



Welcome to the November 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, an important LPS update, and the judicial eye of Sauron descends on new areas to consider (ir)relevant information;

(2) In the Property and Affairs Report: a complex case about when the settlement of an inheritance;

(3) In the Practice and Procedure Report: for how long does a Court of Protection judgment remain binding, and helpful guidance for experts reporting upon capacity;

(4) In the Wider Context Report: challenging reports about the disproportionate effect of COVID-19 upon those with learning disability, young people with learning disability and autism under detention, and capacity and public hearings before the Mental Health Tribunal;

(5) In the Scotland Report: discharge from hospital without proper consideration of ECHR rights.

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.

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### ENGLAND AND WALES

#### Why have so many people with learning disability died of COVID-19?

The Department of Health and Social Care, with the support of the Chief Medical Officer for England, commissioned Public Health England (PHE) to review the available data on the deaths of people with learning disabilities in England during the coronavirus (COVID-19) pandemic. In the [report](#), PHE concluded (having examined data on deaths from Covid from three different sources) that adults with learning disabilities were over-represented by at least 3.1 times

among the numbers of people dying. Further findings include:

- COVID-19 deaths among people with learning disabilities were spread more widely across the adult age groups than in the general population. The age bands with the largest number of deaths was 55 to 64 years for people with learning disabilities, but over 75 for the general population.
- COVID-19 increased the number of deaths for people with learning disabilities by a greater margin than for the general population, across all adult age groups, but by a greater margin in younger age groups.

- The rate of COVID-19 deaths for adults with learning disabilities in residential care was higher than the rates of COVID-19 deaths of adults with learning disabilities generally. This difference is likely in part to reflect the greater age and disability in people in residential care.
- PHE data on the number of outbreaks in care homes indicates that care homes looking after people with learning disabilities were less likely than other care homes to have had COVID-19 outbreaks. This is likely to be related to the fact they have fewer bed spaces.

### Detention of young people with autism and/or learning disability: Government commitments?

The Government has responded to two JCHR reports, the first on detention of young people with autism published in 2019 called '[The detention of young people with learning disabilities and/or autism](#)' and the second published in June 2020 called '[Human Rights and the Government's response to COVID-19: The detention of young people who are autistic and/or have learning disabilities](#)'. The Government's response entitled 'The Government Response to the Joint Committee on Human Rights reports on the Detention of Young People with Learning Disabilities and/or Autism and the implications of the Government's COVID-19 response' can be found [here](#).

In its first report, published in November 2019, the JCHR had concluded that young people's human rights were being abused; that they were detained unlawfully contrary to their right to liberty, subjected to solitary confinement, more

prone to self-harm and abuse and deprived of their right to respect for private and family life. The report made a number of recommendations which are summarised at the start of the Government's response:

- The establishment of a Number 10 unit to urgently drive forward reform, minimise the number of people with learning disabilities and/or autism who are detained and to safeguard their human rights;
- A review to be carried out by the Number 10 unit of the framework for provision of services for those with learning disabilities with new legal duties introduced for Local Authorities and Clinical Commissioning Groups regarding the care of people with learning disabilities and/or autism;
- Stronger legal entitlements to support for individuals;
- Care and Treatment Reviews and Care, Education and Treatment Reviews to be put on a statutory footing;
- Narrowing of the criteria for detention under the MHA to avoid inappropriate detention;
- Families of those with learning disabilities and/or autism to be recognised as human rights defenders, and other than in exceptional circumstances, be fully, involved in all relevant discussions and decisions; and
- Substantive reform of the CQC's approach and processes.

The JCHR also published a report in June 2020 '[Human Rights and the Government's response to COVID-19: The detention of young people who](#)

are autistic and/or have learning disabilities'. This report made 8 recommendations:

- NHS England must write immediately to all hospitals, stating that they must allow families to visit their loved ones unless there are clear reasons specific to the individual's circumstances why it would not be safe to do so;
- Figures on the use of restrictive practices, including physical and medical restraint and any form of segregation, must be published weekly, provided to the Secretary of State for Health and Social Care and reported to Parliament;
- The CQC should carry out all their inspections unannounced;
- The CQC must prioritise in-person inspections at institutions with a history of abuse/malpractice, and those which have been rated inadequate/requires improvement;
- The CQC should set up a telephone hotline to enable all patients, families, and staff to report concerns or complaints during this period;
- The CQC must report on reasons for geographical variation in practice with resultant harmful consequences;
- Rapidly progressing the discharge of young people to safe homes in the community must be a top priority for the Government. The recommendations from the Committee's 2019 report must be implemented in full; and

- Comprehensive and accessible data about the number of those who are autistic and/or learning disabled who have contracted and died of COVID-19 must be made available and include a focus on those in detention.

Of particular interest in the Government's response are the following:

- The Government's decision to consult through the MHA White Paper on new duties to make sure Local Authority and Clinical Commissioning Group (CCG) commissioners ensure an adequate supply of community services for people with a learning disability and autistic people.
- To consult on creating a related duty that would ensure every local area understands and monitors the risk of crisis at an individual-level for people with a learning disability and autistic people in the local population.
- With respect to the recommendation (which endorses the recommendations made by the independent MHA review), that there should be reform of the MHA, the response is the somewhat vague "*we plan to publish a White Paper in due course.*"
- The Mental Health Units (Use of Force) Act statutory guidance, which is currently under development will set out guidance on reporting restrictive practices to NHS England, as well as best practice on notifying families of every incident of a restrictive practice being employed.
- In response to the recommendation that young people should not be placed too far from home, the report states that the NHS

Long Term Plan commits to ensuring that every local area will have a seven-day specialist multidisciplinary service and crisis care by 2023/24. The aim of this is to “enable more people to receive personalised care in the community, closer to home, and to reduce preventable admissions to specialist inpatient settings.”

- With respect to the recommendation about families visiting loved ones during the pandemic in hospital, the report sets out some of the guidance that has been disseminated and states:

*On 22 September 2020, NHS England and NHS Improvement wrote to NHS and independent sector providers of mental health, learning disability and autism inpatient care stating **that they must allow families to visit unless a risk assessment has been carried out that indicates it would be unsafe to do so.** ..... NHS England and NHS Improvement would expect patient and family members to be informed where visits cannot happen and with clear reasons given for this. (emphasis in original)*

### ‘Out of sight – who cares?: Restraint, segregation and seclusion review’

The CQC’s [report](#) published on 27 October 2020 is required reading for anyone supporting those with autism or learning disability. Sadly, it is the latest in a long line of reports demanding change. Inspectors visited many hospital wards, care homes, and children’s residential and secure homes. The CQC also gathered information remotely from 452 questionnaires and sampled care plans and other records.

Inspectors met 66 people in segregation, let down by the health and care system, two-thirds of whom were autistic. Diagnostic delays and inadequate support led in some cases to violent or suicidal distress, where in a crisis hospital was the only option left.

The majority of the 43 hospital wards visited were not therapeutic environments. Some people were admitted without, and remained without, a needs assessment resulting in no clear care and treatment plan. The quality of those plans that were available varied. A common theme was a failure to understand the underlying causes of distress and focusing instead on behaviours that had to be managed.

Some staff did not feel listened to. Some staff felt untrained to understand people’s needs. Wards were described as noisy and chaotic, entirely contrary to the sensory environment required for those with autism. When distress was caused, behaviour was either restrained, secluded, or segregated.

Finding suitable community care was a challenge due to complex commissioning arrangements and poor communication between providers and commissioners. In some cases, community care packages fell through due to issues with funding or providers feeling unable to meet the person’s needs. Such delays and failed placements risked a deterioration in the person’s behaviour as they became stuck in the system, transferring into more secure restrictive environments. The use of physical (including prone), chemical, rapid tranquillising, and mechanical restraint varied across services. The CQC noted that there is no national oversight on the use of restraint and restrictive

practices, such as seclusion and long-term segregation.

Some care homes and supported living services had staff that did not always recognise when patients were being secluded. The conditions of many seclusion rooms in hospital were found to be unacceptable and did not help people to get better, with no access to natural light or fresh air and only some had access to bathrooms or toilets. Most rooms were bare, without personal belongings or access to a TV or music. Blanket restrictions seemed commonplace.

Some people in long-term segregation were in good quality environments with a homely feel. However, for many the physical environment did not meet their needs or help them to get better. Little or no access to outdoor space, unclean accommodation and no access to personal belongings because of blanket restrictions. There was an absence of care plans aiming to re-integrate those segregated back to the main ward as a step towards moving into the community.

Inspectors saw how frightening it could be for people to be restrained but providers did not always recognise it, or the long-term impact it might have. People described how the more they were restricted in hospital the harder they found it to recover, with few staff trained in trauma-informed care and therefore few opportunities for people to talk through their distress.

There were some examples of good practice, mostly in the community. In some hospitals people were being cared for in innovative ways with smaller units and higher staff ratios. But overall the CQC found people got better care in the community than in hospital. It also saw

some great examples of care planning at the secure children's homes they visited, such as screening assessments on admission for autism. For each child placed there was a clear aim for the time they were at the home; the goals were clear, and the success of the service was measured against those goals.

The conclusion section ends with a call to arms:

*There have been too many missed opportunities to improve the lives of autistic people and people with a learning disability and/or mental health condition, whose behaviour others find challenging. Immediate action is needed to put an end to the abuses in human rights that we have seen throughout this review. This action must be owned and led from the top by government, delivered by local systems working together, and involve people and their families to ensure the needs of the individual are met.*

Recommendations were made in four key areas:

- People with a learning disability and or autistic people who may also have a mental health condition should be supported to live in their communities. This means prompt diagnosis, local support services and effective crisis intervention.
- People who are being cared for in hospital in the meantime must receive high-quality, person-centred, specialised care in small units. This means the right staff who are trained to support their needs supporting them along a journey to leave hospital.
- There must be renewed attempts to reduce restrictive practice by all health and social care providers, commissioners and others.

We have seen too many examples of inappropriate restrictions that could have been avoided. We know in absolute emergencies this may be necessary, but we want to be clear – it should not be seen as a way to care for someone.

- There must be increased oversight and accountability for people with a learning disability, and or autistic people who may also have a mental health problem. There must be a single point of accountability to oversee progress in this policy area.

The CQC will publish a report on progress made on the recommendations in Winter 2021/22.

### Short note: an (odd?) inconsistency of judicial concern about deprivation of liberty

In *Re Z (A Child: Deprivation of Liberty: Transition Plan)* [2020] EWHC 3038 (Fam), Knowles J considered the situation of a 14 year old boy with autism and PDA traits who needed to be moved from their home to a residential school. The local authority sought permission to authorise Z's deprivation of liberty during the transfer under the inherent jurisdiction. There was no dispute that the move, the transfer arrangements and the new placement were in Z's best interests, although Z himself had a very troubled history with school placements and was said to have become verbally aggressive and physically violent when he was told of the plan. The parties agreed that Z's placement at the school did not require court authorisation – apparently on the basis that his parents could consent to any deprivation of liberty, and the use of 'reasonable force' to manage his behaviour in

school would fall under s.93 Education and Inspections Act 1996.

The court was therefore only asked to look at the transfer plan, which included the presence of the police and the use of medication and physical restraint as a last resort if Z would not go to the school otherwise: *"it was eventually envisaged that staff would physically hold him and lead him to the car."*

The court held that the local authority should have permission under s.100 CA 1989 to apply to invoke the inherent jurisdiction, and authorised the plan.

In the event, Z went to the school without restraint being required, so the arrangements considered and authorised by the court were not required.

The judgment might be thought to raise more questions than it answers. Why could Z's parents not consent to any deprivation of liberty occasioned by the transfer plan – current caselaw confirms that parents can consent to what would otherwise be a deprivation of liberty on behalf of a child aged under 16. The court formed the view that the transfer plan fell outside the bounds of parental consent even for a child under 16 because it envisaged the use of restraint, and so independent oversight was required. No contrary argument appears to have been advanced before the court.

Is the implication that any use of force that might amount to a deprivation of liberty must be authorised by a court? Apparently not, as the court was satisfied that Z's care at the residential school – a 52 week placement where physical restraint was envisaged – did not require court approval. The court proceeded on

the basis that there were statutory provisions concerning the use of restraint in educational settings, and this provided an adequate legal framework. In fact, the use of excessive and unlawful restraint and seclusion in special schools is a very real problem, and the statutory frameworks alluded to in this judgment do not in themselves provide any recourse to the courts for a child or concerned parent or advocate, nor any independent monitoring. While a claim for judicial review or under the Equality Act or Human Rights Act could be brought after problems have been identified, there is no automatic oversight of such placements beyond standard local authority reviews of children placed pursuant to s.20 CA 1989. One is left with the puzzling conclusion that a short period of physical restraint to get a child from A to B requires the approval of a High Court Judge, while a child's admission to a permanent residential placement where restraint could be used on a daily basis, does not.

### Capacity and public hearings before the Mental Health Tribunal

*AR v West London NHS Trust and the Secretary of State for Justice* [2020] UKUT 273 (AAC) (Upper Tribunal ACC (UTJ Jacobs))

*Mental Health Act 1983 – interface with MCA*

#### Summary

AR had been detained under ss.37/41 MHA 1983 since 1993. The tribunal refused his application for the hearing to be in public. The issues were (a) AR's capacity; and (b) the relevance of incapacity to the application for a public hearing in light of the decision in *AH v West London Mental*

*Health Trust* [2010] UKUT 264 (AAC); [2011] UKUT 74 (AAC).

The Upper Tribunal decided that the tribunal erred in law in two respects:

1. The 'matter' for MCA 2005 purposes was *not* to decide to apply for a public hearing. Instead the matter was the patient's ability to conduct proceedings;
2. That the patient does not have capacity to conduct the proceedings does not mean the hearing cannot be held in public. The starting point is Article 6 ECHR which confers a qualified right to a public hearing and the best interests of the patient should be considered as part of the application.

So a patient does not need to have litigation capacity to apply for a public hearing. UTJ Jacobs then gave some guidance at paragraph 20 as to the salient features of a public hearing which were not intended to be comprehensive:

- The tribunal's powers of disposal are the same, regardless of whether or not the hearing is held in public. Those powers will vary according to the nature of the case. Having the hearing in public will not affect the decision that the tribunal makes within the scope of its jurisdiction under the Mental Health Act 1983. It does not acquire power at a public hearing to deal with any issue that is outside its jurisdiction.
- The tribunal's procedural powers are also the same regardless of the form of the hearing. They include the power to exclude people from all or part of the hearing. The nature of the hearing will not affect the way that the hearing is conducted, the evidence that is



relevant, what the patient is allowed to say, or the outcome of the case.

- Members of the public, including the press, are allowed to observe and may wish to do so, although they may not. They not allowed to take any part in the proceedings.
- A public hearing is no guarantee of publicity, even if members of the public do observe. The tribunal's power to limit disclosure remain the same as for a private hearing.
- A hearing may adversely affect the patient's health, for example as a result of receiving adverse publicity or realising that no one is interested in the case.
- Although the patient may want publicity, this may have a detrimental effect on others, such as his family or any victim.

Accordingly, the case was remitted to a different tribunal.

### Comment

This decision avoids the decisional salami-slicing of litigation capacity, which might otherwise lead to an impractical approach when conducting proceedings, whilst equally ensuring that the voice of the person is not lost when considering issues arising in the course of proceedings. It reflects the increasing role of the MCA 2005 to issues arising under the MHA 1983 and the fleshing out of the tribunal rules.

### Report and webinar – learning from SARs

The first national analysis of learning from Safeguarding Adults Reviews (SARS) in England was carried out during 2020, its purpose being to identify priorities for sector-led improvement in

adult safeguarding. The report is being launched at a webinar on 14 December, where the authors will present key findings from the study, to which 98% of Safeguarding Adults Boards in England contributed material. The resulting analysis of 231 SARs across all types of abuse and neglect provides a significant body of evidence on which to base recommended priorities for sector-led improvement.

The webinar is free to attend: for details and to reserve a place, see [here](#).

### Mental Health Law Online – forum (and website update)

The invaluable Mental Health Law Online [website](#) has now launched an open-access [forum](#) (to accompany the existing email discussion list to which access must be requested). For those who have not already explored the depths of the website, which has an amazing range of resources, you will be able to do so at even greater speed than you might have been able to before as it has had an update behind the scene.

### Short note: when is it right to be held to the consequences of your own actions?

In *Henderson v Dorset Healthcare University NHS Foundation Trust* [2020] UKSC 43, the Supreme Court considered whether Ms Henderson could recover damages for loss of liberty and loss of amenity, consequent upon her detention; and damages for having developed a depressive illness and having lost her share in her mother's estate. The court concluded that she could not; and reaffirmed the proper approach to the common law illegality defence across civil law

generally as distilled by the earlier decision of the court in *Patel v Mirza* [2017] AC 467.

Ms Henderson had a history of schizophrenia with paranoia; and during a psychotic episode she killed her mother. At the time, she was under the care of the community mental health team managed and operated by the defendant trust. The trust admitted breach of duty but contended that since the damages claimed were a consequence of the sentence imposed on her by the criminal court, they were irrecoverable on illegality or public policy grounds.

At first instance, Jay J determined that the facts were identical to *Gray v Thames Trains Ltd* [2009] AC 1339, which was also a case of manslaughter with diminished responsibility (and the first instance decision of *Clunis v Camden and Islington Health Authority* [1998] QB 978). The appeal raised the question of whether *Gray* can be distinguished (because it only concerned claimants with significant personal responsibility) and, if not, whether it should be departed from in light of the decision in *Patel*. In that case, the Supreme Court had provided that a court should consider a trio considerations when faced with an illegality defence: (i) whether the underlying purpose of the prohibition which had been transgressed would be enhanced by denial of the claim ("Stage A"), (ii) whether there existed any other relevant public policy on which the denial of the claim might have an impact ("Stage B") and (iii) whether denial of the claim would be a proportionate response to the illegality ("Stage C").

The Supreme Court determined that *Gray* was compatible with the trial of consideration identified in *Patel*:

1. Stage A – The policy reasons in support of denial of the claim were: the need for consistency as between the civil and criminal law to maintain the integrity of the legal system; the need to maintain public confidence in the law (heightened by the proper allocation of NHS resources); and the public interest in deterring and condemning unlawful killing.
2. Stage B – The court did not consider that there were any countervailing policies that outweighed the policy reasons identified as Stage A.
3. Stage C – The denial of the claim was a proportionate response to the illegality (taking into account (i) the seriousness of the conduct; (ii) the centrality of the conduct to the transaction; (iii) whether the conduct was intentional; and (iv) whether there was a marked disparity in the parties' respective wrongdoing).

Thus, all heads of loss in relation to the killing and detention were irrecoverable.

At a procedural level, the case shows that careful consideration needs to be given to ensuring that any illegality defence is properly pleaded in light of *Patel* as reaffirmed in *Henderson*. In particular, ensuring that, on the facts of the particular case, public policy means that the claimant should not recover; and it is proportionate to deny the claimant recovery.

More broadly, the case raises again the question of whether and how people should be considered to be responsible for their own actions in in the civil as well as the criminal sphere, especially where they have an argument that (at least part of) the reason for their actions

is a failure on the part of others. In assessing how they feel about the judgment, readers might also care to skim the decision in *Campbell v Advantage Insurance Co Ltd* [2020] EWHC 2210 (QB) examining whether it could be said in retrospect that a passenger who was drunk and under the influence of drugs had capacity to decide to get into a car and not fasten his seatbelt before it was driven off by a friend in a similar condition with the inevitable consequences of death and serious injury.

### Short note: suicide and the burden of proof

In *R (Maughan) v Her Majesty's Senior Coroner for Oxfordshire* [2020] UKSC 46, the Supreme Court has confirmed that the standard of proof for all short form conclusions at an inquest, including in relation to suicide, is the balance of probabilities. Whilst formally not before the court, the Supreme Court also held that the same approach applies to determinations of unlawful killing.

Lady Arden, giving the first judgment, identified why the criminal standard (i.e. beyond reasonable doubt) could have adverse public policy consequences:

*73. The retention of the criminal standard for the short form conclusion of suicide is likely to lead to the assessment of when, where and in what circumstances did the deceased meet his death being left in a partially complete and incoherent way, which may give an inaccurate understanding of the position.*

*74. The reasons for suicide are often complex. It is important not to adopt a stereotypical attitude here as elsewhere.*

*Society needs to understand the causes and to try and prevent suicides occurring. Statistics are the means whereby this can be done. If a criminal burden of proof is required, suicide is likely to be under-recorded. This is especially worrying in the case of state-related deaths. If there is an open verdict because the criminal standard of proof cannot be achieved, the circumstances of the case have to be analysed before it can be included in any statistics to show the true number of suicides. There is a considerable public interest in accurate suicide statistics as they may reveal a need for social and medical care in areas not previously regarded as significant. Each suicide determination can help others by revealing how suicide risks may be managed in future. I accept that to some extent policy makers and researchers can seek to mitigate the under-recording of cases by examining cases of open conclusions but they may not be able to do so accurately and lowering the standard of proof would be a more satisfactory way of getting accurate figures.*

Having explained why the appeal should be allowed as a matter of legal principle but then took a step back to ask **why** it should be challenged:

*75. [...] In answer I should like to record some significant changes in the legislative background and in societal attitudes and expectations that have occurred in recent years.*

*76. As to legislative background, suicide used to be a crime, but it ceased to be such in 1961. Section 1 of the Suicide Act 1961 enacts that: "The rule of law whereby it is a crime for a person to*

*commit suicide is hereby abrogated." Although the offence has been abolished, it is still a crime to encourage or assist a person to commit suicide (Suicide Act 1961, section 2).*

77. There has been an unmistakable change in society's understanding and attitude to suicide. This change is charted by Lloyd LJ in *Kirkham v Chief Constable of the Greater Manchester Police* [1990] 2 QB 283. In that case, the court was faced with the argument that there was a defence to a claim for damages against a prison authority where a person had committed suicide in circumstances where it was alleged that the prison authorities had been negligent, on the basis of the defence of *ex turpi causa*, namely that it was contrary to public policy for a person who had committed suicide to recover damages. Lloyd LJ rejected that defence, holding:

*"It is apparent from these authorities that the ex turpi causa defence is not confined to criminal conduct. So we cannot adopt the simple approach favoured by the judge. We have to ask ourselves the much more difficult question whether to afford relief in such a case as this, arising, as it does, directly out of a man's suicide, would affront the public conscience, or, as I would prefer to say, shock the ordinary citizen. I have come to the conclusion that the answer should be in the negative. I would give two reasons. In the first place the Suicide Act 1961 does more than abolish the crime of suicide. It is symptomatic of a change in the public attitude to suicide generally. It is no longer regarded with the same abhorrence*

*as it once was. It is, or course, impossible for us to say how far the change in the public attitude has gone. But that there has been a change is beyond doubt. The fact that aiding and abetting suicide remains a crime under section 2 of the Suicide Act 1961 does not diminish the force of the argument. The second reason is that in at least two decided cases courts have awarded damages following a suicide or attempted suicide. In *Selfe v Ilford and District Hospital Management Committee*, *The Times*, 26 November 1970, Hinchcliffe J awarded the plaintiff damages against a hospital for failing to take proper precautions when they knew that the plaintiff was a suicide risk. In *Pigney v Pointer's Transport Services Ltd* [1957] 1 WLR 1121, to which I have already referred, Pilcher J. awarded damages to the dependants of a suicide under the Fatal Accidents Act 1846. Moreover, in *Hyde v Tameside Area Health Authority*, Court of Appeal (Civil Division) Transcript No 130 of 1981 another hospital case, the judge awarded £200,000 damages in respect of an unsuccessful suicide attempt. The Court of Appeal allowed the defendant's appeal, on the ground that there had been no negligence on the part of the hospital, but not on the ground that the plaintiff's cause of action arose *ex turpi causa*. *Selfe* and *Pigney* are not binding on us. But they are important for this reason. They show, or appear to show, that the public conscience was not affronted. It did not occur to anyone to argue in either case that the granting of a remedy would shock the ordinary citizen; nor did it occur to the court.*

*For the above reason I would hold that the defence of ex turpi causa is not available in these cases, at any rate where, as here, there is medical evidence that the suicide is not in full possession of his mind. To entertain the plaintiff's claim in such a case as the present would not, in my view, affront the public conscience, or shock the ordinary citizen." (p 291)*

78. *Farquharson and Buckley LJJ gave concurring judgments to the same effect.*

79. *However, it must be pointed out that there are those who consider that suicide is a mortal sin, and suicide will constitute a stigma for the deceased and also for his family. In the more recent case of [Braganza v BP Shipping Ltd \[2015\] UKSC 17; \[2015\] 1 WLR 1661](#), this court had to consider the application of the civil standard of proof where an employer alleged that the death of an employee, a chief engineer on a ship, who was lost overboard in the Atlantic, was suicide. The deceased was a Roman Catholic and considered that suicide was a mortal sin (per Lady Hale at para 41). If he had committed suicide, he would be disqualified from receiving a death in service benefit. In determining his entitlement, the employer had to take into account in forming its view the improbability of suicide having occurred. The deceased's view of suicide must be recognised but it could not any more be described as a generally prevailing social attitude.*

80. *Braganza illustrates that others may oppose suicide verdicts for a different reason: it may lead to the loss of*

*employee and other benefits, such as the proceeds of life insurance.*

81. *The role of inquests has also changed (see paras 9 and 10 above). Inquests are concerned today not with criminal justice but with the investigation of deaths. They take a new and different purpose in a case such as this.*

### BMA assisted dying survey

The BMA published a report on its "[Physician-assisted dying survey](#)" on 8 October 2020. The survey was carried out following a call from the union's representative body in June 2019 for a poll of its members to ascertain their views as to whether the BMA should adopt a neutral position with respect to a change in the law on assisted dying. The BMA's current position is that it is opposed to all forms. The survey involved 28,986 members, and was one of the largest surveys of medical opinion ever carried out on the issue. The survey included specific questions on the member's own personal views and what the member considered the BMA's position should be. In terms of trends, there were few surprises, including that members in Northern Ireland were generally more opposed than those in other nations; and medical students were generally more supportive. What is interesting is comparing those specialties that were more supportive (including anaesthetics, emergency medicine, intensive care and obstetrics & gynaecology) with those which were more opposed (clinical oncology, general practice, geriatric medicine and palliative care). The full report detailing the results is over 100 pages in length; and explains how the authors analysed statistical significance, which informed their conclusions on the trends and is available [here](#).

## INTERNATIONAL DEVELOPMENTS

### Human Rights Indicators on the CRPD

The Office of the UN High Commissioner on Human Rights has developed a set of human rights indicators on the Convention on the Rights of Persons with Disabilities (CRPD) as a key tool to facilitate understanding and implementation of the Convention's provisions.

Human rights indicators enhance human rights implementation and measurement by:

- highlighting the practical content of norms;
- measuring progress;
- bringing transparency and accountability; and
- strengthening follow up on recommendations.

The indicators are set out by article, and readers will be likely to focus primarily upon the indicators relating to Articles 12 (the right to legal capacity) and 14 (the right to liberty). They might pause also in relation to the indicators relating to Article 10 to note that, perhaps to the surprise of many disability rights campaigners, the indicators suggest that the High Commissioner would not see legislative provision for assisted dying as contrary to the right to life enshrined in Article 10.

### World Psychiatric Association “call to action”

In a further mark of the impact of the UNCRPD and the activism that it has sparked, the WPA has published in October 2020 a Position Statement and Call to Action: “Implementing

Alternatives to Coercion: A Key Component of Improving Mental Health Care,” the first two paragraphs of which merit reproduction in full (omitting footnotes):

*The purpose of this Position Statement is (1) to recognize the substantive role of psychiatry in implementing alternatives to coercion in mental health care and (2) to support action in this regard, essential to improving mental health treatment and care. The call for alternatives to coercion in mental health care is growing both within the profession and among people with lived experience of coercion in mental healthcare. There is widespread agreement that coercive practices are over-used. Considerable work is warranted across the mental health sector and in communities and governments to ensure that people living with mental disorders and psychosocial disabilities uniformly have access to high-quality care and support that meet their needs and respect their personhood and rights.*

*Of central concern is the protection of human rights, and the extent to which coercive interventions violate these. These include rights to: liberty; autonomy; freedom from torture, inhuman or degrading treatment; physical and psychological integrity of the person; non-discrimination; and a home and family life. These rights have been set out most recently in the UN Convention on the Rights of Persons with Disabilities (2006) as they apply specifically to people with disabilities, including those with psychosocial disabilities. The question of whether coercive interventions can ever be justified as part of mental health treatment, to protect rights holders' own*

*interests or on other grounds, is highly contested. This Position Statement recognises the diversity of views and experiences among mental health professionals, people with lived experience and their families and carers. The WPA would like to stress that this Position Statement and Call to Action is relevant, important, and urgent to improving the quality of mental health care in low-, middle-, and high-income countries. It has been developed in consultation with member societies as detailed in the report attached here. The WPA views this initial consultation and position statement as the beginning of a longer-term process, which will require continued engagement with member societies, people with lived experience, families and other partners to encourage and support the implementation of alternatives to coercion in mental health care. This statement has been crafted to set a direction and practical starting point for action, based on widespread agreement that coercion is overused in mental health systems and that implementing alternatives is crucial to delivering treatment and care that upholds the human rights of people with psychosocial disabilities.*

London and Ipsos MORI, examining public attitudes to intensive care resource allocation during a potential second wave of COVID-19 (the work being done before the potential became rather more actual). The core purpose of the project, involving four deliberative workshops, was to dig deeper than either sound-bites or pure theoretical exercises in ethics allow. The extent to which the participants were willing to grapple with the issues involved was both humbling and also suggests that 'the public' are willing to engage in much more sophisticated discussions about hard decisions that may need to be made than they may be given credit for. Alongside this, much remains to be done both to support ordinary clinical decision-making in extraordinary times, and to make clear more broadly how those ordinary decisions are taken (see also this article co-written by Alex in the [British Medical Journal](#)).

### 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 a [report](#) from a project Alex worked on over the summer involving Kings College

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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](http://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](http://www.lpslaw.co.uk). 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 5<sup>th</sup> 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](#).

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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 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 include a contribution 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.

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Our next edition will be out in December. 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](mailto:marketing@39essex.com).

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