DE, Official Solicitor agreed that the order should be made.

The Court accepted the evidence that DE lacked the capacity to make the decision as to whether to accept blood transfusion if clinically necessary. The Court also held that clinically it would be in DE's best interests to have a blood transfusions in the event that it becomes clinically necessary. The Court articulated the central issue as "*the degree to which DE's wishes and feelings would be overborne by a decision to allow a blood transfusion, in the light of her being a Jehovah's Witness; and therefore whether there was a disproportionate interference in DE's article 8 rights.*"

The Court found that "*although DE described herself as a Jehovah's Witness she was not someone for whom those beliefs were central to her personality or sense of identity*." The Court's view gained at the oral hearing was reinforced by the information from the Official Solicitor, namely that DE was not strongly identifying herself with the beliefs of Jehovah's Witnesses, and indeed her mother supported the operation going ahead. Unsurprisingly therefore the Court granted the Trust's application.

Comment

This case is interesting in the finding that, while DE identified as a Jehovah's Witness, this was not central to her sense of self. It is not entirely clear from the evidence whether DE had been baptised as a Jehovah's Witness and had actively chosen to live as one, or whether she was regarded as one because she had been brought up in a Witness household and had not made a deliberate choice to embrace the faith and live as one. Ordering transfusion in respect of the former is clearly more serious than the latter. We should further emphasise that this case was very fact specific, and should, in particular, not be taken as licence to override refusals by Jehovah's Witnesses by clinicians – this was undoubtedly a case requiring consideration by the Court of Protection. For guidance more generally in relation to medical decision-making involving Jehovah's Witnesses, we recommend the Association of Anaesthetists' *Anaesthesia and peri-operative care for Jehovah's Witnesses and patients who refuse blood* (July 2018).

Deprivation of liberty – appropriate places and appropriate treatment

Rooman v Belgium [2019] ECHR 19 (European Court of Human Rights (Grand Chamber))

Article 5 ECHR – deprivation of liberty

Summary

In an important case determined at the start of 2019, the Grand Chamber of the European Court of Human Rights undertook a review and clarification of its approach to Article 3 and Article 5 ECHR in the context of deprivation of liberty on the basis of 'unsoundness of mind.'

The case was brought by a Belgian prisoner detained in a "social-protection facility," who contended that, that as a result of the failure to provide psychiatric and psychological treatment in the facility in which he was detained, his

compulsory confinement entailed a violation of Articles 3 and 5(1) ECHR.

Article 3

The Grand Chamber took the opportunity to 'recapitulate' its principles in relation to Article 3 ECHR. Most of these were relevant to the position of prisoners, but in a statement that perhaps reveals that Strasbourg has a different idea about deprivation of liberty to the Supreme Court in *Cheshire West*, the Grand Chamber observed (at paragraph 142) that "[m]*easures depriving persons of their liberty inevitably involve an element of suffering and humiliation*." It noted that "*the detention of a person who is ill in inappropriate physical and medical conditions may in principle amount to treatment contrary to Article 3*" (paragraph 144), highlighting the particular vulnerability of detainees with mental disorders. It further noted that it takes account of the adequacy of the medical assistance and care provided in detention, and that "[a] *lack of appropriate medical care for persons in custody is therefore capable of engaging a State's responsibility under Article 3* […] *In addition, it is not enough for such detainees to be examined and a diagnosis made; instead, it is essential that proper treatment for the problem diagnosed should also be provided* [..], *by qualified staff* […]" (paragraph 146). Logically, therefore "[w]*here the treatment cannot be provided in the place of detention, it must be possible to transfer the detainee to hospital or to a specialised unit*" (paragraph 148).

Article 5

Turning to Article 5 ECHR, the Grand Chamber considered that "*in the light of the developments in its case-law and the current international standards* [including the CRPD] *which attach significant weight to the need to provide treatment for the mental health of persons in compulsory confinement, it is necessary to acknowledge expressly, in addition to the function of social protection, the therapeutic aspect of the aim referred to in Article 5 § 1 (e), and thus to recognise explicitly that there exists an obligation on the authorities to ensure appropriate and individualised therapy, based on the specific features of the compulsory confinement, such as the conditions of the detention regime, the treatment proposed or the duration of the detention*" (paragraph 205).

Conversely, and in the most explicit terms used to date, the Grand Chamber made clear that "*Article 5, as currently interpreted, does not contain a prohibition on detention on the basis of impairment, in contrast to what is proposed by the UN Committee on the Rights of Persons with Disabilities in points 6-9 of its 2015 Guidelines concerning Article 14 of the CRPD*."

The Grand Chamber undertook a detailed examination and review of its own case-law to highlight that:

> *208*. [..] *the current case-law clearly indicates that the administration of suitable therapy has become a requirement in the context of the wider concept of the "lawfulness" of the deprivation of liberty. Any detention of mentally ill persons must have a therapeutic purpose, aimed specifically, and in so far as possible, at curing or alleviating their mental-health condition, including, where appropriate, bringing about a reduction in or control over their dangerousness. The Court has stressed that, irrespective of the facility in which those persons are placed, they are entitled to be provided with a suitable medical environment accompanied by*

> *real therapeutic measures, with a view to preparing them for their eventual release*.

The Grand Chamber further emphasised at paragraph 209 that the level of care required must go beyond basic care: "[m]*ere access to health professionals, consultations and the provision of medication cannot suffice for a treatment to be considered appropriate and thus satisfactory under Article 5*." It then highlighted the fact that deprivation of liberty had to take place in an appropriate institution, and such that a "*specialised psychiatric institution which, by definition, ought to be appropriate may prove incapable of providing the necessary treatment*" (paragraph 210). It had, earlier, noted (paragraph 203) that "*although the persistent attitude of a person deprived of his or her liberty may contribute to preventing a change in their detention regime, this does not dispense the authorities from taking the appropriate initiatives with a view to providing this person with treatment that is suitable for his or her condition and that would help him or her to regain liberty*"

The interaction between Articles 3 and 5

The court noted that the

> *question of a continued link between the purpose of detention and the conditions in which it is carried out, and the question of whether those conditions attain a particular threshold of gravity, are of differing intensity. This implies that there may be situations in which a care path may correspond to the requirements of Article 3 but be insufficient with regard to the need to maintain the purpose of the compulsory confinement, and thus lead to a finding that there has been a violation of Article 5 § 1. In consequence, a finding that there has been no violation of Article 3 does not automatically lead to a finding that there has been no violation of Article 5 § 1, although a finding of a violation of Article 3 on account of a lack of appropriate treatment may also result in a finding that there has been a violation of Article 5 § 1 on the same grounds.*
>
> *214 . This interaction in the assessment of complaints which are similar but are examined under one or other provision arises naturally from the very essence of the protected rights. The assessment of a threshold for Article 3, guaranteeing an absolute right, to come into play is relative, and depends on all the circumstances of the case, such as the duration of the treatment, its physical and mental effects and, in some cases, the sex, age and state of health of the victim. With regard to Article 5 § 1 (e), the deprivation of liberty is ordered, inter alia, on account of the existence of a mental disorder. In order to ensure that the link between this deprivation of liberty and the conditions of execution of this measure is preserved, the Court assesses the appropriateness of the institution, including its capacity to provide the patient with the treatment that he or she requires.*

On the facts of the case, the court found that there had been breaches of both articles for a period from 2004 to August 2017, but that, following changes in the regime for the complainant, there was no breach for the subsequent period. Partially dissenting judgments from six of the judges made it clear that they would have found that the breaches continued, in essence on the basis that the changes were inadequate.

Comment

It is also clear now beyond shadow of doubt that the clash between Strasbourg and Geneva regarding deprivation of liberty in the context of disability is not going to be resolved any time soon, but this comment will not dwell on this because the stalemate is, frankly, not very productive, and diverts attention from all the steps that can be taken to ensure that the only decision to take is whether to detain or not.

This decision is both extremely useful, as a summary and clarification of what is now an extensive body of case-law, and challenging for 'how things are done' in the mental health context, in particular. An immediate observation is that it is remarkably difficult in face of this decision to see the basis upon which the majority of those with learning disability/autism can sensibly be said to lawfully to be deprived of their liberty in ATUs or psychiatric hospitals (whether this is under the framework of the MHA or DOLS), as it would appear difficult to see the basis upon which such institutions can be said to be appropriate. The case may also suggest that we need to revisit in the DoLS / LPS context the previous reluctance of the courts to investigate the appropriateness of particular facilities once a broad 'umbrella' justification for deprivation of liberty on the basis of unsoundness of mind has been established: see, for instance, North Yorkshire CC v MAG [2016] EWCOP 6.

It also interesting to note the observation by the Grand Chamber that, almost axiomatically, deprivation of liberty involves an element of suffering and humiliation. This presumably applies to MIG and MEG in the Supreme Court before *Cheshire West*, or Steven Neary if he is to be found to be deprived of his liberty on the *Re X* application currently before the Court of Protection. Is that quite right? Or does it suggest that we have developed a domestic concept of deprivation of liberty going beyond the overbearing of the will suggested by this decision – in a situation where, over 5 years on from *Cheshire West*, the Strasbourg court has yet to declare any situation resembling that of MIG or MEG to be a deprivation of liberty.

Does the Court of Protection have a role in respect of conditionally discharged restricted or detained patients whose living arrangements amount to a deprivation of liberty?

[Editorial note: we are delighted to be able to reproduce here the text of a talk delivered by the former Vice-President of the Court of Protection, Sir William Charles, to the Judicial College, on recent decisions concerning Mental Health Act and Mental Capacity Act powers in relation to living arrangements which amount to deprivation of liberty.]

Introduction

This talk engages some detailed and complex points that I am going to have to take at a gallop

At this stage of the day it may well be difficult to take them on board. But the good news is that my message is that all you need take away is that if you get a case in which the Court of Protection is being invited to address deprivation of liberty issues relating to the regime of care of a conditionally discharged restricted or detained patient send it to a Tier 3 Judge.

This because in my view it is far from clear that the approach set out in guidance issued by HM

Prison & Probation Service- Mental Health Casework Section in January 2019 entitled: "Guidance: Discharge Conditions that amount to deprivation of liberty" and which is advanced by others provides a lawful solution to the problems created by the acceptance by the Supreme Court of the SofS's argument that a deprivation of liberty outside hospital cannot be lawfully created in exercise of MHA powers even though the patient consents to it.

Further introduction

As a law student I thought that an attractive aspect of the study of law as an academic subject was that the House of Lords now the Supreme Court (as the voice of infallibility – even if only by a narrow majority) provided the right answer.

Experience has shown me that it only provides a binding answer. The relevant answers for present purposes are those provided by: (1) *Cheshire West* [2014] UKSC 19; (2) *SoS for Justice v MM [2018] UKSC 60*; and (3) *Welsh Ministers v PJ* [2018] UKSC 66

As many of you will know I was the High Court judge in *MM* and *PJ* and so at risk of being accused of having sour grapes.

MM addressed the issue relating to a patient with capacity identified in *SoS for Justice v KC* [2015] UKUT0376 (AAC) in which I had decided that the argument of the SofS, based on existing Court of Appeal authority, that the discharge of a restricted patient could not create a deprivation of liberty was wrong and that it could do so if that deprivation of liberty was rendered lawful under the MCA or obiter by the consent of the patient. *KC* was not appealed and was I believe applied to patients who lacked relevant capacity.

KC also showed that there was an overlap between the deprivation of liberty issues in cases relating to restricted patients and those relating to detained patients and those subject to guardianship *PJ* was the vehicle for addressing some of those issues in the higher courts although the arguments in the tribunal were more focused and the appellant refused to take part in them.

These cases give rise to the question: *Whether the Court of Protection has a role if the regime of care, support and supervision of a conditionally discharged restricted or detained patient creates a deprivation of liberty*.

This is the question I shall address. And so, I am not addressing residence in a care home to which the DOLS could apply.

As is apparent from *KC* I am sympathetic to the view that the COP should have a role to render lawful a situation that fulfils the purpose of the MHA to return a patient to the community when their mental disorder no longer requires their detention in a hospital for treatment, but a power of recall is necessary.

My approach to achieving this is destroyed by the decisions of the Supreme Court in *MM* and *PJ.*

But, the parts of *KC* founded on the hypothesis that the SofS's jurisdictional argument was right remain relevant and merit consideration.

Some background points

(1) *Cheshire West* confirms and decides that a deprivation of liberty has objective and subjective elements and thus that if a valid

consent is given to the objective element there is no breach of Article 5.

(2) *PJ* confirms that when issues relating to deprivation of liberty are concerned the Convention must be practical and effective and so the courts and other decision makers must look at the concrete situation of the person concerned, otherwise all kinds of unlawful detention might go unremedied and this is the antithesis of what protection of personal liberty by the ancient writ of habeus corpus, and now by Article 5 of the Convention is about (see paragraph 18).

(3) So artificial or back door routes to rendering a deprivation of liberty lawful are unlikely to work.

(4) DOLS (and LPS) work by the giving of an authorisation.

(5) Although the result is effectively the same, and s. 16A refers to including provision in a welfare order that authorises a person to be deprived of his liberty, sections 4A (3) and (4) provide that *D may deprive P of his liberty if, by doing so, D is giving effect to an order under s. 16(2)(a) in relation to a matter concerning P's personal welfare.* And s..16(2)(a) provides that the court *may by making an order make the decision or decisions on P's behalf in relation to the matter or matters in question*.

(6) Accordingly, the underlying approach of s. 16 is, as it states, that by making the order the Court of Protection is making the relevant decision which P lacks the capacity to make on behalf of P and it is the welfare order that renders the deprivation of liberty lawful. So, references to authorisation by the court are founded on the court deciding on P's behalf to accept or consent to a living regime that creates a deprivation of liberty and in doing this the court would have to consider that consequence of the living regime and so whether it was the least restrictive option.

(7) The approach under s. 16 founds or is reflected in:

a. paragraph 18 of the judgment of Lady Hale in *Aintree University Hospitals NHS Trust v James* [2013] UKSC 67, [2014] AC 591 where she says that the MCA:

> *is concerned with doing for the patient what he could do for himself if of full capacity, but it goes no further,*

and the points that

b. the Court of Protection can only choose between available options

and so that:

c. when, for example, the decision on where a person should live is vested in a guardian appointed under the MHA the Court of Protection cannot in that person's best interests make an order that he is to live somewhere else (see *C v Blackburn and Darwen Borough Council* [2011] EWHC 3321 (COP) and to similar effect *ReT (A child: murdered parent)* [2011] EWHC B4 (Fam), [2011] MHLR 133), and

d. a local authority or health authority can seek to rule out an option by not offering it and assert (correctly) that its decision can only be challenged on

administrative law grounds and the Court of Protection cannot deal with a challenge on those grounds (see *KD v A Borough Council, the Department of Health and Others* [2015] UTUK 0251 (AAC) in particular at paragraphs 44 to 54).

(8) In short,

a. the MCA does not put a person who lacks relevant capacity in a better position than a person who has capacity in respect of the choices of regimes of care, support and supervision made available to them by public authorities in exercise of their statutory duties and powers,

b. in general, the court can only obtain and do for P what he could have got and done for himself if he had the relevant capacity, and

c. whether or not a care plan involves a deprivation of liberty, the approach of the Court of Protection is to consent to a regime and its effects selected and implemented by others on behalf of P, and the same applies, for example, in respect of medical treatment that the Court of Protection concludes is in P's best interests.

All of that leads to;

The point that the COP does not set up the relevant living arrangements but gives consent on behalf of P to an available alternative regime that is decided on and provided by others in their exercise of their duties and powers and so in the case of conditionally discharged detained and restricted patients MHA decision makers and providers of accommodation, support and supervision out of hospital.

The question whether the court can give an effective consent to and so authorise a regime which is founded on an unlawful exercise of a statutory power and/or if P could not do have done so himself if he had the capacity to do so.

The binding decisions in MM and PJ

This is not the time or place to address the reasoning in these cases in detail. However, I should record that I do not agree with the 39 Essex Street Report that the majority conclusion in *MM* is based on iron logic.

Having got that off my chest, I naturally accept that all COP judges are bound by the ratio of the conclusions in *MM* and *PJ.*

As already indicated, I think that this is that as a matter of statutory construction the MHA does not empower the MHA decision maker to "impose" (their language), or to specify (the language of s. 17) conditions amounting to a *Cheshire West* deprivation of liberty upon a conditionally discharged restricted or detained patient.

Also, the two cases provide confirmation, should it be needed, that the relevant MHA decision maker is in complete control of the exercise of the power of recall and the conditions of a conditional discharge.

So, the reasons for the conditions and the need for a power of recall are matters that the MHA decision maker must take into account. My references to MHA reasons cover both.

So, the starting point is that the agreement of a capacitous conditionally discharged restricted or detained patient to a deprivation of liberty that is imposed or specified for MHA reasons does not render the deprivation of liberty lawful because it is outside the ambit of the relevant MHA statutory power.

Article 5(1) reflects the common law principle (see paragraph 18 of PJ) and so it seems to me that inherent in the ratio of these cases are the points that the consent of a capacitous patient to such a deprivation of liberty does not satisfy the subjective element of Article 5 or mean that the patient is free to leave.

The references to the Court of Protection by the Supreme Court and the Court of Appeal – and so by inference to the possibility that the engagement of Article 5(1)(e) and the jurisdiction of the MCA enables the lawful deprivation of liberty of a restricted or detained patient who lacks the capacity to consent to the terms and effect of his living arrangements outside hospital.

Lady Hale refers to the reference to the Court of Protection by the Court of Appeal in paragraph 25 of *MM* and wrongly says that the discrimination argument was a new one prompted by that reference. I say wrongly because it was a live argument in *KC* (see paragraphs 116 to 123).

Then, on an assumption that the Court of Protection could "authorise" a deprivation of liberty of a conditionally discharged patient who is not "ineligible" and so there might be an incompatibility within Article 14 between patients who have and do not have capacity, she says this incompatibility did not matter because it would not affect whether it was possible to read the relevant sections as including a power to "impose" conditions that create an Article 5 deprivation of liberty.

It seems to me that this conclusion ignores:

- the subjective element of an Article 5 deprivation of liberty, and
- the possibility of a construction of the MHA being incompatible with Convention rights.

The assertion by the Court of Appeal in paragraph 35 that *the power of deferment to permit arrangements to be made for discharge could be used in an appropriate case to invoke the jurisdiction of the Court of Protection to authorise a deprivation of liberty if the patient is incapacitated is:*

- dicta,
- unexplained and
- does not appear to be founded on argument – but may go back to my decision in *KC* which is founded on a different interpretation of *RB* that cannot stand considering paragraphs 17,18 and 21 of the judgment of the Court of Appeal and now because of the decisions of the Supreme Court.

Accordingly, it does not found a solid foundation for the existence of an exercisable jurisdiction of the Court of Protection.

So, if and to the extent that, the guidance issued by HM Prison & Probation Service- Mental Health Casework Section in January 2019 is founded on either:

- the references to the jurisdiction of the Court of Protection by the Supreme Court and the Court of Appeal, or
- my decision in *KC*

it is built on sand.

Does the Court of Protection have an exercisable jurisdiction?

The Guidance I have referred to envisages a role for and so an exercisable jurisdiction of the Court of Protection, but it does not explain why the court has that jurisdiction.

Also, the approach taken in the guidance chimes with the jurisdictional solution using the MCA taken by the SoS in *KC* which was founded on his position on the construction of the MHA that has been found to be correct by the Supreme Court.

I was of the view that this jurisdictional solution involved:

- MHA decision makers wrongly trying to pass decisions to the MCA decision make, and
- an artificial distinction between the conditions created by the care plan and the conditions of the discharge.

At paragraphs 69 to 73 I said:

> *69. The jurisdictional solution suggested by the Secretary of State recognises the difficulties placed in the way of achieving the underlying purpose of s. 73 MHA by his submission on the ratio of the RB case. But his correct acceptance that the MHA decision maker has to consider what protective conditions are needed and be satisfied that they will be in place on a conditional discharge mean that his jurisdictional solution for a restricted patient who lacks capacity to consent to protective conditions seeks to achieve a result which, on his submission, cannot be achieved under the MHA "through the front door".*
>
> *70. Accordingly, this jurisdictional suggestion seeks to utilise a "back door".*
>
> *71. In my view, if the Secretary of State is right about the ratio of the RB case his "back door" jurisdictional suggestion is not a permissible solution because:*
>
> *a. the MHA decision maker has to consider what the protective conditions should be,*
>
> *b. if the MHA decision maker concludes that they are required to protect the public or the patient (or for any other reason applying the MHA tests) he cannot direct or support a conditional discharge of the restricted patient without them being in place,*
>
> *c. the suggestion that the MHA decision maker can effectively require the imposition of the protective conditions but leave them out of the conditions he imposes and so the s. 73(4) statutory duty on the basis that they are or are to be included in a care plan approved by the Court of Protection (or authorised under the DOLS provided by the MCA) does not reflect the reality of the position,*
>
> *d. that reality is that the MHA decision maker is making the choice on what the protective conditions are to be and is thereby limiting the choices open to the Court of Protection (or under the DOLS) and so imposing*

those protective conditions of the conditional discharge, and

e. the MCA does not fill the jurisdictional gap by providing an alternative regime that serves the same purpose as the MHA or creates the s. 73(4) statutory duty

72. If I am right, the jurisdictional solution suggested by the Secretary of State to achieve the result that he, the FTT and KC supported has to be founded on a conclusion that the ratio of the RB case is not that suggested by Secretary of State but is that the MHA decision maker cannot choose and impose conditions that when they are implemented would be in breach of Article 5 and so unlawful.

73. If that conclusion on the ratio of the RB case is correct it "opens the door" to any deprivation of liberty resulting from the protective conditions being authorised by the Court of Protection or under the DOLS and so rendered lawful (and not a deprivation of liberty under Article 5) (This door is now shut)

I remind you:

- of the confirmation in *PJ* that an artificial approach and so one that does not reflect the concrete position on the ground is inappropriate, and
- that MHA reasons include the reason for the need for the power to recall.

In *KC* the artificiality or back door nature of this jurisdictional route to protective conditions was demonstrated by the stance taken by the SoS that the care plan approved by the court had to include notification provisions to the SofS so that he could consider a recall if *KC* acted in breach of the terms of the care plan or it broke down for any reason.

This need clearly linked the deprivation of liberty created by the care plan to MHA reasons and purposes.

Also test it this way: Would the conditional discharge of *MM* have been lawful if the deprivation of liberty was not founded on a condition of the discharge? I suggest that the answer is "No" because the need for it was founded on MHA reasons.

This answer is reflected in paragraph 3 of the guidance by the conclusion that when the responsible clinician considers that a capacitous patient no longer requires treatment in hospital but is not yet suitable for discharge without constant supervision, that patient cannot consent to the deprivation of liberty that supervision would create but the SoS can consider escorted leave of absence under s.17(3) MHA.

The artificiality or back door nature of the different approach suggested in the guidance depending on whether the patient has or does not have relevant capacity is that:

- if a patient for MHA reasons (the only ones the SofS and FTT can apply) a patient needs a care plan that provides constant supervision it is a necessary element of the conditional discharge which should not be granted / imposed absent that regime being in place, and
- this applies whether or not the patient has the capacity to consent to a care plan that deprives them of their liberty

Whether it applies to a patient who has or does not have relevant capacity such a care plan does not have some free-standing or pre-existing or separate existence created by a provider separately from the discharge. Rather, it is created and agreed with a provider as part of the discharge and is an integral part of it.

Also, in the case of a patient within the jurisdiction of the MCA, the care plan is not created by the Court of Protection. Rather, in such a case the court is being asked to conclude that it is in P's best interests to enable a conditional discharge for MHA reasons that cannot lawfully be put in place under the MHA.

And, an MCA decision maker cannot make an unlawful exercise of an MHA power and its unlawful effects lawful.

Pausing there, it seems to me that *if the reality is that the care plan is or is in part founded on MHA reasons* the MCA does not provide an exercisable jurisdictional route that renders a deprivation of liberty of a conditionally discharged restricted or detained patient who lacks capacity lawful on the basis that all or parts of it are in the best interests of that patient.

The guidance does not address this reality issue.

The guidance takes an approach based on an identification of the reasons why the relevant conditions create a deprivation of liberty are needed.

The first is when the need for a regime of residence and supervision that creates an objective deprivation of liberty is the inability of the patient to perform activities of daily living or self-care. I shall return to this.

The second is to prevent re-offending and the trauma and risk from others to the patient this would involve. It is clearly so categorised because of case law that supports the view that this can be in P's best interests.

But, as seems to be recognised in paragraph 4.2 of the guidance, this second cause will also engage risk to the public (victims of the re-offending). Also, I find it hard to envisage cases where the benefits of avoiding harm to the patient caused by re-offending are not inextricably linked to the reasons for the need to be able to recall the patient to hospital if he re-offends.

A distinction between a condition and so a statutory duty not to re-offend and the need for living arrangements that create a deprivation of liberty to avert that risk and /or are one of the reasons for a power of recall is artificial.

So, it seems to me that the isolation of the second cause identified in the guidance to provide a best interests decision under the MCA is artificial. This is because in reality the deprivation of liberty is, in the words of the Supreme Court being imposed by the MHA decision maker for MHA reasons and so per the Supreme Court is an unlawful exercise of power by the MHA decision maker.

The point that it can also be said to be in the patient's best interests does not alter that conclusion.

In my view, after *MM* and *PJ* if the real or concrete situation on the ground is that for an MHA reason the conditional discharge would not be made unless a regime is in place that creates a deprivation of liberty:

- under the guidance the Court of Protection is being invited to consent on P's behalf to, and so authorise, an unlawful exercise of an MHA power – and I do accept that it can do that, and in any event
- the Court of Protection cannot cure the unlawfulness of such an exercise of an MHA power and its result.

I return to the first reason identified in the guidance - namely an inability to perform activities of daily living and not the discharge from hospital or the need for a power of recall.

I am sympathetic to a view that if the patient had been in hospital for physical reasons and could not be discharged until a placement that objectively created a deprivation of liberty was found then that deprivation of liberty has nothing to do with the discharge or the need for a power of recall so:

- it can be authorised under the DOLS (if at a care home) or be the subject of a welfare order, and
- the need for delay to get the authorisation is simply to render the placement involving a deprivation of liberty lawful.

However, the line between on the one hand the MHA reason "*necessary for the health and safety of the patient*" and the reasons for the power of recall and on the other an inability to perform activities of daily living or self-care is a fine one and it seems to me that the Court of Protection needs to have this possibility fully argued before it adopts it.

If it is to work, it seems clear to me that the patient can have no MHA duty to comply with conditions that create the deprivation of liberty (e.g. to live at a particular place under a particular care plan).

Assuming that is the case, it still seems to me that problems arise if for MHA reasons the existence of such a deprivation of liberty (and so placement) is relevant to and so a reason for the grant of the conditional discharge and/or the existence or exercise of the power of recall. Such a situation would be an indication that without it, for MHA reasons, the conditional discharge would not have been granted if the patient was not being deprived of his liberty outside hospital. Going back to *PJ's* graphic description it is an indication that unless he continues to be deprived of his liberty outside hospital he is fucked – and so in reality the deprivation of liberty is being imposed unlawfully by the MHA decision maker for MHA reasons.

There is a second and parallel issue that needs careful consideration, namely whether as suggested in the guidance the Court of Protection, in exercise its power under s. 16 MCA to make a decision on behalf of P, can bring about a result that P could not have achieved by making his own decision.

On the face of it this is a surprising result if, as is often said, the MCA only enables a patient to do what he could have done himself with capacity and so removes discrimination between those who have and those who do not have the relevant capacity.

The Supreme Court has decided that the decision of *MM* and *PJ* (if he had capacity) to consent to further their best interests could not render an exercise of the relevant MHA power in a way that deprived them of their liberty lawful.

It follows that the court has to ask and answer whether it can do so on their behalf.

This not pedantic, and I do not dispute that the effect of the welfare order can be described as an authorisation.

But as the process to that authorisation is one in which the court makes the decision to consent to the care plan and its effect on behalf of P. If Ps cannot do that themselves it is not clear to me how the Court of Protection can do it for them applying s. 16 and/or the approach described by Lady Hale that the MCA is concerned with doing for the patient what he could do for himself if of full capacity, but it goes no further.

Also, I repeat that it seems to me that nothing done under the MCA would render un unlawful exercise of an MHA power, and so an unlawful situation on the ground created by it, lawful.

A way of testing this in a particular case might be to consider whether, applying *MM* and *PJ*, the patient could by a capacitous consent create a lawful result. There is some unreality in this because it is likely that these reasons for a deprivation of liberty are less likely to apply to capacitous patients. But this approach may show that there is clear blue water between the living arrangements and the MHA reasons because they would not apply to a capacitous patient.

I have toyed with the idea that a way round this might be to adopt the doctrine of "double effect" as in CANH cases. This excludes the purpose of causing death and allows it to be knowingly caused as a side-effect and so draws a distinction between the intention underlying an action of the one hand and the consequences that are foreseen but not intended on the other (see *Briggs* at para (18)).

But I do not think this works because what the court is being asked to do:

- decide to accept on P's behalf the effect of the relevant provisions of the care plan, and
- an unlawful exercise of an MHA power and P could not do this himself.

So, as I said at the start, if you get a case in which you are asked to address the deprivation of liberty of a conditionally discharged restricted or detained patient send it to a Tier 3 judge.

Postscript

I pose two hypothetical questions.

Does the analysis and conclusion in *MM* and *PJ*:

1. Have an impact on the informal admission of patients? This is based on their consent which on one view cannot be said to be freely given and creates a situation in which they are free to leave – because if they tried to they would be sectioned. Why is that different to *PJ's* graphic description of what would happen if he broke the conditions of his conditional discharge.
2. Have an impact on the terms of care plans based on statutory powers? The approach in those two cases is that a statutory power for MHA purposes cannot be exercised to impose or create a deprivation of liberty unless that is expressly provided for. And this may give rise to the question how can this be lawfully done under powers that are directed to providing other care, supervision, treatment or support?

Sir William Charles

PRACTICE AND PROCEDURE

District Judge Eldergill

The Legal Aid Practitioners Group has announced that it will present District Judge Anselm Eldergill with an LAPG Special Awards, at the Legal Aid Lawyer of the Year awards ceremony on 10 July 2019. This is only the third time the LAPG Committee has chosen to make Special Awards. In a press release LAPG CEO Chris Minnoch said:

> *LAPG Special Awards are reserved for truly exceptional individuals who have achieved incredible things, often alongside of their day to day legal practice. Anselm was a mental health lawyer for 25 years, and is a true legend in this field. He now sits as a District Judge in the Court of Protection, and has been responsible for developing the law in relation to people with impaired capacity, in ways far beyond his formal status as a judge. He has made an incomparable contribution to the protection of those with mental illness. Through his 1997 book 'Mental Health Review Tribunals', he shared his expertise, and equipped many practitioners to represent the most vulnerable clients in a way that would not otherwise have been possible in what was a developing area of law. It explicitly recognised the Tribunal as a way of enforcing civil rights and had a transformative effect. Now that he is on the bench, Anselm has lost none of his approachability, and remains vigilant to ensure people can exercise their rights.*

We would whole heartedly endorse this!

Short note: permission test for appeals

In *R (A Child)* [2019] EWCA Civ 895, Lord Justice Peter Jackson and Lord Justice Baker had cause to consider what the test for permission to bring an appeal. Applications for permission to appeal to the Court of Appeal, the High Court, Family Court or the Court of Protection are governed by CPR r.52.6(1), FPR 30.3(7)) and COPR 20.8(1)(a) respectively. All these rules provide that the test to be applied is whether the appeal has 'a real prospect of success'.

The court had no difficulty rejecting the interpretation of the test as set out by Mostyn J in *NLW v ARC* [2012] 2 FLR 129, FD, where he held that a 'real prospect of success' meant it was more likely than not that the appeal would be allowed at the substantive hearing: "*anything less than a 50/50 threshold could only mean there was a real prospect of failure*". Instead and unsurprisingly, the court confirmed the test was as stated in *Tanfern v Cameron-MacDonald (Practice Note)* [2001] 1 WLR 1311 CA at [21], which itself follows *Swain v Hillman* [2001] 1 AER 91 CA, that there must be a realistic, as opposed to fanciful, prospect of success. "*There is no requirement that success should be probable, or more likely than not.*"

Short note: litigation capacity and civil restraint orders

In *Adelaja v LB of Islington* [2019] EWHC 1295 (QB) (not available on Bailii, but only on Lawtel, which we consider problematic), Jeremy Baker J has clarified the circumstances under which it is appropriate to make a civil restraint order against a person whose impairments render them incapable of conducting proceedings.

This case concerned a long-running dispute between a local authority and Mr Adelaja, whose

wife, Sybil, suffered from mental health problems. The local authority had financial safeguarding concerns about Mr Adelaja which resulted in them taking over as his wife's appointee. Mr Adelaja was unhappy about this decision and had instigated numerous sets of legal proceedings against the local authority and one of its officers, including a claim for £1million in damages and multiple judicial review applications.

The local authority sought an extended civil restraint order against Mr Adelaja, which the court was easily satisfied should be made, noting that he had made numerous applications without any discernible basis in law and which were totally without merit, and that the order was needed to protect Mrs Adelaja and the resources of the court.

The local authority also sought an extended civil restraint order against Mr Adelaja's wife - although she had not been personally involved in decisions to issue the various claims and applications, some had been issued with her as a named separate Claimant, and the local authority was anxious to ensure that Mr Adelaja did not circumvent the extended civil restraint order made against him by simply continuing to issue claims in his wife's name and purportedly on her behalf.

The Official Solicitor was appointed as her litigation friend, and evidence was filed that showed she did not want her husband to issue proceedings for her, and that she had signed some of the court forms under pressure from him. The Official Solicitor accepted that the court could make an order against her, in principle, but raised concern that she may not have capacity to understand the effect of the order, as required by *Wookey v Wookey* [1991] Fam 121. Jeremy Baker J observed that the fact that she lacked litigation capacity did not necessarily mean that she lacked the necessary understanding of the nature and requirements of the order. He decided that an extended civil restraint order should be made against Mrs Adelaja, since it was needed to achieve the objectives of protecting both her and the court from further spurious claims, it accorded with her wishes (to the extent she understood what was happening), and the local authority was not applying for a penal notice in respect of her, only her husband.

THE WIDER CONTEXT

ENGLAND, WALES AND NORTHERN IRELAND

Learning Disabilities Mortality Review

The third annual report of the English Learning Disabilities Mortality Review (LeDeR) programme has now been published. It presents information about the deaths of people with learning disabilities aged 4 years and over notified to the programme from 1 July 2016 to 31 December 2018 with a particular focus on deaths for which a review was completed during the last calendar year (1 January to 31 December 2018).

Key findings include:

- The proportion of people with learning disabilities dying in hospital is higher (62%) than in the general population (46%).
- Almost a half (48%) of deaths reviewed in 2018 received care that the reviewer felt met or exceeded good practice, slightly more than the 44% in the 2017 report.
- The proportion of deaths notified from people from Black, Asian and Minority Ethnic (BAME) groups was lower (10%), than that from the population in England as a whole (14%). However, children and young people from BAME groups were overrepresented in deaths of people with learning disabilities.

Shockingly, whilst the report found that the majority (79%) of DNACPR decisions found in records relating to deaths under review were appropriate, correctly completed and followed, 19 reviews reported that the term 'learning disabilities' or Down's syndrome' was given as the rationale for the DNACPR. We note that this represents exactly the sort of discriminatory denial of access to healthcare on the basis of disability that contravenes Article 25(f) CRPD.

Further concerns were raised in the Review about the accuracy of recording the underlying causes of death in people with learning disabilities. This included both the under-reporting that a person had a learning disability when it was relevant to the cause of death, and erroneously listing a learning disability or an associated condition as an underlying cause of death.

The report makes 12 key recommendations, of which we highlight those relating to DNACPR decisions (revealingly, but wrongly, called 'orders' in the Review):

- The Department of Health and Social Care, working with a range of agencies and the Royal Colleges, should issue guidance for doctors that 'learning disabilities' should never be an acceptable rationale for a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order, or to be described as the underlying or only cause of death on Part I of the Medical Certificate Cause of Death.
- Medical Examiners to be asked to raise and discuss with clinicians any instances of unconscious bias they or families identify e.g. in recording 'learning disabilities' as the rationale for DNACPR orders or where it is described as the cause of death.
- The Care Quality Commission to be asked to identify and review DNACPR orders and Treatment Escalation Personal Plans

relating to people with learning disabilities at inspection visits. Any issues identified should be raised with the provider for action and resolution.

A separate report by NHS England provides an overview of the actions taken following mortality reviews and in response to the recommendations made in the LeDeR annual report 2016/2017. For example, the 2016/2016 LeDeR annual report highlighted the need for better understanding and application of the Mental Capacity Act. NHS England notes that an MCA workstream was established to raise awareness of the MCA and to increase competence in using the MCA with people with a learning disability and their families. Whilst the LeDeR programme has been making progress, the report rightly recognises that there is still much more work to do.

Separately, and in recognition of the fact that reviews into deaths of people with a learning disability demonstrated that too many people were still dying from constipation, NHS England has published leaflets to help families and carers of people with a learning disability know the signs of constipation and what to do.

Restraint, seclusion and abuse: the CQC and Whorlton Hall

The Care Quality Commission (CQC) has published its interim findings from a review of the use of restrictive interventions in places that provide care for people with mental health problems, a learning disability and/or autism ().

The interim report focuses on 39 people who are cared for in segregation on a learning disability ward or a mental health ward for children and young people. It makes the following key findings:

- Many people visited had been communicating their distress and needs in a way that people may find challenging since childhood, and services were unable to meet their needs.
- A high proportion of people in segregation had autism.
- Some of the wards did not have a built environment that was suitable for people with autism.
- Many staff lacked the necessary training and skills.
- Several people visited were not receiving high quality care and treatment.
- In the case of 26 of the 39 people, staff had stopped attempting to reintegrate them back onto the main ward. This was usually because of concerns about violence and aggression.
- Some people were experiencing delayed discharge from hospital, and so prolonged time in segregation, due to there being no suitable package of care available in a non-hospital setting.

The Health and Social Care Secretary, Matt Hancock, responded to the CQC's interim report:

> *I have been deeply moved and appalled by the distressing stories of some autistic people and people with learning disabilities spending years detained in mental health units. These vulnerable people are too often left alone, away from their families, friends and communities.*

> *At its best, the health and care system provides excellent support to people, backed by a dedicated workforce. But a small proportion of some of the most vulnerable in society are being failed by a broken system that doesn't work for them.*
>
> *I commissioned the Care Quality Commission to review the use of segregation in health and care settings to tackle this issue head on. Today I have accepted their recommendations in full. I hope this is a turning point so everyone receives the care they need.*
>
> *I will not let these people down – they deserve better.*

The CQC is due to make further recommendations to the Department of Health and Social Care on the wider system in March 2020. We will of course keep our readers posted.

The publication of the CQC's interim report also coincided with the broadcast of BBC Panorama's documentary on Whorlton Hall in County Durham titled "Undercover Hospital Abuse Scandal." The documentary shows horrifying undercover footage of vulnerable patients with learning disabilities and autism being mocked, intimidated and restrained by staff which makes for extremely uncomfortable viewing. Whorlton Hall has since been closed and all patients have been transferred to other services. At least 10 members of staff have been arrested and the police investigation is ongoing.

The CQC has now appointed David Noble QSO to undertake an independent review into how it dealt with concerns raised by Barry Stanley-Wilkinson (an ex-CQC inspector) about Whorlton Hall at an earlier stage in a draft report in 2015 through its internal processes. It is reported that Mr Stanley-Wilkinson left the CQC following a row about the regulator's failure to publish it. Ahead of an appearance before the Joint Committee on Human Rights (JHRC) to answer questions about its regulation of Whorlton Hall, the CQC then shared the previously unpublished report from Mr Stanley-Wilkinson's 2015 inspection of Whorlton Hall. Mr Stanley-Wilkinson's evidence to the Committee was published here. The CQC has also announced its intention to commission a wider review of its regulation of Whorlton Hall between 2015 and 2019 which will include recommendations of how the regulation of similar services can be improved. We will update our readers with more information once it becomes available.

Detained children

The Children's Commissioner has published two important reports on detained children and children in hospital: "Who are they? Where are they? Children locked up" and "Far less than they deserve. Children with learning disabilities or autism living in mental health hospitals".

The first report highlights the fact that, at any given time, almost 1,500 children in England are 'locked up' in secure children's homes, secure training centres, young offenders institutions, mental health wards and other residential placements, either for their own safety or the safety of others. Perhaps most worryingly, in addition to the approximate 1,500 children who are detained under the distinct legislative regimes, there are unknown numbers of children being deprived of their liberty in other settings who are "invisible"; where there is no published

information or publicly available data about where they are living or why they need to be there, and where the legal basis and accompanying safeguards for detention is much less clear. This includes circumstances where a young person of 16-17 years old, who does not have capacity to make decisions about their residence and care, is being confined (in the *Cheshire West* sense of being subject to continuous supervision and control, and not being free to leave) in a placement with their parents' consent. Of those cases that do make it to court (the Family Court, Court or Protection, or High Court), there is very limited information available about the circumstances of the detention, whether authorisation was granted and for how long.

Sir Andrew McFarlane, giving the Nicholas Wall Memorial Lecture on 9 May 2019, echoed some of the concerns expressed in the Children's Commissioner's report. In particular, he expressed the unease from the court's perspective of ad hoc authorisations of deprivations of liberty:

> *Whilst there seems to be no legal basis to question the Family Court's jurisdiction to approve ad hoc placements that restrict a young person's liberty… I do have a profound unease over the court frequently being asked to approve the accommodation of children when it, the court, has no means of checking or auditing the suitability of the facility that is to be used…*
>
> *In any event, there is a need, where a judge is forced by circumstances and the lack of any other option to authorise placement in facilities which have not been approved as a children's home under the statutory scheme, for the court to ensure that steps are taken immediately by those operating the facility to apply to the regulatory authority (OFSTED) for statutory registration. I intend to issue Practice Guidance to the courts before the end of July on this topic so that we can do what we can to bring more of these placements within the statutory regulatory scheme."*

We are still awaiting the judgment of the Supreme Court in *D (by his litigation friend, the Official Solicitor) v Birmingham City Council* which is expected to grapple with the issue of deprivation of liberty and parental consent for 16-17 year olds. Under the Mental Capacity (Amendment) Act, the new Liberty Protection Safeguards (LPS) will cover 16 and 17 year olds which will at lease provide a statutory framework for monitoring young people being deprived of their liberty where other statutory safeguards (such as under the Mental Health Act 1983 or Children Act 1989) do not apply.

The second report by the Children's Commissioner concentrates on children with learning disabilities and autism living in mental health hospitals. It puts the spotlight on children being kept in secure hospitals unnecessarily when they should be in the community. In particular, it highlights that most children should never need to go to an inpatient unit and "*are ending up in units because of challenging behavior due to unmet needs in the community*." It also identifies shocking evidence of poor and restrictive practices and sedation being used on children in mental health hospitals. The report makes a number of recommendations directed primarily at the Government:

- A cross Government plan to provide community support for children;
- A new parent covenant to guarantee parental involvement;
- New funding for the right support in the community to enable children to stay with their families;
- Training on LD and autism; and
- A programme to ensure excellent care within hospitals.

Within this context, we note, finally that the CQC rated the CAMHS service at St Andrew's Healthcare Northampton inadequate on 6 June 2019 and is carrying out a review of its quality.

Inquests, detention and DOLS

R (Maguire) v Her Majesty's Senior Coroner for Blackpool and Fylde [2019] EWHC 1232 (Admin) High Court (Divisional Court (Irwin LJ, Farbey J and HHJ Lucraft QC))

Article 5 – deprivation of liberty – civil proceedings – other

Summary[2]

This was a judicial review brought in respect of the decision of the coroner investigating the death of a 52 year old woman, Jacqueline (Jackie) Morgan that Article 2 ECHR was not engaged. Ms Morgan had a diagnosis of Down's syndrome and moderate learning difficulties. She required one-to-one support and had severely compromised cognitive and communication abilities. By the time of her death, she suffered limited mobility, needing a wheelchair to move around outside. She had lived for more than 20 years in a care home in Blackpool where she was deprived of her liberty pursuant to a standard authorisation.

In the week prior to her death, Ms Morgan had complained of a sore throat and had a limited appetite. For about two days before she died, she had suffered from a raised temperature, diarrhoea and vomiting. On 20 February 2017, Ms Morgan asked to see a GP. Staff at the care home did not act on that request. There then followed a chain of events which included a failure on the part of a GP to respond to calls and make a home visit; a further failure on the part of the out of hours GP to triage Ms Morgan properly or to elicit a full history from carers; and poor advice being given to the carers from NHS111. In fact the first medically trained personnel to attend Ms Morgan were an ambulance crew after 8pm on the 21 February 2017, however they had not been notified that Ms Morgan had Down's syndrome and they found themselves unable to take her to hospital as she simply refused to go.

Ms Morgan therefore remained at the care home overnight. She was found collapsed the following day. She was admitted to hospital by ambulance and died that evening. A post-mortem examination concluded that her death was as a result of a perforated gastric ulcer with peritonitis and pneumonia.

The coroner at a Pre Inquest Hearing determined that Article 2 ECHR was engaged and therefore conducted the inquest on this basis. However,

[2] Note, as Tor was involved in the case, she has not been involved in writing this case report.

at the conclusion of the evidence, the coroner reconsidered the position in light of the decision of *R (Parkinson) v Kent Senior Coroner* [2018] EWHC 1501 (Admin) which had been handed down shortly before the hearing had begun. Relying on this decision, the Coroner ruled that the allegations against Ms Morgan's carers and healthcare providers amounted to allegations of individual negligence, which *Parkinson* had clarified as falling outside the state's obligations under article 2.

The application for judicial review contended that the Coroner was wrong to conclude that Article 2 did not apply. It was argued that the law had developed so that the court should now recognise the state's positive obligations under article 2 towards those who may be described as "*particularly vulnerable persons under the care of the state*". Alternatively, the Coroner ought to have concluded that there was sufficient evidence of systemic problems in events leading to Jackie's death that article 2 ought to have been left to the jury. There had been no effective communication system between those authorities charged with protecting Jackie (GP services, NHS111, the ambulance service and the hospital) and no individual with oversight of Jackie's healthcare who could convey an accurate account of her symptoms in circumstances where she was unable to do so. These were regulatory and structural failures. Together with the failure to sedate Jackie on the evening of 21 February, they were capable of amounting to systemic dysfunction.

The second ground of challenge was that the Coroner had erred in law in failing to leave neglect to the jury.

The Divisional Court held as follows on the law:

First, in the absence of systemic or regulatory dysfunction, article 2 may be engaged by an individual's death if the state had assumed responsibility for the individual's welfare or safety. [...]

Secondly, in deciding whether the state has assumed responsibility for an individual's safety, the court will consider how close was the state's control over the individual. Lord Dyson observed in paragraph 22 of Rabone that the "paradigm example" of assumption of responsibility is where the state has detained an individual, whether in prison, in a psychiatric hospital, in an immigration detention centre or otherwise. In such circumstances, the degree of control is inevitably high. [...]

That the case law has extended the positive duty beyond the criminal justice context in Osman is not in doubt. The reach of the duty, beyond what Lord Dyson called the "paradigm example" of detention, is less easy to define. We have reached the conclusion, however, that the touchstone for state responsibility has remained constant: it is whether the circumstances of the case are such as to call a state to account: …… In the absence of either systemic dysfunction arising from a regulatory failure or a relevant assumption of responsibility in a particular case, the state will not be held accountable under article 2.
As to the responsibility which the state assumed here, Jackie was a vulnerable person for whom the state cared. In her written submissions, Ms Butler-Cole relied on the placement at the care home and the deprivation of liberty in respect of that placement. She emphasised the evidence about Jackie's reliance on her carers and other professionals in relation to medical treatment and healthcare.

> *However, in oral submissions, supplemented by a written Reply, she accepted that mental incapacity sufficient to justify deprivation of liberty under the Mental Capacity Act is insufficient on its own to trigger the engagement of article 2. This was an important and proper concession.*
>
> *We agree that a person who lacks capacity to make certain decisions about his or her best interests - and who is therefore subject to DOLS under the 2005 Act - does not automatically fall to be treated in the same way as Lord Dyson's paradigm example. In our judgment, each case will turn on its facts.*
>
> *Where the state has assumed some degree of responsibility for the welfare of an individual who is subject to DOLS but not imprisoned or placed in detention, the line between state responsibility (for which it should be called to account) and individual actions will sometimes be a fine one.*

Applying this analysis to the facts of the case the court concluded that this was not a case in which there had been an assumption of responsibility on the part of the State; and the chain of events that led up to Ms Morgan's death was not capable of demonstrating systemic failure or dysfunction. The Divisional Court found that such failings as there may have been were attributable to individual actions and so did not require the state to be called to account. The Divisional Court also found, on the facts, that Coroner had been entitled to find there was no individual failing on the part of those involved which could safely be said to be gross, so as to require him to leave a finding to the neglect.

The application was therefore refused.

Comment

This decision may be a surprising one for many. The conclusion that, despite a string of failures on the part of the state to summon basic medical attention for a woman in a totally dependent position due to both physical and mental disabilities, the State should not be called to account for purposes of Article 2 ECHR, may be a surprising one for many. Would it have made a difference if Ms Morgan had been compelled to live in the care home against her will? Must there be a degree of coercion on the part of the State before there is sufficient to found an assumption of responsibility by the State engaging Article 2? No doubt this will be tested in cases to come, and may even be tested further in this case if an appeal is forthcoming.

In relation to the fineness of the line between DoLS and state detention, we note that the Independent Review of the MHA 1983 observed in December 2018 that:

> *following changes to the CJA introduced in 2017, someone who has died whilst subject to DoLS (or, in future, the Liberty Protection Safeguards[103]) is not considered to have been in state detention for purposes of determining that there should be an investigation by a coroner, which means there is no automatic investigation of their death by the coroner. In many cases, this is entirely appropriate, it is simply wrong to consider the natural death of an elderly person in a care home a death in state detention for these purposes simply because they were subject to a DoLS authorisation. But in the case of those in a psychiatric hospital subject to DoLS (or, in future the LPS), it may be far more appropriate to think of them as being in*

> *state detention. We are not recommending further amendments to the CJA, but we do think that it is important that all relevant guidance (including from the Chief Coroner, but also the Mental Health Act Code of Practice) make it clear that in these circumstances it should be presumed that the individual is in state detention for purposes of triggering the duty for an investigation by a coroner* (page 101, footnotes omitted)

Short note: litigation friends, settlement and costs

In *Barker v Confiànce Ltd & Ors* [2019] EWHC 1401 (Ch), Morgan J considered a range of questions concerning the liability of litigation friends for costs, in the context of proceedings involving children. The judgment is of importance and interest for the extent to which he examined the extent to which statements of the law in *Halsbury's Laws* in fact were not supported by the (ambiguous and elderly) cases cited. One aspect of his judgment is of direct relevance in the context of proceedings where the court (whether the Court of Protection or the civil court) is asked to approve a settlement, Morgan J noting that:

> *67. When the court is asked to approve a settlement on behalf of children or protected parties, the court has to make a decision as to what is in the best interests of those persons, because those persons cannot make the decision for themselves. The court must be fairly informed of the facts and considerations which are relevant to the making of that decision. Otherwise, the court is being asked to make a decision on behalf of a party, who is himself unable to make a decision, but in circumstances where the court has not been told a relevant fact or circumstance. That is plainly unacceptable.*
>
> *68. As explained by Megarry J in In re Barbour's Trusts [1974] 1 WLR 1198 at 1201 E-H, the court will normally rely heavily on the litigation friend, solicitors and counsel acting for the child or protected party. Megarry J stressed the heavy responsibility undertaken by these representatives of the child or protected party. Indeed, the responsibility of the court goes further still than those responsibilities. As was said by Lady Hale in Dunhill v Burgin (Nos 1 and 2) [2014] 1 WLR 933 at [33], one of the objects of the requirement that the court approves a settlement involving a child or a protected party is in order to enable the court to protect them from any lack of skill or experience of their legal advisers which might lead to a settlement of a money claim for far less than it is worth. The court is not a rubber stamp and parties should not treat it as if it were.*

Having analysed the position, Morgan J also concluded that – contrary to the position suggested in Halsbury's Laws – there *"is no general rule that the court will not make an order for costs against a child unless they have been guilty of fraud or gross misconduct. Instead, as always, the general rule is that the court must consider all of the circumstances of the case."* The logic of this, based upon the plain wording of CPR rr.21.4(3)(c) and 46.4, would also apply – in civil proceedings – equally to an adult acting via a litigation friend, also covered by these provisions.

Deprivation of liberty – the limits of the inherent jurisdiction

A City Council v LS, RE and KS (A Child) [2019] EWHC 1384 (Fam) (High Court (Family Division))(MacDonald J)

Article 5 – deprivation of liberty – children and young persons

Summary

The issue in this case was whether the High Court had power under its inherent jurisdiction to authorise the deprivation of liberty of a 17-year-old who was at grave risk of serious, possibly fatal, harm but whose parent objected to him being placed in local authority accommodation. The short answer was 'no'.

KS was involved in serious gang activity. The local authority sought an order to delegate to the police the power to enter premises, detain and restrain KS, and transport him to a placement that would deprive liberty. Since the original order which authorised the same, he had absconded and had not been located by the time of the hearing, but had liaised with his lawyer and wanted to return to his mother.

The local authority accepted that the relief sought lay "*at the edge of the court's inherent jurisdiction*" as KS was not, and could not be, a looked after child for the purposes of the Children Act 1989. There was a strict statutory prohibition in s100(2) which prevented the inherent jurisdiction being used to require someone under 18 being placed in the care, supervision, or accommodation of a local authority.

Noting that the inherent jurisdiction's origins date back to the feudal period, MacDonald J observed that "[t]*he boundaries of the inherent jurisdiction, whilst malleable and moveable in response to changing societal values, are not unconstrained*" (para35). There were reasons to doubt the correctness of the decision in *Re B (Secure Accommodation: Inherent Jurisdiction) (No 1)* [2013] EWHC 4654 (Fam), authorising under the inherent jurisdiction the detention in secure accommodation of a child who was not the subject of a care order and who was not accommodated by the local authority (para 42). KS's mother retained "*exclusive parental responsibility for him*" (para 46) and did not consent to the accommodation. This was not a case where the court was being invited to authorise a non-secure placement for a looked after child due to a lack of suitable beds preventing a secure accommodation application under s25. Rather, this was a case where the local authority sought an order because s25 cannot apply to KS. And this was prohibited by s100(2)(b). As Hayden J had observed in *London Borough of Redbridge v SA* [2015] 3 WLR 1617 at [36]:

> *The High Court's inherent powers are limited both by the constitutional role of the court and by its institutional capacity. The principle of separation of powers confers the remit of economic and social policy on the legislature and on the executive, not on the judiciary. It follows that the inherent jurisdiction cannot be regarded as a lawless void permitting judges to do whatever we consider to be right for children or the vulnerable, be that in a particular case or more generally (as contended for here) towards unspecified categories of children or vulnerable adults.*

Accordingly, the High Court dismissed the application.

Comment

We note this case to illustrate that the inherent jurisdiction cannot be invoked by public bodies simply to plug supposed statutory lacuna, even where there are risks to life. Sometimes lacuna are there for good reason. For under 18s, the Children Act s100(2)(b) specifically prohibits the exercise of the inherent jurisdiction in these circumstances. Whether the same is true of adults who fall outside the scope of the Mental Capacity Act 2005 very much remains to be seen. For the 2005 Act contains no similar statutory prohibition. But the ability of the High Court to authorise the detention of those with mental disorder who have decisional capacity is particularly controversial. The decision in *Meyers* very much avoids the issue as the court considered that his choices were constrained, rather than his liberty deprived. But future testing of the boundaries seems likely. The Mental Health Act 1983 permits detention of those with capacity. And whether such controversial terrain ought to be a matter for Parliament, rather than the High Court, will no doubt be a bone of contention for some time to come.

Deprivation of liberty – the Northern Irish perspective

A Health and Social Care Trust v X et al [2019] NI Fam 9 (High Court of Northern Ireland) (O'Hara J)

Article 5 – deprivation of liberty – DoLS authorisations

Summary

Mr X had died by the time of this judgment, but the decision is likely to affect hundreds of individuals in Northern Ireland in similar circumstances. The case concerned a man lacking capacity around his care arrangements who was confined to a care home. The exit doors were secured at all times. He had freedom of movement within the home but not beyond it. Activities were provided for him to join in such as planned trips, visits to an "open unit" within the same home and access to the secure garden area. During almost all of these activities he was escorted.

The Trust applied for a guardianship order and the issue was whether this covered Mr X's deprivation of liberty. For these purposes, the guardian's powers under Article 18 of the Mental Health NI Order 1986 are not dissimilar to those in England and Wales. Only the Attorney General submitted that it was unnecessary to get authorisation to deprive liberty under the inherent jurisdiction of the High Court on the basis that guardianship could be interpreted to cover it. The other parties agreed such an authorisation was necessary.

O'Hara J held:

> *32. Put simply, there is no authority for reading the guardianship provisions in the manner proposed by the Attorney General. It is more than regrettable that there is still a significant gap in our legislation but that is not a reason to interpret it in the manner suggested.*

Pending the coming into force of the Mental Capacity Act (Northern Ireland) 2016, authorisations would therefore be required from the High Court. And the guidance in *Re X* was broadly supported. Equivalent guidance was therefore needed because "*very few of these applications are in any way controversial – but they*

still have to be made and adjudicated upon until some other statutory procedure is put in place" (para 37). Moreover:

> *37 … The obvious solution is to give responsibility to the Mental Health Review Tribunal which is unquestionably the body with all of the necessary skills and experience to fill this role. Whether it is the High Court or the Tribunal, additional resources will be required because the consequence of Cheshire West is to require legal sanction for what were previously regarded simply as benign arrangements.*

Unlike the *Re X* procedure in England and Wales, in every new case an oral hearing is conducted (para 39) but reviews typically 12 months or so later are conducted initially as a paper exercise: "*Consideration might be given to longer periods of renewal where it is entirely clear that there will not be any improvement but a review has to be scheduled for some point in the future. The liberty to apply provision allows the patient's rights to be raised and considered at any time if there is a change in circumstances*" (para 39). Given that the guardianship process already provided a statutory requirement to consult with the nearest relative, the *Re X* consultation requirements were already achieved, although the views of others interested in the person's welfare could be captured in the social work report (para 41).

Comment

This case illustrates the impact of the *Cheshire West* decision in Northern Ireland. Requiring the High Court to authorise deprivations of liberty outside a hospital setting (including in care homes) provides a stark warning of the urgency of the need to implement the liberty deprivation procedure in the 2016 Act – which, subsequent to this decision – have now been announced as coming into force on 1 October 2019.

Short note: when can the police use force to respond to a person in mental health crisis?

In *Gilchrist v Chief Constable of Greater Manchester Police* [2019] EWHC 1233 (QB), the High Court had to decide whether the use of force was justified in the case of a man with mental health difficulties presenting as seriously aggressive in a public place.

Michael Gilchrist was a 59 year old man with learning difficulties, bipolar disorder and an autistic spectrum disorder. He lived alone in the community, with support from his family, and worked as a gardener. In 2014, he became very distressed and damaged his flat, cutting his hands. He went outside into the street and a member of the public called the police. They attended, formed the view that he was acting aggressively and was a danger to himself and others, and attempted to subdue him using CS gas, a taser, and ultimately physical restraint. He was then taken to hospital by ambulance. He sued the police force (his mother acting as his litigation friend) in trepass to the person and negligence, arguing that the use of force was inappropriate and unnecessary, saying that he had suffered severe, life-changing psychological injuries as a result.

The High Court had to decide upon the police's liability. O'Farrell J summarised the interventions used by the police while they awaited the arrival of an ambulance:

- Spraying CS gas into Mr Gilchrist's face
- Taser (two cycles lasting 6 seconds in total)
- Further spraying of CS gas into Mr Gilchrist's face
- Further use of taser by a different officer (eight cycles lasting 72 seconds in total, the last cycle being applied while Mr Gilchrist was lying on the ground)
- Physical restraint by three officers including kicking the Claimant's legs, tackling him to the ground, and the use of handcuffs and leg restraints

There was also an allegation that CS spray had been used a third time. On arrival at hospital Mr Gilchrist was made subject to s.136 MHA 1983, and was given haloperidol.

The court had to decide whether the use of any force by the police was justified, and if so, whether the methods, extent and level of force were justified. The judge found that it was reasonable for the officers to conclude that Mr Gilchrist was a potential aggressor who had probably assaulted someone given his presentation when they arrived. The two uses of CG gas and the first use of the Taser were similarly justified. (Even though a Taser should not be used when a flammable substance like CS gas has been deployed, the court accepted that the officer did not know this). The subsequent use of the Taser was not justified – by this time, there were sufficient officers present to restraint Mr Gilchrist without using weapons, an attack did not appear imminent, it was no longer an emergency situation and by this stage, Mr Gilchrist's family were present and had informed the police of his mental health conditions. The use of physical force to restrain Mr Gilchrist on the ground however, was reasonable as he continued to be agitated and to struggle.

Readers may find it illuminating to compare and contrast the approach taken here – where there was considered to be a risk posed to other people as well as the person himself – to the rather different approach adopted by the Court of Appeal in *ZH*, which looked rather more critically at what other steps could have been taken to de-escalate the position.

The financial cost of unlawful psychiatric detention

In an unusual, and stark, case of unlawful psychiatric detention, a full report of which can be found on the Mental Health Law Online website, the Claimant, PB, accepted by way of settlement a Part 36 offer of £11,500 plus legal costs made by the Priory Hospital.[3]

PB attended an out-patient appointment at the Hospital on 30 September 2016 to discuss a lower dose of her medication. Within 15 minutes of the appointment she was detained by the Hospital. Moreover, the Second Claimant (PB's husband) was required to make an immediate down-payment of £10,626 to cover the cost of the bed. The detention lasted for 17 days until the Claimant was discharged by her Responsible Clinician.

[33] We normally only covered reported cases, rather than settlements, but make an exception here because of the detailed nature of the summary given by Matthew Seligman, a former member of our Chambers, and now a solicitor with Campbell-Taylor Solicitors.

The first 72 hours of the detention were said to be under s.5(2) of the Mental Health Act 1983 (even though this power only applies to the detention of in-patients), there was then a 7 hour period when the detention was not authorised under any power at all, and subsequently the detention continued under s.2 MHA 1983.

When the Hospital later sought £3,000 in outstanding fees, PB and her husband consulted solicitors. Following the rejection by the Hospital of a complaint, a claim was brought for damages for the whole 17 days of detention under common law and under Article 5 ECHR.

The Hospital subsequently made a Part 36 offer of £11,500 plus damages. We understand that this was accepted on the basis that it covered the 72 hours of detention under s.5(2) MHA plus 6 hours and 45 minutes when detention was without legal authority. It seems that the Claimant accepted there was litigation risk that the period under s.2 might have been held to have appeared to be "duly made" which would make it lawful for the purposes of s.6(3) of the MHA 1983.

Short note: unincorporated international conventions and treaty bodies

In *R (DA) v Secretary of State for Work and Pensions* [2019] UKSC 21, the Supreme Court dismissed a challenge to the Government's revised welfare benefits cap which limits the amount of benefits that non-working households can receive. The decision is of relevance to mental capacity practitioners given the court's observations:

1. on the relevance of international unincorporated conventions – including, by analogy – the CRPD to domestic litigation; and
2. the status of guidance given by UN treaty bodies.

Lord Wilson (who gave the leading judgment) considered the effect of the United Nations Convention on the Rights of the Child ("UNCRC"), the relevant unincorporated convention in that case. He began by observing, in light of the Supreme Court's decision in *Mathieson v Secretary of State for Work and Pensions* [2015] UKSC, that guidance from the relevant UN committee, while not binding nor conclusive on the question of whether the convention has been breached, is nonetheless "authoritative" and "may influence" the court's conclusion on this issue (para 69). However, "*such guidance is not binding even on the international plane and that, while it may influence, it should, as mere guidance, never drive a conclusion that the article has been breached*."

He went on to add, as is now well-established, that interpretation of the ECHR is, where relevant, informed by unincorporated conventions (para 71). This means that the UNCRC can "*inform inquiry*" into an alleged violation of Article 14 (para 72).

Lord Wilson went on to consider the relevance for the purposes of a domestic claim the finding by the court that a relevant unincorporated convention has been breached. Specifically in that case, "*in what circumstances is any breach of article 3.1 of the UNCRC relevant to an alleged violation of article 14?*" (para 73). He concluded that while a breach would not be determinative, it was relevant to whether the Government had justified the discrimination under Article 14 (para

78). Therefore, in circumstances where the "*manifestly without reasonable foundation*" test applied, a failure to comply with article 3.1 of the UNCRC may be indicative of a decision that was manifestly unreasonable. However, finding on the facts that the Government was not in breach of UNCRC, this matter was not then addressed in further detail.

Mental ill-health and appeals from the Employment Tribunal

In *J v K & Anor* [2019] EWCA Civ 5, the Appellant, who suffered mental ill health at the time, "left it till almost literally the last minute" to file appeal documents [27]. However, the EAT server has a 10mb limit and the documents would not go through in time. The appeal was allowed on "*very particular circumstances*":

> *…the obstacle here was not, as it generally is, something extraneous to the EAT – such as documents going astray in the post, or a traffic accident delaying the appellant's arrival at the EAT, or a computer failure at his or her end. Rather, the problem was the limited capacity of the EAT's own system (insufficiently notified to the Appellant).* (paragraph 28)

Though the outcome of the appeal did not depend on this point, the Court of Appeal noted it was "common ground" that mental ill-health is an important consideration in deciding whether an extension should be granted under rule 37 (1A) of the 1993 Rules (paragraph 33). Although Underhill LJ "*was hesitant about prescribing any kind of detailed guidance for the Registrar and Judges of the EAT about the exercise of what is inevitably a broad discretion which will fall to be exercised in a wide variety of circumstances. But I am persuaded that there may be some value in making the following few, very general, points*:"

> *(1) The starting-point is independent evidence of mental illness preferably "in the form of a medical report directly addressing the question" or possibly "medical reports produced for other purposes.*
>
> *(2) Medical evidence specifically addressing whether the condition in question impaired the applicant's ability to take and implement a decision of the kind in question will of course be helpful, but it is not essential…the EAT is well capable of assessing questions of this kind on the basis of the available material.*
>
> *(3) If the Tribunal finds that the failure to institute the appeal in time was indeed the result (wholly or in substantial part) of the applicant's mental ill-health, justice will usually require the grant of an extension. But there may be particular cases, especially where the delay has been long, where it does not: although applicants suffering from mental ill-health must be given all reasonable accommodations, they are not the only party whose interests have to be considered.* (paragraph 39)

The case of *Anderson v Turning Point Eespro* [2019] EWCA Civ 815 dragged on for almost seven years due to "*extraordinary difficulties and delays*". The Appellant "*suffered a serious breakdown in her mental health*" (paragraph 2) following the liability hearing. She said in her grounds of appeal that, at the hearing when she was unrepresented, she "*was subjected to criminal style advocacy which included a two day aggressive and or oppressive criminal cross*

examination" (paragraph 19). It would have been interesting to see what the Court of Appeal would have made of that, but it was not a ground on which the appellant had permission (paragraph 26). Notably, the Criminal Division has repeatedly emphasised that "[a]*dvocates must adjust to the witness, not the other way around*" Lubemba [2014] EWCA Crim 2064.

This appeal was argued by counsel largely on the fact that there was no "ground rules hearing" (see The Advocate's Gateway Ground Rules Hearings toolkit). The Court of Appeal said there is a risk "*that if the tribunal itself takes the lead in seeking to protect a party (or witness) it may give the impression of taking their side*" (paragraph 27) and it would "*have made no sense for the tribunal to proceed with a ground rules hearing…in advance of the Appellant obtaining representation*" (paragraph 28). Oddly this suggests that an unrepresented, mentally unwell person giving evidence in a contested hearing could be left vulnerable on account of no ground rules and no counsel. The tribunal and opposing counsel might not be *indifferent* to the idea of adjustments, but they could be *unaware* of what is necessary. The end result is the same.

It was also said that a *"specifically labelled" ground rules hearing is not necessary*" (paragraph 30) because in a case of any complexity "*there will be a case management hearing, and any difficult or contentious issues about accommodations that might be required as a result of a disability suffered by a party or other witness would typically be canvassed on that occasion*" (paragraph 31). However, having devised and researched the ground rules hearing, I am confident that informed discussion about "ground rules" focusses minds on specific, detailed accommodations (Cooper, Backen & Marchant, 2015). A "ground rules" label, which costs nothing, puts a spotlight on what is essential.

The "*basic common law duty of fairness…is reinforced, where the vulnerability is the result of disability, by the various international instruments referred to in J v K"* (paragraph 32). The appellant *"was professionally represented by counsel, free of charge, at the two subsequent hearings which were in practice decisive of the remedy issue*" (paragraph 24). The court found nothing wrong with the tribunal's approach in this case and the appeal was dismissed.

Professor Penny Cooper

INTERNATIONAL DEVELOPMENTS

Irish Law Commission: a statutory framework for safeguarding

As part of its recently announced Fifth Programme of Law Reform, the Irish Law Commission will undertake consideration of the statutory framework for the safeguarding of vulnerable or at-risk adults. As the Commission notes:

> *The Department of Health and a number of other bodies also made detailed submissions requesting the Commission to include this matter in the Fifth Programme. The Commission has previously completed work in this general area, including a 2006 report which recommended the replacement of the adult wardship system with legislation on adult capacity based on a functional test of capacity, largely reflected in the Assisted Decision- Making (Capacity) Act 2015 (which has not yet been fully*

> *commenced). This project will consider a range of matters, including co-ordination of any new proposed powers of existing or new bodies with other regulatory and oversight bodies, such as the Health Information and Quality Authority on health matters, the Central Bank on financial matters and the Department of Employment Affairs and Social Protection on social welfare matters. It will also consider what regulatory powers may be needed in this area, including those considered by the Commission in its Fourth Programme project on Regulatory Powers and Corporate Offences, on which the Commission published its Report in 2018.*

Independent living across Europe

The European network of academic experts in the field of disability (ANED) has recently produced important research for the European Commission on the right of disabled people to live independently and to be included in the community in European States. Concerningly, ANED's conclusion is that, across Europe, there is still too much institutional care and that choice, control and inclusion are too often not the focus of strategies and action. While progress has undoubtedly been made, "*too many features of the alternate housing and support arrangements that have or are being implemented, while often marking progress from the large-scale institutions they replace, continue to fall significantly short of the promise of Article 19 of the UNCRPD.*"

ANED's report on the position in the UK was published on 1 May 2019. The report identifies as positive the UK's work on ensuring that adults with learning difficulties are looked after in community-based settings rather than hospitals. It is said that care and treatment reviews and personal health budgets have helped significantly with the achievement of this.

In terms of poor practice, however, the report observes that often national strategies concerning the rights of people with disabilities have not been updated in recent years. Further, there is evidence that local commissioners are continuing to invest in both inpatient care and supported accommodation that is institutional in character, particularly with respect to congregate living. In addition, it is considered concerning that there have been steep rises in the numbers of people detained under mental health legislation, subject to deprivation of liberty applications or who have been the object of restraint, seclusion and medication. Recommendations are made to address these shortcomings.

Deprivation of liberty and disability – good practices

A collection of good practice has been prepared by the Centre for Disability Law and Policy NUI Galway as part of a wider research project on deprivation of liberty in collaboration with the office of the Special Rapporteur on the Rights of Persons with Disabilities. It:

> *aims to stimulate the imagination of the different stakeholders to see what can be done and where to start asking for information. A word of caution must be issued at this stage – the practices listed here may not be 100% compliant with the CRPD and should be used as examples of steps towards change, not as perfect models. Replication of positive practices always require taking into account the context in which they are to be*

> *implemented and with the participation of all stakeholders, particularly persons with disabilities*

The report forms part of research that has been conducted over two years on deprivation of liberty, which explored human right standards, available data and legislation on deprivation of liberty of persons with disabilities, including field work with the help of local research teams in five countries: France, Ghana, Jordan, Indonesia and Peru to further explore why persons with disabilities are being deprived of liberty. The researchers note that:

> *When examining the underlying causes during phase II, several themes emerged from the interviews. Firstly, many situations that potentially qualify as deprivation of liberty under the CRPD are not recognized as such, and the research team found resistance to this description. Secondly, stakeholders described how in situations of urgency, acute need for support, distress or exhaustion of a person's social network, professionals' most common response (due to a duty under the law or because no other option was imagined or available) was to deprive the person of liberty to provide 'care', education or to subject them forcefully to treatment. The interviews revealed a lack of information and of imagination on how things could be done differently. Stigma was a recurrent theme in all countries.*

We commend the good practice guide (alongside the recently published Alternatives to Coercion in Mental Health Settings: A Literature Review); there is much that can and should be done to secure against the risk that the only choice appears to be detention. But we ask two questions, neither of which the CRPD Committee have yet grappled with[4]:

(1) Are MIG, MEG and Steven Neary (where he now lives) to be considered to be deprived of their liberty? Those who resist the description that they are deprived of their liberty may not showing inappropriate resistance but indicating that the Committee needs to consider more carefully precisely what it means by deprivation of liberty;

(2) If – as it must – the state must have an obligation to secure life (including under Article 10 CRPD), is the Committee really contending that there are no circumstances under which that obligation could **ever** trump the right to liberty for a person in crisis?

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.

Harrington, J., Series, L., & Ruck Keene, A. (2019). Law and Rhetoric: Critical Possibilities. *Journal of Law and Society*, *46*(2), 302-327, which looks at the role rhetoric plays in the law, including in the context of capacity and the Court of Protection.

[4] See, for more on this, Alex's post.

Wade, D. T. (2019). Determining whether someone has mental capacity to make a decision: clinical guidance based on a review of the evidence. *Clinical Rehabilitation*, 0269215519853013, a detailed look at mental capacity in the clinical context.

Finally, and not strictly a research article, the Article 22 project at Newcastle University has launched a consultation on an Economic, Social and Cultural Rights Bill developed together with colleagues from other universities and from civil society. It is the first stage in a process that they hope will eventually end in such a bill being introduced in Parliament. For details, and to respond (by 14 July) see here.

SCOTLAND

Scottish Government extended review

On 19th March 2019 Ms Clare Haughey MSP, Minister for Mental Health, announced a review of the Mental Health (Care and Treatment) (Scotland) Act 2003, to encompass existing Scottish Government reviews including the review of the Adults with Incapacity (Scotland) Act 2000. We welcomed that announcement, for the reasons given in the April Report. On 20th May 2019 Ms Haughey announced the appointment of Mr John Scott QC Solicitor Advocate to chair the extended review. We welcome that announcement also, and welcome John Scott's first contribution to the Report, which appears immediately after this item, and which outlines his initial approach to the task entrusted to him.

John is a fine lawyer with a high reputation principally in criminal law practice, but with a strong background in human rights issues. He has a proven track record in discharging tasks similar to that now entrusted to him. Opinions may be divided as to whether it was appropriate to appoint someone with no great background in mental health and adult incapacity law and practice. We welcome the appointment of someone with the qualities that John undoubtedly possesses, and the fact that he comes to the task with no preconceptions or fixed positions, open to persuasion as to how the issues should be defined, to whom he should listen in approaching them, and what best solutions may ultimately emerge from that process. To those who remain doubtful, we would simply say "wait and see".

John qualified as a solicitor over 30 years ago. He obtained Rights of Audience before the High Court of Justiciary in 2001, and took Silk in 2011. In November 2018 he was awarded Silk of the Year in the Law Awards of Scotland, jointly with Aidan O'Neill QC. Within his criminal law specialism, he is the only person to have received on four consecutive occasions the Criminal Lawyer of the Year Award by Firm Magazine. He has appeared in several major cases, up to and including in the UK Supreme Court. His approach to self-education is reflected in the two Post Graduate Courses that he has undertaken in Forensic Medicine, in Glasgow and Edinburgh Universities respectively, and his ensuing instructions in cases involving substantial and complex evidence in various areas of forensics. He provides continuing professional development to the profession and to others.

He chaired the Scottish Human Rights Centre from 1997 to 2005. He was involved in Justice Scotland from the early planning stages through to chairing it for a year in 2014. He was convener of the Howard League for Penal Reform in Scotland from 2006 to 2018.

In 2015 he chaired an Independent Advisory Group on Stop and Search at the request of the Cabinet Secretary for Justice. The Group's 10 recommendations were all accepted by Government and incorporated in relevant provisions of the Criminal Justice (Scotland) Act 2016. After he had given evidence to the Justice Sub-Committee on Policing, he continued to chair an extension of the Group which produced a Code of Practice which entered into force in May 2017, and review of the operation of the Code which continued through into this year. He

chaired an independent review of Biometrics in Policing in Scotland, again at the request of the Cabinet Secretary for Justice. That report was published in March 2018 and led to the Scottish Biometrics Commissioner Bill, introduced at the Scottish Parliament on 30 May 2019. Most recently, yet again at the request of the Cabinet Secretary for Justice, he has been chairing an independent review into the Impact on Communities of the Policing of the Miners' Strike 1984-85 (due to report to the Cabinet Secretary in August 2019). Completion of that task has not deterred him from launching himself with enthusiasm into the work of his latest appointment, immediately upon announcement of that appointment.

The foregoing identifies some points of particular relevance to his latest task in the field of mental health and incapacity law and practice. It is not comprehensive.

The Report will continue to follow the progress of the review, as support teams are put in place, the remit for the review agreed and announced, and a methodology for its conduct structured and announced.

Adrian D Ward

Review of the Mental Health (Care and Treatment) Act 2003: the Chair's perspective

Until a few weeks ago, I was aware of this independent review which was announced by the Scottish Government in March. Obviously, I could see the importance of the review but thought little more about it until I was asked to chair it. Since then, I have been familiarising myself with the area, including related work which is currently underway and similar reviews in England and elsewhere, as well as the latest developments and thinking around the UN CRPD.

I am well aware that there are many more qualified than me in terms of knowledge and experience in the relevant law and practice but, as one of those said to me, "When your name was mentioned, I was glad that I had never heard of you". What I hope to bring is an ability to listen and work collaboratively with key individuals, organisations and groups.

Within the field, the welcome has been extremely warm and, within days of the announcement of my role, I had benefitted from conversations with many who are leaders in the field.

The next few weeks will be taken up with finalising the Terms of Reference; establishing a group or groups to carry out the review work with me; identifying the most effective and participative method of working; preparing the terms of a Call for Evidence and, crucially, making sure that we approach our work mindful of what Clare Haughey, the Minister for Mental Health, said in March: "As part of the review we want to gather views from as wide a range of people as possible and I am determined to ensure that the views of service users, those with lived experience and those that care for them are front and centre so they can help shape the future direction of our legislation."

I look forward to this important and challenging work and hope to be able to keep you updated as the review progresses.

John Scott QC

Independent review of learning disability and autism in the Mental Health Act: Stage 1 report

During the passage through the Scottish Parliament of the bill that eventually became the Mental Health (Scotland) Act 2015 (amending the Mental Health (Care and Treatment) (Scotland) Act 2003) the Scottish Government gave a commitment to commission an independent review into the issue, also raised and left undecided in the Millan Review, of whether learning disability and autism should continue to be conditions covered by mental health legislation. The review was subsequently established, with Andrew Rome as its chair, and full details of it can be found on its very accessible website.

On 31st May 2019 the review published its Stage 1 Report containing the views of people across Scotland who have experienced care under the 2003 Act, including person with learning disabilities and autism, professionals, unpaid carers, organisations of autistic people or people with learning disability and professional organisations. It also provides summaries of the findings from various relevant reports on mental health and human rights in Scotland. The report is clearly and concisely written so rather than regurgitate its content here I would urge you to go directly to the supplied link.

Stage 2 of the review is currently ongoing and is looking at possible options for reform of the 2003 Act which in turn will form the basis of a consultation (Stage 3) that will seek comment on options for law reform and which will commence at the end of August 2019. The review's final report and recommendations will be submitted in December 2019 to the Scottish Government's Minister for Mental Health and will without doubt inform the wider 2003 Act review

Although I must confess a personal interest in the review, being one of its advisors, the Review Team must be commended for the extremely thorough, structured, wide-reaching and inclusive human rights-based approach they have adopted to date in their information gathering and analysis of such information.

Jill Stavert

More on anonymisation – the *MH* case again

In the May Report Jill and I commented on two decisions in the case *MH v Mental Health Tribunal for Scotland*, Jill upon the decision as to whether it was necessary for the convener of a Mental Health Tribunal hearing to be personally present at the hearing, and I upon the issue of whether the patient in that case – indeed patients in proceedings before the Tribunal generally – should be entitled to anonymity. The decision on personal presence of the convener has now been reported at 2019 SLT 615. That report is followed by a note relevant to the court's refusal of *MH*'s appeal for an anonymity order. The note states that the appellant remains anonymised in the reports, and in the Opinions published on the scotcourts website, because after receiving the usual copies of the Opinions upon that aspect, *MH*'s representatives provided the court with a medical report. The court determined that the report justified anonymising the appellant's name in those proceedings. In consequence the published Opinions, and the report, preserve anonymity.

Notwithstanding that particular outcome, both decisions in the *MH* case carry considerable implications. We shall endeavour to report whether leave for appeals in respect of either or both decisions to the Supreme Court is sought, and if so whether it is granted.

Adrian D Ward

Visiting team from Singapore

Scotland's adults with incapacity legislation was world-leading when first enacted, and still attracts international attention. There is also interest in related legislation, particularly our adult support and protection legislation, and in our current review processes.

The latest in visiting teams from various continents was a visit of a team from Singapore's Ministry for Social and Family Development, accompanied by three members of NGOs providing relevant services, on 22nd – 24th May 2019. The team included Mr Desmond Lee, Minister for Social and Family Development, Ms Regina Ow, Public Guardian, and Ms Christine Ong, Assistant Director in the Office of the Public Guardian. The team arrived well informed, but keen to learn more. While Singapore's Mental Capacity Act was modelled upon the Act of England & Wales of the same name, their Vulnerable Adults Act (which came into force in December 2018) was modelled upon Scotland's Adult Support and Protection Act of 2007, which has no equivalent in England & Wales or some other jurisdictions. All members of the visiting team impressed in a series of two-way interchanges in which all concerned benefited. Mr Lee in particular listened modestly and attentively to discussions and presentations, and only in his perceptive questions and comments did he reveal not only how much he had absorbed from the discussions, but his own mastery of a massive ministerial brief, with clear understanding of overall long-term factors and trends, as well as of details.

The team was initially hosted at the Law Society of Scotland by Amanda Millar, a leading expert in relevant topics and now Vice-President of the Law Society of Scotland. I gave an overview of relevant Scots law. The team then proceeded to St Andrew's House for informative discussion and a pleasant lunch hosted by Scotland's Minister for Mental Health, Ms Clare Haughey. St Andrew's House helpfully provided accommodation for the remainder of the first day's programme, comprising a presentation by the "mypowerofattorney" team, an overview presentation by Fiona Brown, Public Guardian, on the work of Scotland's Office of the Public Guardian, and a meeting with Kirsty McGrath and members of her team conducting review of Scottish adult incapacity legislation. The following day commenced at the usual Thursday Guardianship Court at Edinburgh Sheriff Court, preceded by a welcome and introductory discussion led by Sheriff Principal Stephen, with Sheriffs Reith and Corke also participating. Sheriff Reith conducted the Guardianship Court that morning. Discussions before and after the court itself enhanced the value for the visiting team of sitting in throughout the court itself. Most helpfully, a number of themes that had emerged during the visit were addressed and exemplified in the course of that particular court. That afternoon's sessions were hosted by the Mental Welfare Commission for Scotland, incorporating presentations by, and discussions with, Colin McKay (Chief Executive) and Yvonne

Bennett of the Commission; Bob Leslie (Team Manager, Mental Health Officer Services, Renfrewshire Council); and solicitors Alison Hempsey and David McClements on the role of "professional guardians", which the visitors had explicitly asked to hear about. Mr Lee and his special assistant had to leave that afternoon. The remainder of the team spent the entire final day at the Office of the Public Guardian in Falkirk, hosted by Fiona Brown, gaining very full experience of "how it's all done" in practice.

One is left to reflect about the extent to which trends in Asia in general, and Singapore in particular, though perhaps different when detailed figures are considered, might nevertheless have significant impact in Scotland: large increases in the numbers of elderly people as a proportion of total population, longer life expectancy of people with severe and profound disabilities, reducing birth rates, reduction in "traditional family units" with more people remaining single or entering more transient and less committed relationships, and so forth.

Adrian D Ward

The Independent Inquiry into Mental Health Services in Tayside: Interim Report – Inquiry update and Emergent Key Themes

Introduction

In May 2018 concerns were raised in the Scottish Parliament about the provision of mental health services in Tayside, notably after several suicides had occurred. This resulted in NHS Tayside commissioning an independent inquiry chaired by David Strang (former HM Chief Inspector of Prisons for Scotland) tasked with investigating the accessibility, safety, quality and standards of care provided by its services[5]. The remit of this five-stage inquiry is to consider end-to-end mental health services.

Following a public call for evidence in September 2018, the inquiry has published an interim report in May 2019 providing an update and information on some key themes that have emerged to date and which will require further investigation. The purpose of identifying these key themes is to assist with making specific conclusions and recommendations in the inquiry's final report.

A reading of the interim report itself is recommended for detail and greater perspective and it must be noted that analysis of the evidence is ongoing. However, the evidence gathered so far appears to reveal a long and deeply concerning catalogue of inadequate and poor provision throughout the service many of which have serious human rights implications including the rights of persons with mental disabilities to the highest attainable standard of mental health,[6] life,[7] to rehabilitation[8] and community living[9], to be free from inhuman or

[5] Recommendations had also been made in Health Improvement Scotland and Mental Welfare Commission inspection reports concerning such services.

[6] Article 12 International Covenant on Economic, Social and Cultural Rights; Article 25 Convention on the Rights of Persons with Persons (CRPD).

[7] Article 2 European Convention on Human Rights (ECHR); Article 10 CRPD.

[8] Article 26 CRPD.

[9] Article 19 CRPD.

degrading treatment[10] and to exercise choice and one's legal capacity.[11] It also raises questions about the equal and non-discriminatory treatment of persons with mental disabilities.[12] Further, although the Act is not specifically mentioned in the interim report one might ask whether the principles that underpin use of the Mental Health (Care and Treatment) (Scotland) Act 2003 are being properly applied at all times, something that might be of interest in the current review of the Act. The following, however, is simply a summary of the key themes referred to.

Key themes identified to date

Patient Access to Mental Health Services

It was reported that whilst many patients and families report receive professional and caring support from service staff during times of crisis the service struggles to respond to sudden increases in demand and there are out-of- hours crisis issues. Inadequate risk assessment at an early stage and police officers effectively having to manage patients in crisis here are also noted. There are long waits for referrals to mental health services and where referrals are rejected there is limited GP expertise or time available to support patients with ongoing mental ill-health and post-referral waiting times to Allied Health Professionals may be as long as a year.

Where children and young persons are concerned delays in referrals to and rejections by CAMHS are noted as well as difficulties in the transition from CAMHS to General Adult Psychiatry for young people.

Patients presenting to mental health services following alcohol or drug consumption are reporting rejection from crisis assessment and people with addiction to alcohol and/or illegal drugs may be refused access to mental health services. Patients with multiple mental health diagnoses often find only one of their diagnosed conditions is addressed. Concerns are also expressed about patient safety both within the inpatient facilities and in community setting.

The use of restraint within inpatient facilities is also of concern to patients and staff as is the presence of illegal drugs on wards. It further seems possible for patients to discharge themselves from inpatient facilities without any support being in place for them and some subsequently being found in a heightened state of distress.

Finally, staffing levels are perceived to be low both on inpatient wards and in the community accompanied by excessive workloads and a lack of staff training.

Quality of Care

Poor communication between staff and patients, poor ward environments physically and in terms of activity and patient safety, issues about continuity and consistency of care, the availability of services and inconsistent or non-

[10] Article 3 ECHR; Articles 15 and 16 CRPD.

[11] Article 8 ECHR; Article 12 CRPD.

[12] Noting that ECHR rights must be enjoyed without discrimination based on, amongst other things, disability (e.g. *Glor v Switzerland* (Application No.13444/04) ECtHR judgment 30 April 2009) and this is promoted, without even differential treatment that can be objectively and reasonably justified being permitted, by the CRPD (see CRPD General Comment No.6).
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existent reference to carers in patient's care plans.

Organisational Learning

A disconnect between policy and practice and failure to learn from adverse events and critical incidents raises some important concerns.

Leadership

A lack of clarity as to leadership of the service, accountability and reporting lines are noted.

Governance

There appears to be little visibility of mental health service performance monitoring and management at all levels accompanied by poor change management.

Conclusion

As already indicated, the interim report lists some potentially serious failures in service delivery which will need to be fully addressed. It will be interesting to see what the inquiry's ultimate conclusions and recommendations are and as this interim report states: "[t]here is now a real opportunity for Tayside to transform its provision of comprehensive mental health services to meet the needs of all people living in Angus, Dundee and Perth & Kinross."[13] If any reform - whether it is at legislative, policy and/or practice levels – is to be successful it must be accompanied by adequate and appropriate information, training and, more often than not, commensurate resourcing. It will therefore be equally interesting to see how the Scottish Government and relevant services respond to this inquiry.

Jill Stavert

[13] p11 of the Interim Report.

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Katie advises and represents clients in all things health related, from personal injury and clinical negligence, to community care, mental health and healthcare regulation. The main focus of her practice however is in the Court of Protection where she has a particular interest in the health and welfare of incapacitated adults. She is also a qualified mediator, mediating legal and community disputes. To view full CV click here.

Katherine Barnes: katherine.barnes@39essex.com

Katherine has a broad public law and human rights practice, with a particular interest in the fields of community care and health law, including mental capacity law. She appears regularly in the Court of Protection and has acted for the Official Solicitor, individuals, local authorities and NHS bodies. Her CV is available here: To view full CV click here.

Simon Edwards: simon.edwards@39essex.com

Simon has wide experience of private client work raising capacity issues, including *Day v Harris & Ors* [2013] 3 WLR 1560, centred on the question whether Sir Malcolm Arnold had given manuscripts of his compositions to his children when in a desperate state or later when he was a patient of the Court of Protection. He has also acted in many cases where deputies or attorneys have misused P's assets. To view full CV click here.

Adrian Ward: adw@tcyoung.co.uk

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; national awards for legal journalism, legal charitable work and legal scholarship; and the lifetime achievement award at the 2014 Scottish Legal Awards.

Jill Stavert: j.stavert@napier.ac.uk

Jill Stavert is Professor of Law, Director of the Centre for Mental Health and Capacity Law and Director of Research, The Business School, Edinburgh Napier University. Jill is also a member of the Law Society for Scotland's Mental Health and Disability Sub-Committee. She has undertaken work for the Mental Welfare Commission for Scotland (including its 2015 updated guidance on Deprivation of Liberty). To view full CV click

Conferences

Conferences at which editors/contributors are speaking

Medical decision-making and the law

Tor is giving a speech at Green Templeton College in Oxford on 20 June on medical decision-making and the law. For more details, and to book (tickets are free but limited), see here.

Human Rights in End of Life

Tor is speaking at a free conference hosted by Sue Ryder on 27 June in London on applying a human rights approach to end of life care practice. For more details, and to book, see here.

Essex Autonomy Project summer school

Alex will be a speaker at the annual EAP Summer School on 11-13 July, this year's theme being: "All Change Please: New Developments, New Directions, New Standards in Human Rights and the Vocation of Care: Historical, legal, clinical perspectives." For more details, and to book, see here.

Liberty Protection Safeguards: Implementation of the Mental Capacity (Amendment) Act 2019

Alex is chairing and speaking at a conference about the LPS on Monday 23 September in London, alongside speakers including Tim Spencer-Lane. For more information and to book, see here

Advertising conferences and training events

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

Our next edition will be out in July. 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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