39 Essex CHAMBERS

MENTAL CAPACITY REPORT:
THE WIDER CONTEXT

June 2019 | Issue 95

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.

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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[1]

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, 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

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

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.[2]

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.

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.

[22] 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.

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[3]:

(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.

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.

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

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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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