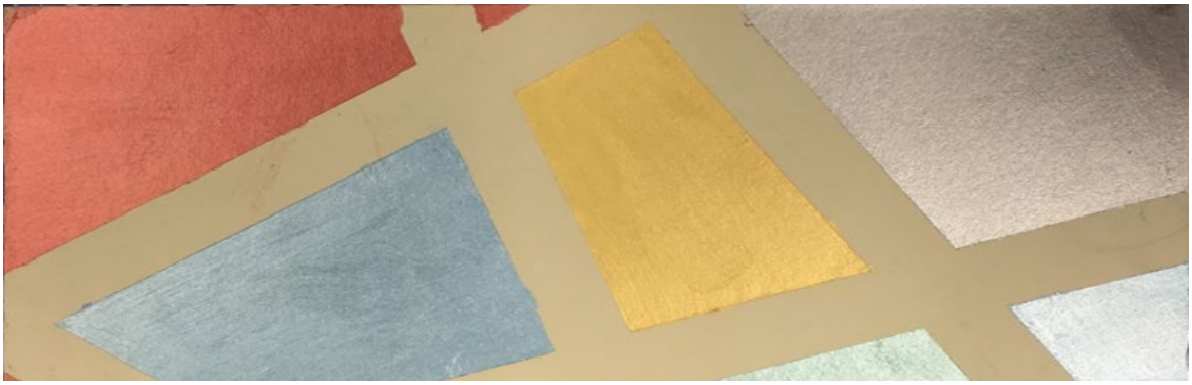
MENTAL HEALTH MATTERS
April 2025 | Issue 149



Welcome to the April 2025 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: a masterclass in determining a particularly complex set of capacity questions;

(2) In the Property and Affairs Report: statutory will applications and publicity; OPG guidance on family care payments, and the bond provider saga continues;

(3) In the Practice and Procedure Report: a helpful reminder of elephant traps for the unwary as regards when time runs for purposes of appealing decisions;

(4) In the Mental Health Matters Report: the Mental Health Bill progresses, and the CQC reports on the MHA 1983 in 2023-24;

(5) In the Children's Capacity Report: a new BMA toolkit to help with capacity and other issues in relation to those aged 16 and 17, and back to the vexed question of parental consent to confinement;

(6) In the Wider Context Report: the inherent jurisdiction rebuffed in a personal injury case, recent research of relevance, and strong views from the CRPD Committee on medical assistance in dying and the 2000 Hague Convention.

(7) In the Scotland Report: what is appealable in the AWI context, and the complexities of the position of those aged 16 and 17 in Scotland.

The progress of the Terminally Ill Adults (End of Life) Bill can be followed on Alex's resources page here.

You can find our past issues, our case summaries, and more on our dedicated sub-site here, where you can also sign up to the Mental Capacity Report.

Editors
Alex Ruck Keene KC (Hon)
Victoria Butler-Cole KC
Neil Allen
Nicola Kohn
Katie Scott
Arianna Kelly
Nyasha Weinberg

Scottish Contributors
Adrian Ward
Jill Stavert

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

Contents

Mental Health Bill progress

The Mental Health Bill had the first day of its Report stage in the House of Lords on 31 March, and its second day on 2 April.[1] Tim Spencer-Lane has, ever, provided an exceptionally helpful summary, which we reproduce below.

The first day of report on the Mental Health Bill in the House of Lords took place on 31 March. The Government suffered defeats on the following amendments:

1. To create a new category of "authorised person" who can carry out detentions, as well as the police, under the Mental Health Act. The authorised person would include health and care professionals. This was passed by 223 – 157 votes.
2. To limit the duration of community treatment orders to 12 months and provide they can only be extended following consultation with the patient and others, and are subject to six-monthly reviews. This was passed by 272 – 157 votes.
3. To require that when an AMHP appoints a nominated person for a child lacking competence, they must appoint a local authority (if the child is subject to a care order), a special guardian, someone named in a child arrangements order or anyone with PR. This was passed by 218 – 143 votes.
4. To require the de-briefing of mental health patients after they have left hospital, to review their experience of hospital treatment. This would be carried out by IMHAs within 30 days of discharge. This was passed by 209 – 143.

There were also a number of commitments made by the government minister, Baroness Merron.

Learning disability and autism

The Minister committed to monitoring the number of people with a learning disability and autistic people who are detained under the Mental Capacity Act, and will "include a line on this in standard publications". If there is an increase in numbers and the Mental Capacity Act is being used inappropriately, "we will ensure that appropriate action is taken."

The Minister also committed that within a year of Royal Assent, and each year subsequently, government will lay a Written Ministerial Statement in both Houses, setting out what has been done to implement the Bill.

[1] The current version of the Bill can be found here, as can Alex's annotated version of the MHA as it would look if amended by the MHA Bill as it stands.

Nominated person and parental involvement

The Minister committed to establishing an expert taskforce to support the development of the code of practice on the nominated person appointment process for children and young people. This would include Baroness Berridge and Baroness Butler-Sloss.

Treatment

The Minister said that government will engage with stakeholders on whether revisions to regulations should provide extra safeguards for artificial nutrition and hydration being provided under the MHA.

Advance choice documents

On Advance Choice Documents (ACDs) – the Government will explore how the duties can be strengthened and clarified, and intend to bring forward an amendment in the Commons. Also, there will be a requirement in regulations to include a plan to make an ACD where appropriate, in the patient's care and treatment plan.

Government amendments

All Government amendments were agreed without a vote.

Reforms to criminal justice system

MoJ committed to the introduction of a new strategic body to oversee transfers from prison to hospital.

The second and final day of report on the Mental Health Bill in the House of Lords took place on 2 April.

The Government managed to avoid defeat on three votes:

1. Mental Health Commissioner - Baroness Tyler (Lib Dem) tabled an amendment to establish the office of the Mental Health Commissioner and make provision for relevant duties and responsibilities. This was defeated by 129 – 49 votes.

2. Long-term segregation - Baroness Hollins (Crossbench) tabled an amendment to introduce an independent review process for patients with learning disabilities or autism placed in long-term segregation under the Mental Health Act 1983. This was defeated by 106 – 51 votes.

3. Funding - Lord Stevens (Crossbench) tabled an amendment to require that each financial year mental health spending under the Mental Health Act 1983 in England by the Government does not decrease. This was defeated by 112 – 19 votes.

Human Rights Act 'gap'

There was no vote on Baroness Keeley's (Labour) amendment to ensure private care providers are covered by the Human Rights Act 1998 when delivering mental health care on behalf of the NHS and local authorities.[2] The Government minister agreed to revisit this matter when the Bill is considered in the House of Commons. The amendment was withdrawn.

Children and young people

Lord Meston (Crossbench) withdrew his amendment to introduce a statutory test of competence for children subject to the Mental Health Act 1983.

[2] [our editorial note – identified in the *Sammut* case: see also below]

The next stage is third reading before the Bill goes to the House of Commons.

Monitoring the Mental Health Act in 2023 – 2024

The CQC has published its annual Monitoring the Mental Health Act report. Its summary largely speaks for itself.

> *CQC and the Mental Health Bill*
>
> *We welcome the Mental Health Bill, which was introduced in the House of Lords in November 2024 and will bring about important reforms to increase the safeguards for people who are detained.*
>
> *The new statutory principles embedded within the Bill, and accompanying changes to the Code of Practice, will provide for a sharper focus on the rights and experiences of mental health patients, people in custody who have a mental disorder, and people with a learning disability and autistic people.*
>
> *However, as highlighted in our 2022/23 report, legislation alone won't bring the changes needed. Better funding, improved community support and investment in workforce are essential to improving mental health care and providing better outcomes for patients.*
>
> *Systems*
>
> *We remain concerned that the high demand for mental health services, without the capacity to meet it, means people cannot always get the right care at the right time. Not being able to access care in a timely way can lead to people's mental health deteriorating while they wait for support.*
>
> *Through our monitoring activity, we have seen how system pressures mean people are detained far from home or in environments that do not meet their needs. Many services told us that patients seem to be more unwell on admission than in the past. Services need to balance the increase in demand for inpatient beds with ensuring existing patients are not discharged too soon.*
>
> *Workforce*
>
> *In 2023/24 there were continuing problems with workforce retention and staffing shortages, as well as concerns around training and support for staff. Although the mental health workforce has grown by nearly 35% since 2019, shortages in both medical and support roles continue to have a negative impact on patient care.*
>
> *Shortages of doctors also continue to affect the delivery of our second opinion appointed doctor (SOAD) service. We remain concerned about the long-term sustainability of the service, with proposals in the Mental Health Bill due to increase the numbers of second opinions required while reducing the timeframes for delivery of some second opinions.*
>
> *Inequalities*
>
> *We are concerned that some of the key issues we raise in this report, including access to mental health support, are particularly challenging for certain groups of people, such as people from ethnic minority groups and those living in areas of deprivation. We identified several issues around people not understanding their rights, despite services having a legal duty to provide this information.*

There was variation in how well services met people's needs. While many provided access to spiritual leaders, we remain concerned about gaps in the knowledge of staff around caring for autistic people.

Children and young people

Children and young people continue to face challenges in accessing mental health care. Increasing demand is leading to long waits for beds, and increases the risk of being placed in inappropriate environments and/or being sent to a hospital miles away from home.

Once in hospital, we are concerned that access to specialist staff is being affected by low staffing levels, leading to patients' needs not being met. In addition, the quality of physical environments for children and young people varies; access to food and drink, and food preparation facilities were key issues for many children and young people.

Challenges in transitions of care between children and young people's mental health services and adult mental health services remain, with many young people still falling through the gaps and not getting the care and support they need.

Environment

Through our MHA monitoring visits, we found that the quality of inpatient environments continues to vary. We are concerned about the impact of poor-quality environments on patients and have seen examples of how ageing and poorly-designed facilities affect people's care.

Being able to go outside brings therapeutic benefits for patients, but access to outdoor facilities varied across services. Gardens were usually well maintained, and in some services, patients were encouraged to grow plants and vegetables. However, we also found examples of unwelcoming gardens and at some services, patients' access to outdoor spaces was limited. This issue was also raised by members of our Service User Reference Panel.

The CQC also have some familiar (but nonetheless problematic) things to say about the MHA / MCA interface:

We also continue to see different interpretations of the interface between the Mental Health Act and the Mental Capacity Act, which the Deprivation of Liberty Safeguards (DoLS) are part of. In recent State of Care reports, we have raised concerns that providers' understanding of DoLS remains varied. This affects how the safeguards are applied and, in some cases, means people may not have a DoLS authorisation in place when they need one.

In the 2018/19 Monitoring the Mental Health Act report we raised our concerns that neither patients nor professionals were likely to be clear on when the MHA or DoLS should be used. This could lead to the safeguards and rights relating to deprivation of liberty being applied inconsistently. We suggested that the government should update the respective codes of practice to reflect evolving case law needs, but this has not happened.

In 2019, the government passed the Mental Capacity (Amendment) Act, which planned to replace the DoLS

> *system with the Liberty Protection Safeguards (LPS). While this has been delayed, the introduction of LPS will not resolve the questions of interface between these systems and the MHA.*
>
> *We remain concerned that clinicians may not always be considering where the MHA can be used when the DoLS framework is not appropriate and where the patient is objecting to their placement. This concern is heightened by widespread delays in DoLS assessments, which can mean that some patients never receive an independent assessment of their clinician's decision to initiate an urgent deprivation of liberty. When such urgent applications expire, delays in the system mean that patients and clinicians are left in legal limbo, without any effective safeguard or procedure.*

Interestingly, and perhaps stretching precisely what had formed the focus of the decision in *Sammut*, the CQC continued:

> *In 2024, the High Court decided that such legal limbo excludes patients in independent health providers from the reach of state obligations to its detainees under the Human Rights Act. In other words, the High Court found that, since a DoLS authorisation was not in place, it could not be argued that the functions carried out by the independent health provider were of a public nature. As such, the significant procedural failures in DoLS implementation have the effect of pushing some detained people beyond the reach of the Human Rights Act.*
>
> *The court also found that neither the joint-funding arrangement under section 117 of the MHA nor CQC regulation could be used as evidence to conclude that the provider in question was delivering functions of a public nature. As a member of the National Preventive Mechanism, we are concerned that failure to close this gap may also have implications for ensuring that people have protections against inhuman or degrading treatment. We note that this issue has been raised in parliament over the passage of the Mental Health Bill and hope that government will want to close this gap in the protection of patients.*

Finally, we also take this opportunity to congratulate Dr Arun Chopra on his appointment as the first Chief Inspector of Mental Health for the CQC. We strongly hope that Dr Chopra will bring with the spirit of the Scottish Mental Welfare Commission where he has been for the past few years, as that latter body plays such a helpful role as critical friend north of the Border.

Identifying whether a person truly means to take their own life

The difficulty of determining whether a person truly intends to end their own life is an issue that is vexing Parliament at the moment. It is also highlighted in the decision in *Shipsey & Anor v HM Senior Coroner for Worcestershire* [2025] EWHC 605 (Admin). It concerned the inquest into the death of Bethany ('Beth)' Shipsey, who died in Worcestershire Royal Hospital on 15 February 2017, aged 21. Beth died from the toxic effects of Dinitrophenol ("DNP") in a quantity of unlicensed slimming tablets she had purchased over the internet. At the time of her death, she was on home leave from the in-patient mental health unit at Holt Ward, Newtown Hospital, Worcester.

At the inquest in 2018, the Coroner recorded the following narrative verdict:

> *Bethany Shipsey was a young woman with significant mental health difficulties who, on 15 February 2017, died as the result of suicide having deliberately*

> *ingested a quantity of tablets containing the drug Dinitrophenol which she had purchased over the Internet.*
>
> *She did so intending to take her own life and was admitted into the Worcestershire Royal Hospital at approximately 5:30 PM on that day.*
>
> *The clinicians having care of her recognised the extreme toxicity of the drug, the lack of antidote, the risk of rapid deterioration and the need for close monitoring of her condition with a view to providing supportive treatment.*
>
> *Notwithstanding this the clinicians failed to take sufficient or adequate steps to monitor her leaving them unprepared to deal with the rapid deterioration which ensued.*
>
> *There were significant failings in the care given to her which amounted to a lost opportunity to provide supportive treatment which although probably would not have saved or prolonged her life may nevertheless have done so".*

Beth's parents initially attempted to challenge the coroner's finding that the death was as a result of suicide – rather than, as they contended, a cry for help in the context of substandard care which amounted to neglect – by way of judicial review. This was refused at the permission stage by a decision of David Lock QC, sitting as a Deputy High Court Judge.

Some two years later – and now six years after the initial claim for judicial review, the matter having been stayed pending the hand down of the Supreme Court judgment on the standard of proof in suicide, *Maughan* [2020] UKSC 46 – Beth's parents renewed their challenge by way of a s.13 Coroners Act 1988 application.

One element of the challenge – which went through a variety of iterations, was that Beth "*lacked the mental capacity to form the intent to take her own life*." As the Divisional Court noted: *"The Claimants argued that, relying on the judgment of the Court of Appeal in R v Rebelo [2021] Cr App R 3, [2021] 4 WLR 52, a fresh inquest could find that Beth was unlawfully killed due to gross negligence manslaughter perpetrated by the person who sold her the DNP pills*" (paragraph 45).

Much of the judgment is concerned with the complex procedural issues in the case which arose from a multitude of applications brought over time by the claimant parents. Ultimately, however, the court accepted fresh evidence that Beth had not intended to take her own life – or, as it put it at paragraph 81, the fresh evidence was consistent with the suggestion that "*Beth's underlying EUPD condition drove her to take the DNP pills to relieve tension, as opposed to her actions being motivated by an intention to end her life.*"

The Divisional Court determined to amend the Record of Inquest rather than ordering a fresh coronial investigation.

While the claimants achieved victory for their daughter after an exceptionally lengthy and no doubt exhausting fight, they were not rewarded in costs. As the court set out:

> *118.* […] *authority at the highest level makes clear that a Coroner will not be ordered to pay costs on a section 13 application that has succeeded, unless the Coroner has acted flagrantly improperly, "entered the fray" or unreasonably refused to consent to a section 13 application: R (Davies) (No. 2) v HM Deputy Coroner for Birmingham [2004] 1 WLR 2739, per Brooke LJ at [22], [43] and 47] and Sir Martin Nourse at [58]; and the related authorities of R (Gudanaviciene) v Immigration and Asylum First Tier Tribunal [2017] 1 WLR 4095, per Longmore LJ at [36] and R*

(Maguire) v HM Senior Coroner for Blackpool and Fylde [2023] 3 WLR 103, per Lord Sales at [117].

While the fresh evidence gave rise to the court's conclusion that Beth's suicide had not been intentional and that the conclusion of suicide could not stand, there was no criticism of the coroner who had handed down a lengthy and thorough conclusion.

Editors and Contributors

Alex Ruck Keene KC (Hon): alex.ruckkeene@39essex.com
Alex has been in cases involving the MCA 2005 at all levels up to and including the Supreme Court. He also writes extensively, has numerous academic affiliations, including as Visiting Professor at King's College London, and created the website www.mentalcapacitylawandpolicy.org.uk. To view full CV click here.

Victoria Butler-Cole KC: vb@39essex.com
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 is Vice-Chair of the Court of Protection Bar Association and a member of the Nuffield Council on Bioethics. To view full CV click here.

Neil Allen: neil.allen@39essex.com
Neil has particular interests in ECHR/CRPD human rights, mental health and incapacity law and mainly practises in the Court of Protection and Upper Tribunal. Also a Senior Lecturer at Manchester University and Clinical Lead of its Legal Advice Centre, he teaches students in these fields, and trains health, social care and legal professionals. When time permits, Neil publishes in academic books and journals and created the website www.lpslaw.co.uk. To view full CV click here.

Arianna Kelly: Arianna.kelly@39essex.com
Arianna practices in mental capacity, community care, mental health law and inquests. Arianna acts in a range of Court of Protection matters including welfare, property and affairs, serious medical treatment and in inherent jurisdiction matters. Arianna works extensively in the field of community care. She is a contributor to Court of Protection Practice (LexisNexis). To view a full CV, click here.

Nicola Kohn: nicola.kohn@39essex.com
Nicola appears regularly in the Court of Protection in health and welfare matters. She is frequently instructed by the Official Solicitor as well as by local authorities, CCGs and care homes. She is a contributor to the 5th edition of the *Assessment of Mental Capacity: A Practical Guide for Doctors and Lawyers* (BMA/Law Society 2022). To view full CV click here.

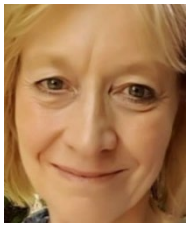
Katie Scott: katie.scott@39essex.com
Katie advises and represents clients in all things health related, from personal injury and clinical negligence, to community care, mental health and healthcare regulation. The main focus of her practice however is in the Court of Protection where she has a particular 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.

Nyasha Weinberg: Nyasha.Weinberg@39essex.com

Nyasha has a practice across public and private law, has appeared in the Court of Protection and has a particular interest in health and human rights issues. To view a full CV, click here

Adrian Ward: adrian@adward.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; honorary membership of the Law Society of Scotland; national awards for legal journalism, legal charitable work and legal scholarship; and the lifetime achievement award at the 2014 Scottish Legal Awards.



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 here.

Conferences

Members of the Court of Protection team regularly present at seminars and webinars arranged both by Chambers and by others.

Alex also does a regular series of 'shedinars,' including capacity fundamentals and 'in conversation with' those who can bring light to bear upon capacity in practice. They can be found on his website.

Advertising conferences and training events

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

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

Sheraton Doyle
Senior Practice Manager
sheraton.doyle@39essex.com

Peter Campbell
Senior Practice Manager
peter.campbell@39essex.com

Chambers UK Bar
Court of Protection: Health & Welfare
Leading Set

The Legal 500 UK
Court of Protection and Community Care
Top Tier Set

clerks@39essex.com • DX: London/Chancery Lane 298 • 39essex.com

LONDON
81 Chancery Lane,
London WC2A 1DD
Tel: +44 (0)20 7832 1111
Fax: +44 (0)20 7353 3978

MANCHESTER
82 King Street,
Manchester M2 4WQ
Tel: +44 (0)16 1870 0333
Fax: +44 (0)20 7353 3978

SINGAPORE
Maxwell Chambers,
#02-16 32, Maxwell Road
Singapore 069115
Tel: +(65) 6634 1336

KUALA LUMPUR
#02-9, Bangunan Sulaiman,
Jalan Sultan Hishamuddin
50000 Kuala Lumpur,
Malaysia: +(60)32 271 1085