Mental Capacity Law Newsletter February 2015: Issue 53

Capacity outside the Court of Protection

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Introduction

Welcome to the February 2015 Newsletters, revamped to reflect our new name of 39 Essex Chambers. We have taken the opportunity of the launch of our new Chambers website to bring together all our mental capacity resources in one place.

Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Newsletter: a further chapter in the saga of consent to sex; unlawful removals from the family home; and the new DOLS forms;

(2) In the Property and Affairs Newsletter: failed attempts to prevent the OPG/COP having oversight over an attorney and to get costs against the OPG and the OPG's review of deputy monitoring;

(3) In the Practice and Procedure Newsletter: an important case on declarations and contempt; a rare decision on permission;

(4) In the Capacity outside the COP Newsletter: the new Practice Note for representation before the MH Tribunal; the new MHA Code of Practice; and the new offences of ill-treatment and wilful neglect;

(5) In the Scotland Newsletter: detailed coverage of the Special Case that has resolved the question mark over the validity of powers of attorney raised by Sheriff John Baird, as well as important guidance on vulnerable clients and Practice Rules relating to powers of attorney and an update on the Mental Health (Scotland) Bill.

We also bid temporary farewell and all best wishes to Anna Biccaregui as she goes on maternity leave, and a very warm welcome to Annabel Lee who joins the editorial team in her place.

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Hyperlinks are included to judgments; if inactive, the judgment is likely to appear soon at www.mentalhealthlaw.co.uk.

Short Note: getting creative with the inherent jurisdiction

In a case that received wide media coverage at the end of 2014, *Birmingham City Council v Sarfraz Riaz* [2014] EWHC 4247 (Fam), Keehan J granted civil injunctions under the inherent jurisdiction of the High Court to prevent any further contact or association by 10 men with a vulnerable 17 year old, AB or with any female under the age of 18 years, previously unknown to them, in a public place.

The case is significant in that it was the first time that the inherent jurisdiction had been deployed in this way; Keehan J confirming at paragraph 46 that:

> *"the use of the inherent jurisdiction to make injunctive orders to prevent* [child sex exploitation] *strikes at the heart of the parens patriae jurisdiction of the High Court. I am satisfied that none of the statutory or the 'self imposed limits' on the exercise of the jurisdiction prevent the court from making the orders sought by the local authority in this case."*

It will be very interesting to see whether Birmingham seek continuation of the orders made in respect of the protection of AB when she turns 18, and whether the 'great safety net' (*Re DL*) of the inherent jurisdiction is equally apt to be deployed in this regard in respect of those over 18.

New Mental Health Act Code of Practice

The new Mental Health Act Code of Practice has been published, to come into force in April subject to Parliamentary approval.

The main changes to the 2008 version are:

- 5 new guiding principles
- new chapters on care planning, human rights, equality and health inequalities
- consideration of when to use the Mental Health Act and when to use to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and information to support victims
- new sections on physical healthcare, blanket restrictions, duties to support patients with dementia and immigration detainees
- significantly updated chapters on the appropriate use of restrictive interventions, particularly seclusion and long-term segregation, police powers and places of safety
- further guidance on how to support children and young people, those with a learning disability or autism

We focus here on the new chapter (13) specifically on mental capacity and deprivation of liberty. The chapter title is actually slightly misleading, as it includes a useful rehearsal of the key principles of the MCA 2005 as they apply in the mental health context including such matters as the importance of the MCA 2005 in care planning.

The Code of Practice makes a heroic stab at explaining Schedule 1A, including a useful 'options grid.'

We note, though, that the Code continues to peddle the canard that, where a patient can (and must) be the subject of an authorisation either under the MCA 2005 or the MHA 1983:

> *"13.59 Both regimes provide appropriate procedural safeguards to ensure the rights of the person concerned are protected during their detention. Decision-makers should not therefore proceed on the basis that one regime generally provides greater safeguards than the other. However, the nature of the safeguards provided under the two regimes are different and decision-makers will wish to exercise their professional judgement in determining which safeguards are more likely to best protect the interests of the patient in the particular circumstances of each individual case."*

We respectfully suggest that the first sentence of this paragraph does not stand up to close analysis, and anticipate that the day is not too far off where a claim will be made that Schedule 1A is incompatible with Article 5 and/or Article 5 in conjunction with Article 14 in light of: (1) the very differing outcomes that a patient will face depending upon whether they are deprived of their liberty under the MCA 2005 or the MHA 1983; and (2) the near impossibility of identifying in advance which route will be adopted.

New Practice Note for Mental Health Tribunals

The Law Society[1] has issued an updated Practice Note for those representing patients before Mental Health Tribunals. It represents a significant revision of the previous version (from 2011). For present purposes, we highlight the guidance given to those representatives who have been appointed under Rule 11(7) of the Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 (or the equivalent rules in Wales) where a patient does not have capacity to appoint a representative, but the Tribunal believes that being represented is in the patient's best interests.

As the Practice Note indicates:

> *Once appointed by the tribunal you have a heightened responsibility to identify and then to act in the interests of the client. The duty to act in the client's best interests is set out in Principle 1 of the SRA Code 2011 and applies to clients with or without litigation capacity. In our view the client's interest in a fair hearing to determine the lawfulness of their detention is paramount. When your client lacks litigation capacity, you will not take instructions in the same way that you would in respect of a client with capacity. Instead you must do your best to ascertain their wishes and feelings. You must give weight to the wishes that your client expresses. The closer the patient is to having capacity, the greater the weight you must give to their wishes in seeking to formulate and advance submissions on their behalf. Nonetheless, you remain under the same duty to the tribunal to advance only submissions which are properly arguable as if your client had capacity (see Buxton v Mills-Owen and section 4.1 Clients with capacity). There are likely to be few cases where a client who is able to express their wish to be discharged by a tribunal will be assessed as lacking capacity to instruct you. Similarly, where a client without litigation capacity tells you they wish to be discharged from hospital, there will be few cases it will not be appropriate to argue for their discharge. This is because of the over-riding importance of the client's right under Article 5(4) to challenge the lawfulness of their detention - a right that exists without the detained individual needing to show that they*

[1] Full disclosure, Alex is a member of the Law Society's Mental Health and Disability Committee, which had responsibility for preparing the updated Note.

have any particular chance of success in obtaining their release - see Waite v UK (2003) 36 EHRR 54. Where the client lacks the ability to express their wishes you should:

- *ensure that the tribunal receives all relevant material so that it can determine whether the criteria for continued detention are satisfied*
- *test the criteria for continued detention*
- *remember your client's right to treatment in the least restrictive setting and alert the tribunal to possible alternatives to detention under the MHA 1983 such as Community Treatment Orders (CTOs) and guardianship*

In the case of a patient who is unable to consent to be detained for purposes of assessment or treatment in hospital but appears to be compliant, you may wish to consider whether the DoLS regime under Schedule A1 to the MCA 2005 might provide a better and less restrictive way of ensuring that your client receives treatment or assessment in hospital: see AM v SLAM NHS Foundation Trust [2013] UKUT 365 (AAC). You should not automatically argue for discharge if you are unable to ascertain the patient's wishes, but you are obliged to test the criteria for detention.

The Guidance also addresses the various different shades of meaning in the phrase 'best interests,' pointing out the difference between what has been termed the patient's 'legal best interests' and their 'clinical best interests,' and the potential that the two might clash, as in *RM v. St. Andrew's Healthcare* [2010] UKUT 119 (AAC), where the Upper Tier Tribunal ruled that documents revealing the patient was being covertly medicated should be disclosed to the patient because his fair trial rights (which the Upper Tier Tribunal referred to as his best legal interests) required it, even though it was accepted it was likely to affect his health adversely (which the Upper Tier Tribunal referred to as the patient's best clinical interests).

One final important change of note here is in the relation to is in relation to confidentiality. As the Practice Note indicates:

"This duty is covered in Chapter 4 of the SRA Code of Conduct. You must achieve Outcome 4.1 which requires solicitors to keep the affairs of clients and former clients confidential except where disclosure is required or permitted by law or the client consents. Practitioners should be aware that the previous version of the code provided for specific exceptions to the absolute duty of confidentiality. These do not appear in the current version of the code and we recognise that this may give rise to difficult questions for practitioners. For example, you are speaking to a client on the ward and as you are about to leave they tell you they have been saving up their medication. They know the ward will be short-staffed tonight and intend to take an overdose and end their life. You know that they have attempted to take their own life before. You suggest that the two of you speak to one of the nurses to tell them this but they will not agree. In this situation, as the client has refused consent to disclose their intentions, any subsequent disclosure by you would appear to be a technical breach of Outcome 4.1 yet not to do so could also potentially be said to conflict with your duty to act in the best interests of your client. For guidance as to how you should approach situations such as this you should contact the SRA Ethics Helpline."

Review of ss.135-6 MHA 1983

A joint review by the Home Office and the Department of Health of ss.135-6 MHA 1983 has concluded that there was:

- Widespread variation in the frequency of use and the extent to which police stations were used as places of safety, access to health-based safe places being a key factor in avoiding police cells.
- A lack of clarity as to whether workplaces, private car parks, and railway lines were public places.
- Support for a reduction in the maximum period of detention.
- Mixed views as to whether there should be a power to remove someone needing help from their home without a warrant.

The following legislative recommendations were made:

- Ensure no-one under 18 is ever taken to a police cell under MHA ss.135-6
- Only use a police cell as a place of safety for adults if the person's behaviour is so extreme that they cannot otherwise be safely managed
- Extend the list of places of safety to anywhere which is considered suitable and safe
- Amend MHA s.136 to apply anywhere except a private home (and therefore include railway lines, private vehicles, hospital wards, rooftops, hotel rooms, workplaces.
- Reduce maximum period of detention from 72 to 24 hours in any place of safety (with some scope for extension in limited circumstances)
- Requiring police to consult a suitable health professional prior to detaining a person under s.136 if feasible and possible to do so (e.g. street triage arrangements)
- Making it clear in legislation that an assessment can take place in the person's home when a s.135 warrant is used and that police, paramedics, and AMHPs can remain present while this is carried out
- Potential new power for paramedics to convey a person to a health-based place of safety from anywhere other than a private home

There were also a number of non-legislative recommendations to improve commissioning arrangements and guidance.

Self-neglect

A very useful report by Suzy Braye, David Orr and Michael Preston-Shoot has been published by SCIE as regards policy and practice in self-neglect adult social care. Entitled "Self-neglect policy and practice: building an evidence base for adult social care," the work built on in-depth interviews with practitioners and service users.

Key themes emerging from the in-depth interviews were around the areas of creating a strategic and operational infrastructure for self-neglect practice and using approaches that resulted in positive outcomes. Issues discussed include the inter-agency governance regarding policies and protocols (such as LSAB or other mechanism); improved inter-agency training and

support; referral pathways and better data collection on self-neglect. Approaches to practice that helped achieve positive outcomes by those involved included the importance of relationship-based and person-centred practice; considering the whole person; an understanding of the Mental Capacity Act 2005; the use of creative interventions; and the value of multi-agency working.

We would also recommend that those concerned with the area also read Vile Bodies: Understanding the Neglect of Personal Hygiene in a Sterile Society, a free resource published by Peter Bates.[2]

Choices at the end of life

A useful booklet giving information about choices at the end of life has been published by Compassion in Dying. Likely to be of use for advocates and providers of care to the elderly, as well as individuals, the resource gives information about topics including lasting powers of attorney for welfare decisions and advance decisions to refuse treatment. Copies can be downloaded or ordered in hard copy here.

Winterbourne View – an update

In December 2012, in the aftermath of the Winterbourne View abuse scandal, the Government published a report *"Transforming Care: A National Response to Winterbourne View Hospital"* setting out a programme of action to transform services so that vulnerable people no longer lived inappropriately in hospitals. Two years on, the Government published on 29 January a report entitled *"Winterbourne View: Transforming Care 2 Years On"* setting out its progress to date.

This latest report is frank. It readily acknowledges that the system has not delivered was set out to be achieved two years ago. The central ambition was to reduce the number of people with challenging behaviour inappropriately placed in hospitals. This has not been achieved.

There is still much to be done – just how much being emphasised by the damning NAO report on progress (or lack thereof) published on 4 February, indicating – for instance – that of the 48 patients resident at Winterbourne View at the time of its closure in June 2011, 10 were still in hospital in January-June 2014.

The DH report notes the growing calls from multiple sources – including families, national exerts and statutory agencies – that the current statutory framework is not sufficient to transform care for people. The report looks ahead to the impending changes which will soon be brought in by the Care Act 2014 to improve safeguarding. From April 2015, all providers of health and adult social care must meet certain standards and the CQC will also be able to take enforcement action where breaches are found. There are two new statutory offences of "ill-treatment" and "wilful neglect" which will apply across all healthcare settings (see the next article). Going forward, the *Transforming Care* programme has been revised which will hopefully lead to faster and better progress.

Ill-treatment and wilful neglect – the Criminal Justice and Courts Bill

Although Royal Assent has yet to be given to the Criminal Justice and Courts Bill, all outstanding issues on the Bill were resolved on 21 January 2015, thereby clearing the way for the enactment

[2] Full disclosure, Alex had some very modest input into the section relating to the law.

of the Bill. The Bill covers much ground, including (controversially) significant limitations upon judicial review. It will also introduce amendments to appeals in relation to decisions of the Court of Protection and, importantly, new offences of ill-treatment and wilful neglect.

When the Bill becomes law, it will be an offence (under s.20) for an individual who has the care of another individual by virtue of being a care worker to ill-treat or wilfully to neglect that individual. A "care worker" is an individual who, as paid work, provides health care for an adult or a child (with certain exceptions), or social care for an adult. Significantly, a care worker also includes those with managerial responsibility and directors (of equivalents) of organisations providing such care.

There is also a separate offence (under s.21) relating to care providers. A care provider will commit this offence where:

- an individual who has the care of another individual by virtue of being part of the care provider's arrangements ill-treats or wilfully neglects that individual,
- the care provider's activities are managed or organised in a way which amounts to a gross breach of a relevant duty of care owed by the care provider to the individual who is ill-treated or neglected, and
- in the absence of the breach, the ill-treatment or wilful neglect would not have occurred or would have been less likely to occur.

It should perhaps be noted in relation to what will be s.21 that this does not include those who are receiving direct payments.

Whilst we anticipate that use will be made wherever possible of the potential for using these new charges, the offence under s.44 MCA 2005 will remain of importance to cover instances of ill-treatment or wilful neglect by family members or others falling outside the category of paid care workers. In the circumstances, it is to be regretted that the opportunity was not taken in this Bill also to revisit s.44 MCA 2005 and the extremely flawed approach adopted there to capacity.

Monitoring of OPCAT

The UK is a signatory to the Optional Protocol to the UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT), and, as such, is required to establish an independent National Preventive Mechanism (NPM) to undertake inspections and other preventive activity.

The fifth annual report of the NPM on monitoring places of detention in 2013-4 is now available. This includes – very brief – consideration of deprivation of liberty under the MCA 2005, noting the effect of the *Cheshire West* judgment (but not then considering, for instance, the extent to which the definition of 'places of detention' may need to be extended in consequence).

The CPRD comes to the rescue

The Mental Disability Advocacy Centre reports an important success in the Czech Supreme Administrative Court, winning a case concerning the obligation of public authorities to enable mentally disabled children to live with their families rather than in institutions. The Czech court relied on the UNCRPD, holding that:

> *"When the Czech Republic signed and ratified this international convention [CRPD], it was also obliged to adhere to it (Article 1, Paragraph 2 of the Constitution of the Czech Republic) and the effective fulfilment of this convention is an obligation of authorities of the legislative, executive and judiciary....Therefore it is necessary to take into account the provision of the UN Convention on the Rights of Persons with Disabilities when identifying the concrete content of the social right claimed by the applicants, since it must be considered as a law which is executing this social right … The same applies for … the European Social Charter. … Other documents claimed by applicants that are considered as international soft-law must be also taken into account, particularly the General Comment of the UN Committee on Economic, Social and Cultural Rights."*

Summary of Strasbourg case-law relating to disability

With thanks to Lucy Series for bringing this to our attention, we note a very useful summary that the ECtHR has prepared of cases in which the rights of those disabilities have been considered by the Court, across the whole gamut of rights protected by the Convention.

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Conferences at which editors/contributors are speaking

Grasping the Thistle: A Discussion about Disabled People's Rights within the United Nations Disability Convention and Scottish Public Policy

Jill will be speaking at this roundtable arranged by Inclusion Scotland on 6th February.

Capacity and consent: complex issues

Jill is chairing, and Adrian will be speaking at, the next workshop of the Centre for Mental Health and Incapacity Law, Rights and Policy on 11th February, which will be addressing complex issues in capacity and consent. For further details, see here.

Royal Faculty of Procurators in Glasgow

Adrian is speaking at conferences convened by the RFPG on 11 February (Private Client) and 25th February ('Demand-led' – i.e. on topics selected in advance by attendees). Details available here.

The National Autistic Society's Professional Conference

Tor will be speaking at this conference, to be held on 3 and Wednesday 4 March in Harrogate. Full details are available here.

DoLS Assessors Conference

Alex will be speaking at Edge Training's annual DoLS Assessors Conference on 12 March. Full details are available here.

Elderly Care Conference 2015

Alex will be speaking at Browne Jacobson's Annual Elderly Care Conference in Manchester on 20 April. For full details, see here.

'In Whose Best Interests?' Determining best interests in health and social care

Alex will be giving the keynote speech at this inaugural conference on 2 July, arranged by the University of Worcester in association with the Worcester Medico-Legal Society. For full details, including as to how to submit papers, 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 Mind in return for postings for English and Welsh events. For Scottish events, we are inviting donations to Alzheimer Scotland Action on Dementia.

Chambers Details

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

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THE QUEEN'S AWARDS FOR ENTERPRISE INTERNATIONAL TRADE 2013

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Alex been recommended as a leading expert in the field of mental capacity law for several years, appearing in cases involving the MCA 2005 at all levels up to and including the Supreme Court. He also writes extensively about mental capacity law and policy, works to which he has contributed including 'The Court of Protection Handbook' (2014, LAG); 'The International Protection of Adults' (forthcoming, 2015, Oxford University Press), Jordan's 'Court of Protection Practice' and the third edition of 'Assessment of Mental Capacity' (Law Society/BMA 2009). He is an Honorary Research Lecturer at the University of Manchester, and the creator of the website www.mentalcapacitylawandpolicy.org.uk. To view full CV click here.

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Victoria regularly appears in the Court of Protection, instructed by the Official Solicitor, family members, and statutory bodies, in welfare, financial and medical cases. She previously lectured in Medical Ethics at King's College London and was Assistant Director of the Nuffield Council on Bioethics. Together with Alex, she co-edits the Court of Protection Law Reports for Jordans. She is a contributing editor to Clayton and Tomlinson 'The Law of Human Rights', a contributor to 'Assessment of Mental Capacity' (Law Society/BMA 2009), and a contributor to Heywood and Massey Court of Protection Practice (Sweet and Maxwell). To view full CV click here.

Neil Allen
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Neil has particular interests in human rights, mental health and incapacity law and mainly practises in the Court of Protection. Also a lecturer at Manchester University, he teaches students in these fields, trains health, social care and legal professionals, and regularly publishes in academic books and journals. Neil is the Deputy Director of the University's Legal Advice Centre and a Trustee for a mental health charity. To view full CV click here.

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Annabel appears frequently in the Court of Protection. Recently, she appeared in a High Court medical treatment case representing the family of a young man in a coma with a rare brain condition. She has also been instructed by local authorities, care homes and individuals in COP proceedings concerning a range of personal welfare and financial matters. Annabel also practices in the related field of human rights. To view full CV click here.

Simon Edwards
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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.

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Adrian is a practising Scottish solicitor, a partner of T C Young LLP, who has specialised in and developed adult incapacity law in Scotland over more than three decades. Described in a court judgment as: "*the acknowledged master of this subject, and the person who has done more than any other practitioner in Scotland to advance this area of law*," he is author of *Adult Incapacity*, *Adults with Incapacity Legislation* and several other books on the subject. To view full CV click here.

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Dr Jill Stavert is Reader in Law within the School of Accounting, Financial Services and Law at Edinburgh Napier University and Director of its Centre for Mental Health and Incapacity Law Rights and Policy. Jill is also a member of the Law Society for Scotland's Mental Health and Disability Sub-Committee, Alzheimer Scotland's Human Rights and Public Policy Committee, the South East Scotland Research Ethics Committee 1, and the Scottish Human Rights Commission Research Advisory Group. She has undertaken work for the Mental Welfare Commission for Scotland (including its 2013 updated guidance on Deprivation of Liberty) and is a voluntary legal officer for the Scottish Association for Mental Health. To view full CV click here.