MENTAL CAPACITY REPORT: THE WIDER CONTEXT

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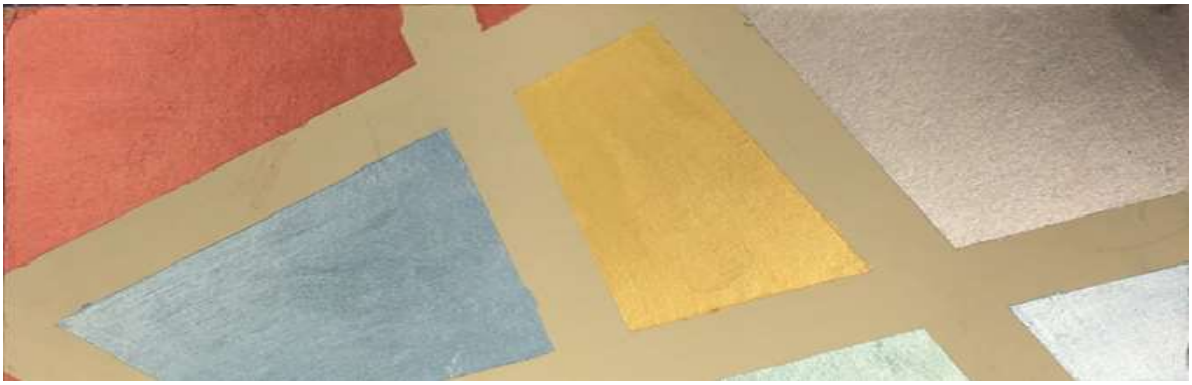

Welcome to the October 2020 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: updated DHSC MCA/DoLS COVID-19 guidance, the CRPD in the Court of Protection and spotting the signs of abuse;

(2) In the Property and Affairs Report: two important cases about deputies and fixed costs and how to get financial deputyship applications right;

(3) In the Practice and Procedure Report: s.21A applications and interim declarations; the limits of the court's jurisdiction; contempt proceedings and when not to recognise a foreign order;

(4) In the Wider Context Report: new GMC consent guidance, Sir James Munby returns to the inherent jurisdiction, new CQC publications and relevant ECHR developments;

(5) In the Scotland Report: a new Chief Executive for the Mental Welfare Commission, MWC publications, and what COVID-19 has revealed about ageism and disability discrimination.

We thank Katherine Barnes for all her contributions to date, and wish her well as she steps down to focus her activities on other areas; we welcome Rachel Sullivan and Stephanie David as new contributors.

You can find our past issues, our case summaries, and more on our dedicated sub-site here, where you can also find updated versions of both our capacity and best interests guides. We have taken a deliberate decision not to cover all the host of COVID-19 related matters that might have a tangential impact upon mental capacity in the Report. Chambers has created a dedicated COVID-19 page with resources, seminars, and more, here; Alex maintains a resources page for MCA and COVID-19 here, and Neil a page here. If you want more information on the Convention on the Rights of Persons with Disabilities, which we frequently refer to in this Report, we suggest you go to the Small Places website run by Lucy Series of Cardiff University.

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

Contents

ENGLAND AND WALES

As if Expendable

In a very hard-hitting and detailed report (complementing the equally hard-hitting report by the Joint Committee on Human Rights looking at wider issues), Amnesty International has set out a series of stark failures in the Government's protection of older people in care homes during the COVID-19 pandemic. It should perhaps be noted that, whilst referring to the UK Government, the report is in fact focused upon England & Wales: there is, sadly, much to suggest that the picture may not have been radically different in other parts of the UK.

GMC Consent Guidance updated

At the end of September, the GMC published new guidance on decision making and consent. It comes into effect on 9 November 2020.

It sets out seven "principles" of decision making and consent:

1. All patients have the right to be involved in decisions about their treatment and care

and be supported to make informed decisions if they are able.

2. Decision making is an ongoing process focused on meaningful dialogue: the exchange of relevant information specific to the individual patient.

3. All patients have the right to be listened to, and to be given the information they need to make a decision and the time and support they need to understand it.

4. Doctors must try to find out what matters to patients so they can share relevant information about the benefits and harms of proposed options and reasonable alternatives, including the option to take no action.

5. Doctors must start from the presumption that all adult patients have capacity to make decisions about their treatment and care. A patient can only be judged to lack capacity to make a specific decision at a specific time, and only after assessment in line with legal requirements.

6. The choice of treatment or care for patients who lack capacity must be of overall benefit to them, and decisions should be made in consultation with those who are close to them or advocating for them.

7. Patients whose right to consent is affected by law should be supported to be involved in the decision-making process, and to exercise choice if possible.

There has been much discussion online about the fact that the new Guidance requires disclosure of a risk of serious harm "however unlikely it is to occur" (23(d)). On close reading, however, paragraph 23 is slightly more nuanced, stating that practitioners should "usually" include information on serious harm, however unlikely it is to occur.

As the GMC has been quick to point out, paragraph 5 of the Guidance sets out the importance of "*taking a proportionate approach*" and provides that "*not every paragraph of this guidance will be relevant to every decision*" and that a "*judgement*" will be required in any decision as to how the guidance is applied, consideration including factors such as the nature and severity of a patient's condition and the speed with which a decision must be made. To this end, paragraph 22 states in terms: "*it wouldn't be reasonable to share every possible risk of harm, potential complication or side effect. Instead, you should tailor the discussion to each individual patient, guided by what matters to them, and share information in a way they can understand.*"

Separately, the Guidance suggests (para 6) that "*obtaining a patient's consent needn't always be a formal, time-consuming process. While some interventions require a patient's signature on a form, for most healthcare decisions you can rely on a patient's verbal consent*". The paragraph that follows gives the example of minimally or non-invasive interventions, particularly examinations. Clearly, this is an area which, like others, will require the "*judgement*" of the practitioner who may wish to be cautious about choosing not to record a formal consent process in many circumstances.

Of particular interest to readers of this Report will be the sections on supporting decision making (para 27), which adopts some of the MCA language of understanding and retaining;

the section on future decision making including end of life care (32-39), which sets out circumstances in which practitioners and patients may be able to anticipate future impairment of decision making powers, and the specific section on mental capacity (76-96). They all make clear the importance of recording such discussions that may take place regarding present and future treatment and patients' wishes and feelings.

As the Guidance makes clear (paras 40-47) the support of colleagues and a "team-based approach" to the taking of consent can be helpful. However, the Guidance emphasises that while some elements of the decision-making process may be delegated – for example to colleagues with particular communication skills – the ultimate responsibility for ensuring the patient has been given sufficient information, time and support to give their consent rests with the treating clinician (para 45). As the section on capacity emphasises, "*assessing capacity is a core clinical skill and doesn't necessarily require specialist input (eg by a psychiatrist)*" (para 82). Importantly, the Guidance makes clear that doctors cannot 'hide' behind the presumption of capacity, stating in terms at para 84 that "[i]*f you believe that a patient may lack capacity to make a decision, you must assess their capacity using the test set out in the relevant legislation, taking account of the advice in the relevant guidance*."

The guidance naturally reflects the judgment in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 in which the Supreme Court emphasised the importance of patients being informed to make decisions for themselves: the thread of the importance of dialogue is visible throughout the Guidance. *Montgomery* was a key subject of debate in the recent "trans" judicial review, *Bell v Tavistock*: it will be interesting to see whether there are any further developments in this area ahead.

CQC publications

Three recent CQC publications are of particular relevance to readers of this Report.

1. Its Annual State of Care Report, divided into the world before and the world after COVID-19 (16 October 2020). Amongst many other things, the report highlighted the impact of COVID-19 on the operation of DoLS: "[f]*rom March to May, we saw a sharp fall in the number of notifications compared with the same period in 2019. Notifications from adult social care services dropped by almost a third (31%), and in hospitals by almost two-thirds (65%), compared with the same period in 2019. By July, the numbers received from adult social care services had risen again, although they fell back in August*." It also highlighted the impact of the uncertainty around the date for LPS implementation (now fixed for April 2022): "*poor understanding of DoLS has remained a fundamental issue throughout its years in legislation. This, together with the delays and uncertainty over the progress of LPS, may mean there is an increasing risk of people being deprived of their liberty without the proper authorisation. Given that DoLS authorisations can last up to a year, it may not be until March 2023 that DoLS is fully behind us. This underlines the importance of continuing to improve the way providers, local authorities and others work together to support the proper use of the DoLS – and to give careful consideration of how the two*

systems will work alongside each other in the first year of implementing the LPS. The time ahead also provides an opportunity to consider what can be done now within the current DoLS system to ease the transition."

2. The themed report on Assessment of mental health services in acute trusts (16 October 2020), looking at findings from over 100 acute hospital inspections. Of particular note is the CQC's findings that governance around the legal framework was poor, and that there was often confusion between the MHA 1983 and the MCA 2005. This reinforced the urgent need to update the codes of practice for the MHA, the MCA and DoLS to provide clear guidance for professionals on these complex interface issues.

3. The updated guidance on the regulation of services for autistic people and/or people with a learning disability (8 October 2020). Now called "Right support, right care, right culture," the guidance outlines three key factors that CQC expects providers to consider if they are, or want to care for autistic people and/or people with a learning disability: (a) Right support: The model of care and setting should maximise people's choice, control and independence; (b) Right care: Care should be person-centred and promote people's dignity, privacy and human rights; and (c) Right culture: The ethos, values, attitudes and behaviours of leaders and care staff should ensure people using services lead confident, inclusive and empowered lives. This guidance has always been set alongside other standards in health and social care - this includes NICE guidance (CG142) on the definition of 'small'' services for autistic people with mental health conditions and/or behaviour that challenges. This states that residential care "should usually be provided in small, local community-based units (of no more than six people and with well-supported single person accommodation)". While CQC use NICE guidance in describing what 'small' means for how they apply their approach, this is not the same as having an absolute upper limit for the size of services. CQC have never applied a six-bed limit in their registration or inspection assessments and will continue to register based on care that is person-centred, and promotes choice, inclusion, control and independence. We note that CQC's review into restraint, prolonged seclusion and segregation for people with a mental health problem, learning disability or autistic people supports this and, for people currently in the hospital system, this is likely to require commissioners and providers to develop bespoke services.

Short note: Sir James Munby explores the inherent jurisdiction

As Sir James Munby noted at the outset of his judgment in *FS v RS and JS* [2020] EWFC 63: "[t]*his is a most unusual case. Indeed, so far as I am aware, and the very experienced counsel who appear before me do not dispute this, the case is unprecedented. Certainly, the researches of counsel have identified no decision directly in point. The applicant's own description is that his applications are 'novel.' I suspect that the initial reaction of most experienced family lawyers would*

be a robust disbelief that there is even arguable substance to any of it." In short terms, the applicant, who was the 41-year old son of the respondents, sought financial relief against them: (i) pursuant to Section 27 of the Matrimonial Causes Act 1973; (ii) pursuant to Schedule 1 to the Children Act 1989; and (iii) pursuant to that branch of the recently rediscovered inherent jurisdiction which applies in relation to adults who, though not lacking capacity, are "vulnerable." Barbara Rich has written an interesting and thoughtful blog on the judgment as a whole; for present purposes, we draw attention to it because of the opportunity that it gave Sir James to make further comment upon an aspect of the inherent jurisdiction which he more or less singlehandedly discovered (or, perhaps more accurately, invented). At paragraphs 100-138 of his judgment, Sir James undertook a tour d'horizon of the jurisdiction as it now stands. Whilst those missing his characteristically erudite exegeses of difficult areas of the law will no doubt want to read these passages in full, we suggest that the following observations are of particular wider significance:

- Whilst the inherent jurisdiction may be the great safety net which lies behind all statute law, and is capable of filling gaps left by that law, if and insofar as those gaps have to be filled in the interests of society as a whole, "*the inherent jurisdiction is a safety net, not a springboard*" (paragraph 100). Whatever its theoretical reach, it is in settled practice, recognised as being subject to limitations on what the court can and should do. Whilst it may be called upon to address new problems, *"novelty alone does not demand a remedy. Any development of the inherent jurisdiction must be principled and determined by more than the length of the Chancellor's foot (John Selden, Table Talk, 1689; Selden Society, 1927)*" (paragraph 103);

- "[P]*recisely because they do not lack capacity, those subject to this branch of the inherent jurisdiction [i.e. that relating to vulnerable adults] are fully autonomous adults; and (2) that, fundamentally, the jurisdiction exists to protect and to facilitate their exercise of that autonomy*" (paragraph 114);

- Sir James Munby's observations as to whether the jurisdiction might be extended as far as had been identified by Hayden J in *Southend-On-Sea Borough Council v Meyers* [2019] EWHC 399 (Fam), as then explained by Lieven J in *London Borough of Croydon v KR & Anor* [2019] EWHC 2498 (Fam).[1] As he noted, "[t]*here is no need for me to consider whether this is correct, though I have to confess to some doubt. But even if correct, it must, not least for the reasons articulated by Lieven J, mark the extremity of what can be done in exercise of the jurisdiction*" (paragraph 122);

[1] In which she had said (at paragraph 63) that she did "*not reject the possibility that in extremely exceptional cases the inherent jurisdiction might be used for long term or permanent orders forcing the vulnerable adult not to live with the person(s) he wants to, as was the case in Meyers. However, that must be a truly exceptional case. As was contemplated by Macur J in LBL, and apparently supported by McFarlane LJ in DL at [67], the normal use of the inherent jurisdiction is to secure for the individual, who is subject to the alleged coercion or undue influence, a space in which their true decision making can be re-established. If the inherent jurisdiction is used beyond this then the level of interference in the individual's article 8 rights will become increasingly difficult to justify*."

- The "*fundamental principle that the inherent jurisdiction cannot be used to compel an unwilling third party to provide money or services*" (paragraph 123). In other words, and just as is the position for a Court of Protection judge, a judge exercising the High Court's inherent jurisdiction cannot seek to generate options for the vulnerable adult that are not, in fact, on the table;

- The equally fundamental principle that the inherent jurisdiction cannot be used to cut across or usurp any relevant statutory scheme enacted by Parliament. Sir James expressly endorsed the "very pithy" formulation of the point by Lieven J in *JK v A Local Health Board* [2019] EWHC 67 (Fam), namely that "[t]*he inherent jurisdiction cannot be used to simply reverse the outcome under a statutory scheme, which deals with the very situation in issue, on the basis that the court disagrees with the statutory outcome*." As Sir James noted, on *"one view this all depends on the degree of generality or specificity with which one chooses to define or describe the ground or scope or ambit of the relevant statutory scheme*" (paragraph 136). The Supreme Court will, we should note, be grappling with precisely this question in the appeal it is shortly to hear in the *Re T* case concerning the question of when the inherent jurisdiction can be used lawfully to deprive a child of their liberty where no secure accommodation is available.

Best interests, children and religious belief

Birmingham Women's and Children's NHS Foundation Trust v JB [2020] EWHC 2595 (Fam) (Hayden J)

Best interests – medical treatment

Summary[2]

In *Birmingham Women's and Children's NHS Foundation Trust v JB* [2020] EWHC 2595 (Fam), Hayden J provided an important clarification regarding MacDonald J's judgment in *Barts Health NHS Trust v Raqeeb* [2019] EWHC 2530 (Fam) in relation to the evaluation of a child's best interests in the context of medical treatment.

The application was brought by the NHS Trust in relation to a 12-year old young person, J, who acquired a severe brain injury for a declaration sanctioning the withdrawal of intensive care and effectively confirming the absence of any alternative procedures that might otherwise be in his best interests.

Hayden J recognised that the case was *"of almost unbearable sadness."* He had been found with a ligature around his neck on the back of his bedroom door on 28 April 2020, having only been in his room for 20 minutes. His mother administered basic life support before the paramedics arrived and he was taken to hospital.

Whilst J did not fulfil the criteria for brain stem death, he had a profoundly severe neurological injury, which manifested by unconsciousness. He required augmentation by ventilator; and

[2] Note, Tor having been involved in this case, she has not contributed to the summary or comment.

whilst a tracheostomy was trialed, the conclusion was that it was not possible. When the ventilator was disconnected, his muscle spasms would impede regular breathing.

Hayden J emphasised the circumstances of a global pandemic, which intensified the human suffering and included J contracting COVID-19. The consequence of which was that only his mother could visit him for two weeks, which was heartbreaking for his father and other family members.

Hayden J was satisfied that medical treatment was providing no benefit for him, the limited and hypothetical alternatives to ventilation having been explored. The burdens of treatment included irritation, his airway was vulnerable due to loss of cough and gag reflex and he risked acquiring chest infections. He determined that the prospects for J's life were futile: as captured in the evidence of the paediatric intensive care specialist, the professional ethical dilemma was: "*I am no longer saving J's life, I am prolonging his death.*"

In the course of his judgment, Hayden J helpfully confirmed that MacDonald J in *Barts Health NHS Trust v Raqeeb* [2019] EWHC 2530 (Fam) *"did not for a moment intend that a Trust should ever approach an evaluation of a child's best interests, in the context of medical treatment, as secondary to the wishes or religious beliefs of the parents"*, as had been suggested by commentary in the Medical Law Review. He expanded:

> *That would subvert the framework of the established law which preserves the interests of the child as paramount. Nor do I believe Macdonald J intended to sever medical 'best interests' from an overall evaluation of the child's interests. Such an approach would be artificial. A true and meaningful assessment of a child's best interests requires a conscientious survey of the wide canvas of his life, in which process the views of his parents concerning matters of faith, culture and more widely will be important but never a determinative factor.*

Hayden J considered the views of J's family who were firm followers of the Pentecostal church, however he declined to investigate what J might have wanted for himself in the circumstances in which he was in. He considered that in many cases, the views and wishes of a child aged 12 extrapolated from the facts surrounding the way he lived his life would be appropriate, but the circumstances leading up to his hospital admission left too many unanswered questions.

He was satisfied that he should grant the declaration, because prolonging his present situation risked compromising his dignity and for no identifiable benefit.

Comment

In addressing the commentary on the *Raqeeb* judgment, Hayden repeated the authorities of *Wyatt v Portsmouth NHS Trust* [2006] 1 FLR 554 and *Re J (a minor) (Wardship: Medical Treatment)* [1991] Fam 33 in relation to the court's approach in evaluating the best interests of a child. The *"intellectual milestones"* in carrying out that evaluation as laid out in *Wyatt* are worth restating:

> *In making that decision, the welfare of the child is paramount, and the judge must look at the question from the assumed point of view of the patient (Re J). There is a strong presumption in favour of a course of action which will prolong life,*

> *but that presumption is not irrebuttable (Re J). The term 'best interests' encompasses medical, emotional, and all other welfare issues (Re J). The court must conduct a balancing exercise in which all the relevant factors are weighed (Re J) and a helpful way of undertaking this exercise is to draw up a balance sheet (Re A).*

Further, the global pandemic coloured the judgment in a number of different ways, which will be equally relevant to cases involving adults:

- The opportunity afforded by "remote hearings" which has meant that judges have been able to "visit" patients to a degree not considered possible in the past.
- The pain and suffering of J's family had only been heightened by the pandemic and intensified the distress due to the visiting restrictions, particularly when J contracted the virus.
- The pandemic presented a stark check on the limits to the growing therapeutic possibilities of medical science in eliminating disease and prolonging people's life span.

Short Note: An infertile lie

We briefly mention the criminal case of *R v Lawrance* [2020] EWCA Crim 971 where the defendant allegedly lied about having a vasectomy before having unprotected sex, after which he was prosecuted for rape. The issue was whether a lie about fertility negated ostensible consent for the purposes of s.74 of the Sexual Offences Act 2003 which provides that, "*For the purposes of this Part, a person consents if he agrees by choice, and has the freedom and capacity to make that choice*."

The Court of Appeal distinguished between (a) lies closely connected to the performance of the sexual act, and (b) lies relating to the broader circumstances of that act. The former can vitiate the consent; the latter did not. Examples of the latter included lies concerning marital status or being in a committed relationship; lies about political or religious views; and lies about status, employment or wealth. The lie in this case fell into the broader category:

> *37… She agreed both to penetration of her vagina and to ejaculation without the protection of a condom. In so doing she was deceived about the nature or quality of the ejaculate and therefore of the risks and possible consequences of unprotected intercourse. The deception was one which related not to the physical performance of the sexual act but to risks or consequences associated with it.*

Accordingly, she was not deprived by the lie of the freedom to choose whether to have intercourse and the rape convictions were quashed.

This decision is of interest for those considering the relevance of deception on the issue of consent. One must tread carefully before drawing jurisdictional analogies between the criminal and civil law. After all, consent is defined in s.74 only for the purposes of the SOA 2003 and not for MCA 2005 purposes. Indeed, the relationship between the two was considered in *A Local Authority v JB* [2020] EWCA Civ 735 where the Court of Appeal identified the information relevant to the decision whether to engage in sexual relations. This requires an understanding

that you should only have sex with someone who is able to consent and gives and maintains consent throughout. It was held that "*a full and complete understanding of consent in terms recognised by the criminal law*" was not an essential component of the capacity test. Rather, if a person lies in connection with the performance of the sexual act, the consent of P will be negated and an offence committed in the same way as for those without mental impairment which, we suggest, is the proper non-discriminatory approach to take.

Coronavirus Public Health Officer powers in action

A case history in *Progress in Neurology & Psychiatry* exemplifies the difficult interface between Covid-19 legislation and mental health.

The patient was a woman with diagnoses of schizophrenia and mild learning disability. Her condition had been stable for some years but concerns had been raised in preceding months about a deterioration in her mood. She lived in a care home with mental health support.

In April 2020 she developed a cough: given that other residents of the care home had tested positive for Covid-19 the suspicion was that she was infected. She continued to leave, despite staff advice. A request was made for a capacity assessment, which concluded that she had fluctuating capacity to understand the pandemic.

Her GP escalated concerns to Public Health England. Following discussions with PHE, an order was made (purportedly pursuant to Schedule 21 of the Coronavirus Act 2020) for her detention at a local mental health unit.

Schedule 21 of the 2020 Act provides for powers in relation to potentially infectious persons. These include powers to direct or remove someone to a place for assessment and treatment if there is reason to believe they are potentially infectious, for up to 48 hours (paras 6-9). Once assessed, there is a power to impose 'such requirements and restrictions' as are necessary and proportionate in the interests of the person, for the protection of others or for the maintenance of public health for a maximum of 14 days (paras 14-15). Failure to comply with such requirements is a potential offence. The only route of appeal is by application to a magistrate.

In this case, the order appears to have provided for the patient to be detained at the mental health unit for an initial period of seven days. It is also reported as having provided for staff to use reasonable endeavours to prevent the patient leaving, applying reasonable restraint to prevent injury or the commission of a criminal offence and offering mental and physical healthcare as appropriate.

Within 24 hours of admission, her condition deteriorated and she was transferred to hospital. Testing there by way of swab revealed that was not infected with Covid-19, and she recovered to be discharged home 72 hours later.

Comment

This case is alarming as an illustration of the use of covid legislation to effect the detention of a patient with mental health problems. The pandemic has undoubtedly created difficult issues around keeping vulnerable people safe but the measures adopted here are concerning.

One issue is the appropriateness of using the 2020 Act in these circumstances at all. It is reported that a capacity assessment was carried out, and that the patient was assessed as having fluctuating capacity 'to understand the impact of Covid-19'. It is unclear what precisely was assessed, or whether given the conclusion of fluctuating any further consideration was given to whether DOLS or an application to court were appropriate. It is also unclear whether any consideration was given to whether the MHA 1983 was engaged. Under either the MCA or MHA regimes, appropriate safeguards would have been in place and the patient (who is noted as having had 'limited awareness of the risk to herself or others, nor why she was in hospital') would not have been exposed to potential criminal sanctions.

A further concern is the appropriateness (or indeed lawfulness) of the manner in which powers under the Act were used. If the order provided for an initial period of seven days' effective detention before assessment, that appears to be outside the powers afforded by the Act. Requiring someone to remain on a mental health unit – albeit on a ward set up for treatment of covid patients – raises at least a question as to how this was identified as a suitable location. Finally, the appropriateness of authorising the use of restraint through such an order is questionable.

We also note in this context that the powers under Schedule 21 have barely been used: a FOI request by Lucy Series has produced the information that the power to require a person to remain in isolation at a specified place had been used twice between April 2020 and September 2020, and the power to require a person to remain somewhere to be screened once in the same period.

Nick Lewis

We – belatedly – note the death of Nick Lewis, an extraordinarily dedicated mental health solicitor and President of the Mental Health Lawyers Association, whom Alex had the privilege of serving alongside on the Law Society Mental Health and Disability Committee. A lovely tribute can be found to him on the Law Society Gazette's website.

BOOK REVIEW

Adolescent Mental Health Care and the Law (Camilla Parker, Legal Action Group, 2020, £50)

Camilla Parker set herself a hugely difficult task in identifying and seeking to make sense of the overlapping, tangled, and frequently incoherent and mutually inconsistent legal frameworks relating to the mental health care of those under 18. It is a task which many have recognised as necessary before, but which has not been done to date, much to the detriment of the interests of the children and young people concerned. All those who work with such clients – importantly, including professionals seeking to discharge their functions in relation to those clients – owe Camilla a debt for taking it on, and doing so well. The result of her work is a tour de force. Not only does it cover everything that you might be going to a book on this subject to find, and does so with sure-footed accuracy and helpful summary route-maps at key points, but as with all the best books, it also

includes matters that you would not realise that you should be aware of.

I only have two regrets in relation to the book. The first is that, understandably, given the amount of terrain covered, Camilla has chosen to limit herself to England only – there is the equivalent book to be written, and I would hope soon, in relation to Wales, where the law is evolving in some fascinatingly different ways to that in England. The second is perhaps not a regret about the book per se, but rather that the book expertly shows how badly both the legislators and the courts have approached the specific issues that arise in relation to those under 18 and their mental health needs. I would hope that this book, by allowing a stock-take and highlighting the current problems, not only allows people to navigate the current minefields, but also to encourage them to plot a course towards better ways of thinking about the law in this area.

Alex Ruck Keene

[Full disclosure, I had sight of this book, and made comments upon it, in draft form, and was also provided with a copy by the publishers. I am always happy to review books in the field of mental capacity and mental health law (broadly defined).]

JERSEY

The small body of case-law relating to Jersey's Capacity and Self-Determination Law 2016 has been added to in two very interesting decisions that have recently appeared on the Jerseylaw website:

- *Re C* [2020] JRC 150A, concerning orders that a woman with significant learning difficulties, C, reside at a specific address, that she be subject to a care plan that involves substantial supervision and restrictions on her freedom; that she lacked capacity to give consent for arrangements for her placement and where she should reside, her care plan, and her social contact which would need to be supervised; contact with her husband D and her capacity to consent to sexual intercourse. The Royal Court drew heavily, as it has done on other occasions, on the case-law of the Court of Protection – in particular in relation to the approach to take to capacity and sexual intercourse. The Royal Court in its judgment made clear that its determination in relation to sexual relations was not a "once for all" one, and expressed the expectation that work would be done with her to assist her develop her abilities in this context; it will be interesting to see when the case does come back whether the Royal Court will then follow the evolution in the English case-law from the focus on capacity to consent to sexual relations to capacity to engage in sexual relations.

- *In the Matter of B (Medical)* [2020] JRC 153, concerning the meaning of "significant restriction upon liberty" (a statutory term within the 2016 Law) and also the circumstances under which a delegate should be appointed. Of particular interest to those outside Jersey may be the Royal Court's observation at paragraph 92 that it would be reluctant to treat someone "*who is physically incapacitated such that he is unable to leave a relevant place such as the special*

> *needs home are subject to a significant restriction on his liberty as a result of any activity by the State. The objective position is that the First Respondent is unable to leave the special needs home because of his physical impairment, but that does not amount to a significant restriction on his liberty imposed by the State. As a matter of law, in the hypothetical situation where he woke up with physical and mental capacity, there would be nothing to prevent him from doing so, and in practice we do not think any impediment would be put in his way by staff members*."

EUROPEAN COURT OF HUMAN RIGHTS

Short note: Article 3, restraint and the psychiatric setting

In *Aggerholm v Denmark* [2020] ECHR 628, the ECtHR considered the situation where a man with paranoid schizophrenia was strapped to a restraint bed for almost twenty-three hours in a psychiatric hospital. He contended that this was in breach of Article 3 ECHR. The court reiterated (at paragraph 83) the familiar mantra that:

> *"it is for the medical authorities to decide, on the basis of the recognised rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves, and for whom they are therefore responsible. The established principles of medicine are admittedly, in principle, decisive in such cases; as a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading. The Court must nevertheless satisfy itself that the medical necessity has been convincingly shown to exist (M.S. v. Croatia (no. 2), cited above, § 98).*

Turning to physical restraint, the court noted (at paragraph 84) that:

> *the developments in contemporary legal standards on seclusion and other forms of coercive and non-consensual measures against patients with psychological or intellectual disabilities in hospitals and all other places of deprivation of liberty require that such measures be employed as a matter of last resort, when their application is the only means available to prevent immediate or imminent harm to the patient or others* […] *Furthermore, the use of such measures must be commensurate with adequate safeguards against any abuse, provide sufficient procedural protection, and be capable of demonstrating sufficient justification that the requirements of ultimate necessity and proportionality have been complied with and that all other reasonable options have failed to satisfactorily contain the risk of harm to the patient or others. It must also be shown that the coercive measure at issue was not prolonged beyond the period which was strictly necessary for that purpose* […].

The court found that the situation could be distinguished from those it had previously considered, and (at paragraph 105) that, it could:

> *not be concluded that the duration of almost twenty-three hours for the applicant to be strapped to the restraint bed is, per se, sufficient to find a violation of Article 3. It will depend on whether the continuation and duration of the measure of physical restraint in respect of the*

> *applicant was the only means available to prevent immediate or imminent harm to himself or others* […].

On the facts of the case, the court found that this justification was not made out, such that the circumstances did breach Article 3 ECHR.

Equinet Equality Law Working Group's analysis of Article 14 jurisprudence

The European Network of Equality Bodies ('Equinent') Equality Law Working Group has published the fruits of a year's worth of labour focused on analysing Article 14 of the European Convention on Human Rights ("ECHR"). The first output was a publication entitled, "Compendium: Article 14 cases from the European Court of Human Rights," which offers a detailed analysis of the court's recent Article 14 case law. The group searched for all cases where Article 14 had been argued, and then focused on those where the court made a substantive finding in relation to the article. As part of their analysis, the group considered (inter alia) the scope of "other status", the range of sectors that Article 14 can reach, the legal definition of discrimination, positive obligations and the influence of international instruments (including the UN Convention for the Rights of Persons with Disabilities) and the approach of the Court to the margin of appreciation and justification.

The second output was a third party intervention in the case of *Toplak and Mrak v Slovenia* (a case concerning accessibility of polling station to individuals with disabilities). The case raised critical questions as to the nature and extent of Contracting States' obligations to secure the rights of persons with disabilities to vote without discrimination. The intervention provides a useful overview of the international human rights standards on this issue and national legislation and practice across Contracting States." The case has been held admissible, and a judgment will be rendered in due course.

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.

This month, we highlight the new Mental Disability Law Network website and blog established by Peter Bartlett at the University of Nottingham.

We also highlight the two most recent publications from the Mental Health and Justice Project appearing in Frontiers of Psychiatry: Insight Under Scrutiny in the Court of Protection: A Case Law Survey and Advance Decision Making in Bipolar: A Systematic Review.

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Alex is recommended as a 'star junior' in Chambers & Partners for his Court of Protection work. He 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.

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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. 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), and a contributor to Heywood and Massey Court of Protection Practice (Sweet and Maxwell). To view full CV click here.

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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.

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Annabel has experience in a wide range of issues before the Court of Protection, including medical treatment, deprivation of liberty, residence, care contact, welfare, property and financial affairs, and has particular expertise in complex cross-border jurisdiction matters. She is a contributing editor to 'Court of Protection Practice' and an editor of the Court of Protection Law Reports. To view full CV click here.

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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 2019). To view full CV click here.

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

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Rachel has a broad public law and Court of Protection practice, with a particular interest in the fields of health and human rights law. She appears regularly in the Court of Protection and is instructed by the Official Solicitor, NHS bodies, local authorities and families. To view full CV click here.

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Steph regularly appears in the Court of Protection in health and welfare matters. She has acted for individual family members, the Official Solicitor, Clinical Commissioning Groups and local authorities. She has a broad practice in public and private law, with a particular interest in health and human rights issues. She appeared in the Supreme Court in *PJ v Welsh Ministers* [2019] 2 WLR 82 as to whether the power to impose conditions on a CTO can include a deprivation of liberty. To view full CV click here.

Simon Edwards: simon.edwards@39essex.com

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

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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.

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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 are regularly presenting at webinars arranged both by Chambers and by others.

Alex is also doing 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.

Jill Stavert's Centre for Mental Health and Capacity Law (Edinburgh Napier University)'s Autumn 2020/January 2021 webinar series will include contributions by Adrian Ward on 11 November at a webinar about Advance Care Planning: advance care and treatment planning, end of life, COVID-19, and by Alex on 2 December 2020 at a webinar about Psychiatric Advance Statements. Attendance is free but registration via Eventbrite is required. For more details, 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 November. 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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