MENTAL CAPACITY REPORT:
MENTAL HEALTH MATTERS
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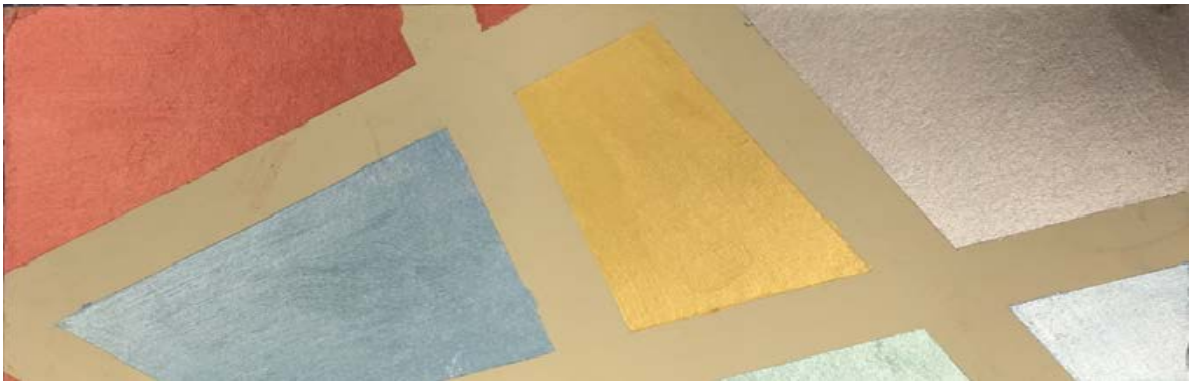

Welcome to the March 2024 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: sexual and contraceptive complexities and an important light shed on DoLS from Northern Ireland;

(2) In the Property and Affairs Report: the obligations on the LPA certificate provider, telling P their damages award, and dispensing with notification in statutory will cases;

(3) In the Practice and Procedure Report: when it is necessary to go to court in serious medical treatment cases, and a Scottish cross-border problem;

(4) In the (new) Mental Health Matters Report: medical evidence, mental disorder and deprivation of liberty, and the approach to propensity evidence;

(5) In the Wider Context Report: when not to try CPR, developments in the context of assisted dying / assisted suicide and with Martha's Rule, and news from Ireland;

(6) In the Scotland Report: a Scottish take on the *Cheshire West* anniversary and a tribute to Karen Kirk.

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

Finally, we should note March 2024 contains three ten year anniversaries. One is national – indeed international – significance: the decision in *Cheshire West*; one is of national significance: the House of Lords Select Committee post-legislative scrutiny report on the MCA 20025; and the third is of personal significance to Alex: the launch of his website.

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

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Long-term s.17 MHA leave: a further go-round (by analogy) before the Supreme Court

Re RM (Application for Judicial Review) (Northern Ireland) [2024] UKSC 7 (Supreme Court (Reed, Sales, Stephens, Rose and Simler SCJJ))

Article 5 – deprivation of liberty

Summary

In this case before the Supreme Court, the provisions of the Mental Health Order (Northern Ireland) 1986 came under scrutiny, shedding light at the same time on the operation of s.17 Mental Health Act 1983 in England & Wales.

In 2018 the Supreme Court held in *Re MM* that conditional discharge under the 1983 Act could not authorise deprivation of liberty in the community. In consequence, and in both jurisdictions, the use of extended periods of authorised leave of absence as a tool for enabling detained patients to continue their rehabilitation in a community setting where appropriate has assumed greater clinical importance.

RM, a restricted patient in Northern Ireland, had sought discharge before the Mental Health Review Tribunal but had been unsuccessful. The Tribunal had accepted the recommendation of his responsible medical officer that his long term leave of absence under article 15 of the 1986 Order (the equivalent of s.17 MHA 1983) would shortly be authorised, and he would move to a community-based setting as a means of transition from secure conditions to ultimate discharge. The Tribunal considered that as a patient subject to leave of absence, RM would nonetheless remain a patient detained in hospital for treatment for the purposes of article 77(1)(a) of the 1986 Order (the equivalent of s.72 MHA 1983). RM challenged this decision by way of judicial review, arguing that, as a matter of law, he should have been discharged unless "a significant component" of his medical treatment was being administered or was to take place within a hospital or equivalent health care facility. Since no treatment in hospital was envisaged in RM's case, he argued that should have been discharged from hospital and the only remaining issue was whether the discharge should be absolute or conditional.

The reference to "significant component" was an allusion to the situation in England where the courts had reconciled full-time leave of absence under s.17 MHA 1983 with the need for continued detention for treatment in a hospital by adopting a test that permitted leave of absence where a "significant component" of the treatment plan for the patient was treatment in a hospital: see, in particular, *R (on the application of DR) v Mersey Care NHS Trust* [2002] EWHC 1810 (Admin) (Wilson J) and *R(CS) v Mental*

Health Review Tribunal [2004] EWHC (Admin) 2958.

While it was accepted on RM's behalf that the significant component test for the connection with a hospital could be gossamer thin, he argued that, on the evidence in this case, where no medical treatment of any kind was taking place at a hospital, nor was any envisaged at any time in future, that connection was not made out.

The High Court upheld the Tribunal's decision. RM then took matters to the Northern Ireland Court of Appeal, which allowed his appeal. It considered that article 15 "*cannot and should not be used as a mechanism for providing legitimacy for what amounts to detention in the community when the grounds for detention in hospital for medical treatment no longer exist and it cannot and should not be seen as a means of avoiding the difficulties presented by the MM decision in respect of the conditions which can be imposed upon a patient who is subject to a conditional discharge*" (paragraph 40 of the NICA decision).

The Department of Justice and the Tribunal appealed.

Before the Supreme Court two questions arose. The first was whether the NICA was justified in drawing distinctions between the 1986 Order and the MHA 1983 so as to support the conclusion that authorities from courts in England and Wales could not be relied on to construe the requirement of detention in hospital for medical treatment. The Supreme Court had little hesitation in finding that the differences in wording did not bear the weight placed upon them by the NICA, such that English authorities could be relevant.

The second question – of relevance both in Northern Ireland and, by analogy, in England & Wales – was set out by Lady Simler, giving the judgment of the Supreme Court, at paragraph 10 as being:

> *whether the grant of leave of absence under article 15 of the 1986 Order is inconsistent with a conclusion that a patient still satisfies the test for detention in hospital for medical treatment and should have no bearing on the decision whether detention for medical treatment is warranted.*

If so, Lady Simler continued,

> *such leave which may form an important and valuable part of a detained patient's treatment plan, that can and frequently does support a safe transition from the institutional setting of a hospital to a less secure, less institutionalised setting in the community, as part of the continuum from detention to discharge, is considerably restricted in its availability.*

Having examined the statutory wording of the 1986 Order, the clear conclusion of the Supreme Court (at paragraph 79) was that a period of leave under article 15 of the 1986 order could be regarded as detention in hospital for medical treatment, so that the Tribunal had been correct to regard RM as continuing to be regarded as a detained patient. Lady Simler continued at paragraph 80 that:

> *The NICA's observation that article 15 leave is not to be used to legitimise detention in the community when the grounds for detention in hospital for medical treatment no longer exist or for avoiding the difficulties presented by MM is unfortunate. While I agree that article 15 leave should not be used illegitimately, that is not what the review tribunal did in this case, and I see no justification for this implied criticism. To the contrary, the proposed treatment plan included a regime of care, support,*

> *rehabilitation, and supervision that constituted "a significant amount of medical supervision and treatment" on the review tribunal's findings. Initially the medical supervision and treatment was planned to take place in the community in circumstances that were more restrictive than those then imposed on RM in hospital. There was uncertainty as to how RM would cope with leave of absence. It was evident from Dr Devine's evidence that the package of care, treatment, support and supervision that would be in place in the community would be tested by the leave of absence and that it would have to be developed and adapted to meet RM's needs. This was "medical treatment" under the 1986 Order. The review tribunal also concluded that it was necessary for the treatment to continue while RM met the statutory conditions for detention and remained liable to recall from leave. In other words, the review tribunal's conclusions meant that even when on leave, RM has a hospital at which he is detained when not on leave.*

Importantly, however, Lady Simler noted that, in agreement with the NICA (but for different reasons), she did:

> *not regard the "significant component" test as necessary, or indeed helpful, when deciding whether a patient's ongoing treatment is treatment in a hospital. The test has no statutory basis and is a gloss on the statutory words. I agree with the submission on behalf of RM that it risks unnecessary treatment being devised in an effort to ensure that the test is met and is arbitrary and subject to happenstance. For these reasons, it should no longer be followed. As explained, even when on authorised article 15 leave, the patient has a hospital at which he or she is detained when not on leave, and article 15 (with the liability to recall in article 15(5)) itself provides a sufficient connection to a hospital for a patient who is liable to be detained.*

The appeal was therefore allowed, and the decision of the review tribunal restored that the statutory test for detention in hospital for medical treatment was met notwithstanding the responsible medical officer's decision that RM should reside on a long-term basis in a community setting, initially on article 15 leave.

Comment

One oddity of this case is that the Supreme Court made no reference to the decision of Lieven J in *Cumbria, Northumberland Tyne & Wear NHS Foundation Trust & Anor v EG* [2021] EWHC 2990 (Fam), in which the operation of long-term s.17 leave with no medical treatment taking place in hospital was considered in considerable detail. It is perhaps because this case was decided at the same time as RM's case was going through the Northern Ireland courts. Lieven J had reached the conclusion that EG could be maintained in the community in such a situation, albeit by having to read the provisions of the MHA through the prism of s.3 HRA 1998.

By contrast, the Supreme Court here reached the same conclusion through a rather more direct route, dismissing the relevance of the 'significant component' test altogether. The observations of Lady Simler in relation to the test are just as applicable to s.17 MHA 1983 as they are to the 1986 order – something of which she was no doubt aware because (although only referred to indirectly), the English Department of Health and Social Care and Ministry of Justice had intervened in RM's case.

The observations of Lady Simler therefore reinforce the ability to use long-term s.17 MHA 1983 as a work-around for situations where a restricted patient cannot be discharged into the

community other than under circumstances giving rise to a deprivation of liberty. However, the use of s.17 leave in this way is sufficiently problematic (for instance as regards the continued operation of Part 4 MHA 1983 and the implications for s.117 aftercare) that it is to be hoped that the primary legislation can be amended in due course in England & Wales so that the recourse does not have to be had to it, and s.17 can be returned to its proper, more limited, purpose.

A final irony of the case is that it concerns legislation that should no longer be in force, the Mental Capacity Act (Northern Ireland) 2016 having been supposed to have swept away standalone mental health legislation in favour of a capacity based-framework applicable to both mental and physical health matters. Unfortunately, and causing considerable ongoing difficulties, the 2016 Act is only partially in force, and the 1986 Order remains operative in respect of those with mental health conditions warranting admission and treatment.

Discharge from mental health inpatient settings

DHSC has published a new statutory guidance, 'Discharge from mental health inpatient settings.' The guidance is issued pursuant to several legislative powers, including s.82 NHS Act 2006, s.74 Care Act 2014 (as a guidance issued under NHS England) and is for NHS bodies (including NHS England, special health authorities, NHS Trusts, and ICBs) and local authorities.

The purpose of the guidance is to clarify what the *"duties to cooperate…mean in practice in the context of discharge from all mental health and learning disability and autism inpatient settings for children, young people and adults. It aims to share best practice in relation to how NHS bodies and local authorities can work closely together to support the discharge process and ensure the right support in the community. It provides clarity in relation to responsibilities in the discharge process, including funding responsibilities. In addition, the guidance incorporates best practice in relation to patient and carer involvement in discharge planning."* The guidance sets out a series of eight principles for how NHS bodies and local authorities should work together for effective discharge planning from mental health inpatient services:

- *principle 1: individuals should be regarded as partners in their own care throughout the discharge process and their choice and autonomy should be respected*
- *principle 2: chosen carers should be involved in the discharge process as early as possible*
- *principle 3: discharge planning should start on admission or before, and should take place throughout the time the person is in hospital*
- *principle 4: health and local authority social care partners should support people to be discharged in a timely and safe way as soon as they are clinically ready to leave hospital*
- *principle 5: there should be ongoing communication between hospital teams and community services involved in onward care during the admission and post-discharge*
- *principle 6: information should be shared effectively across relevant health and care teams and organisations across the system to support the best outcomes for the person*
- *principle 7: local areas should build an infrastructure that supports safe and timely discharge, ensuring the*

right individualised support can be provided post-discharge

- *principle 8: funding mechanisms for discharge should be agreed to achieve the best outcomes for people and their chosen carers and should align with existing statutory duties*

The document also contains specific guidance relating to children and young people, people with a learning disability and autistic people, people with dementia, people in forensic settings, people who are homeless or at risk of homelessness, people with co-occurring drug and alcohol conditions and people with no recourse to public funds. The guidance *'sets out roles and responsibilities of organisations in the discharge process, including commissioners of services, NHS trusts and local authorities. In the annex, there is additional statutory guidance on how budgets and responsibilities should be shared to pay for section 117 aftercare.*' The guidance also contains a s.117 'maturity matrix', which is described as a *'quality assurance tool is designed to assist local systems in self-assessing their current compliance with the national guidance on section 117 aftercare. It is designed to enable local systems to identify areas that might need further operational, strategic, commissioning and financial development, and agree actions to initiate improvement for people subject to this legal entitlement.'*

The s.117 guidance at Annex B is notable, and arises out of *"the recommendation of the Independent Review of the Mental Health Act 1983 that there should be guidance 'on how budgets and responsibilities should be shared to pay for section 117 aftercare."* This guidance is for England only and applicable across all ages to include section 117 responsibilities for children and young people (CYP) and adults.' It emphasises that:

- *Funding decisions must be conducted in a timely manner prioritising and promoting the least restrictive approach while promoting the strengths of the individual. No assessment, care or support arrangements should be refused or delayed because of uncertainty or ambiguity as to which public authority is responsible for funding an individual's health and/or care provision.*

- *Section 117 funding arrangements and associated funding decisions should be based upon clear and transparent funding arrangements which can be evidenced by each partner organisation.*

- *Section 117 funding arrangements should therefore be determined in accordance with local agreement between NHS and LSSAs to meet the needs of the eligible persons. Local systems will choose to administer a joint funding process which will fall within different broad categories of aligned or pooled budget arrangements.*

- *health and local authorities 'should conduct a joint review of the section 117 care plan no later than every 12 months, which must take into account the views of the person who is receiving the aftercare. The timetable of review arrangements should be refreshed and updated in the event of potential change in circumstances for example a hospital admission and discharge plan.*

- *Specific reference to the application of funding for young people subject to section 117 needs to be made in local section 117 policies and procedures, referencing the role of the various agencies that might be involved with*

the experience of transition. It is incumbent on CYP commissioning managers to bring people entitled to section 117 to the attention of adult commissioning colleagues in a timely manner to support effective future planning, and it is incumbent on adult commissioning colleagues to request details of those young people subject to section 117 who may require adult services from their CYP counterparts. Local CYP and adult commissioners from NHS bodies and local authorities should convene on a regular basis to review the circumstances of young people who are subject to section 117 and ensure that suitable preparations are being made to support a structured and smooth transition allowing for the forecasting of care costs and necessary market provision.

- *'The involvement of the person and their carer where applicable is essential in the decision-making process for the successful ending of aftercare.'*

We would also note that the guidance appears to contemplate that a stay in prison would not extinguish an entitlement to s.117 aftercare, stating 'Individuals being released from prison, an IRC or the Youth Justice Estate who have a section 117 aftercare entitlement should be referred by the prison mental health team or IRC healthcare team to the relevant ICB and local authority as soon as is practicable so as to facilitate maximum opportunity for a section 117 aftercare plan to be drawn up prior to release.' We would note the contrast between the position here and the obiter dicta at paragraph 49 of the *Worcestershire* judgment, which appeared to suggest that a s.117 duty would end due to incarceration (we would emphasise that this issue was not part of the factual scenario in *Worcestershire* and this comment was not part of the decision of the court):

> *49. As a matter of linguistic analysis, the answer to this argument, in our view, is that the duty under section 117(2) is to provide after-care services "for any person to whom this section applies". The duty will therefore cease not only if and when a decision is taken that the person concerned is no longer in need of after-care services but, alternatively, if the person receiving the services ceases to be a person to whom section 117 applies. As Mr Sharland KC pointed out, that would be the case if, for example, the person concerned were to die or was deported or imprisoned. Although there is nothing in section 117(2) which says that the duty will cease in that event, there would then be no person to whom section 117 could apply.*

'Who Pays?' Guidance updated following the *Worcestershire* s.117 Supreme Court decision

NHS England has published an update to the 'Who Pays?' guidance to consider the effect of the *Worcestershire* s.117 decision in the Supreme Court. The update states in relevant part:

> *The position under the Integrated Care Board (ICB) Responsibilities Regulations, under which the originating ICB retains responsibility for care during subsequent detentions, even if the patient moves to a different part of the country, is not affected by the Supreme Court's judgment in the case of R (on the application of Worcestershire County Council) (Appellant) v Secretary of State for Health and Social Care concerning which local authority was responsible for the provision of aftercare under section 117 of the Mental Health Act 1983….*
>
> *In the case of the ICB Responsibilities Regulations, the continuing obligation of*

> *the originating ICB derives from the regulations, not section 117(3) itself. In particular, regulations 5 and 7 have the effect that if an ICB has core responsibility for a patient individual when a "relevant application" is made for detention, then it retains responsibility for commissioning mental health services during detention and aftercare even if it would otherwise not be responsible (eg because the patient had moved out of area). A relevant application is an application made either before or after an "exclusion period" beginning with detention and ending with a person's "next discharge from aftercare services". So, unlike the local authority position in Worcestershire, a second detention made before the person is actively discharged from after care does not bring to end the responsibility of the originating ICB.*
>
> *Similarly, where under the transitional provisions in regulation 6, an ICB had core responsibility for a person who was detained or in aftercare on 1 July 2022, the responsibility for mental health services continues during any second or subsequent detention and related aftercare, and is not brought to end by a second or subsequent detention, only by an active discharge from aftercare.*

Associate Hospital Managers – their employment status

In *Lancashire and South Cumbria NHS Foundation Trust v Moon (Jurisdiction – Employee, Worker or Self-Employed)* [2024] EAT 4, Ellenbogen J has held (in dismissed an appeal from the Employment Tribunal) that Associate Hospital Managers are workers and employed by the Mental Trusts in question. The decision gives rise to a number of thorny employment law issues outside the remit of this Report, but of note was Ellenbogen J's conclusion at paragraph 31 that:

> *the status of worker and its associated rights do not themselves serve to compromise the independence or integrity of the role, which, to paraphrase Mr Young's submission, is what it is and has no impact upon a patient's rights under Article 5 ECHR; indeed — see Gilham [36] — independence and integrity are likely to be promoted by enabling an AHM to make public interest disclosures without fear of retribution. It follows that worker status does not serve to defeat the purpose of section 23(6) of the MHA.*[1] *Nothing in that conclusion is inherently undermining of the requirements of the Code (as Dr Morgan acknowledged in discussion), or of Article 5 ECHR.*

If you do not know you are doing wrong, can you sue for not being prevented from doing it?

Alexander Lewis-Ranwell v G4S Health Services (UK) Ltd & Ors [2024] EWCA Civ 138 (Court (Court of Appeal (Dame Victoria Sharp P, Underhill LJ and Andrews LLJ))

Other proceedings – civil

Summary

If you have been found by a criminal court that you did not know what you were doing was wrong when you killed someone, should you able to sue those statutorily charged with assessing your mental health for failing to stop you?

That was the stark question before the Court of Appeal in *Alexander Lewis-Ranwell v G4S Health Services (UK) Ltd & Ors* [2024] EWCA Civ 138. On 10 February 2019, in the course of a serious

[1] Which provides that the power of discharge conferred on the Trust "may be exercised by any three or more persons authorised by the board of the trust in that behalf each of whom is neither an executive director of the board nor an employee of the trust."

psychotic episode, the claimant had attacked and killed three elderly men in their homes in Exeter in the delusional belief that they were paedophiles. He was charged with murder but following a trial in Exeter Crown Court he was found not guilty by reason of insanity: in law, this meant that because of his mental illness he did not know at the time of the killings that what he was doing was wrong. He was ordered to be detained in Broadmoor Hospital pursuant to a hospital order with restrictions under sections 37 and 41 of the Mental Health Act 1983. In the two days before the killings he had twice been arrested, and detained for some time before being released. During both periods of detention the claimant behaved violently and erratically and was apparently mentally very unwell. He was seen or spoken to by mental health professionals employed by G4S Health Services (UK) Ltd and Devon Partnership NHS Trust. A face to face assessment by the mental health nurse employed by the Liaison and Diversion Service of the NHS Trust was discussed but did not take place. The need for a Mental Health Act Assessment was discussed with an Approved Mental Health Professional employed by Devon County Council but was not arranged.

On 4 February 2020 the claimant commenced proceedings in the High Court against G4S, the Police, the Trust and the Council. In broad terms it was his case that it should have been obvious to all concerned during both detentions that if he were released there was a real risk that he would injure other people, and that the necessary steps should have been taken to keep him in detention until it was safe for him to be released. The claims were advanced in negligence and under section 7 of the Human Rights Act 1998. The heads of damage pleaded in the Particulars of Claim were for personal injury, loss of liberty, loss of reputation, and "pecuniary losses". The claimant also sought an indemnity in respect of any claims brought against him "as a consequence of his violence towards others on 9-11 February 2019".

All of the organisations involved (bar the police) sought to have the claim struck out on the basis, broadly, that they were entitled to rely "the illegality defence" – that is, the rule that the Court will not entertain a claim which is founded on a claimant's own unlawful act – because the claim was based on the consequences of the claimant's three unlawful homicides.[2]

As Underhill LJ (one of two judges in the majority, along with Andrews LJ) noted, the question of whether the illegality defence operated in a case where the claimant was insane at the time that he or she did the unlawful act was not the subject of any binding authority. In *Clunis v Camden and Islington Health Authority* [1998] QB 978, the Court of Appeal held that a mentally ill person who had been convicted of manslaughter by reason of diminished responsibility was barred by illegality principle from bringing a claim against his doctors for negligent treatment which was said to have caused or contributed to his committing the offence; and that decision had since been upheld by the House of Lords in *Gray v Thames Trains Ltd* [2009] UKHL 33, and by the Supreme Court in *Henderson v Dorset Healthcare University NHS Foundation Trust* [2020] UKSC 43 However, as Underhill LJ identified, the reasoning in those decisions, though clearly relevant to this case, was not determinative because diminished responsibility is not the same as insanity. The issue had, however, been directly considered in some U.S. and Commonwealth cases, and also in a recent decision of the High Court, *Traylor v Kent & Medway NHS Social Care Partnership*

[2] Using Latin terms which should no longer be in use, the defence is often described as depending on "the *ex turpi causa* principle" (or "rule"), referring to the maxim *ex turpi causa non oritur actio*.

Trust [2022] EWHC 260 (QB).

Underhill LJ considered that the public authorities should not be able to rely on the illegality defence, and after an extensive review of the case-law, took each the arguments in favour of the defence in turn to explain why they did not avail the public authorities.

First, as regards the inconsistency that would arguably arise between the civil and criminal law, he accepted the claimant's case that the "*verdict of not guilty by reason of insanity was an acquittal. Accordingly the law has not treated him as criminally responsible for his actions, and there is no inconsistency in allowing him to recover for the loss that he has suffered in consequence of them*" (paragraph 93). He noted that "[t]*hat approach also seems to me to accord with the fundamental justice of the matter. At a superficial level you could still say that it was inconsistent to allow a person to recover for the consequences of an unlawful act which they have done. But at a more fundamental level the criminal law is concerned not with acts as such but with personal responsibility for those acts, and a difference in treatment based on differences in personal responsibility cannot be said … to undermine 'the integrity of the justice system*.' *This reflects the basic perception reflected in the authorities […] based on the requirement of moral culpability*" (paragraph 96). Underhill LJ emphasised that he was only dealing at this stage with the inconsistency principle, and that the argument that the claimant should not be entitled to recover compensation for the consequences of his criminal act (albeit one for which he had no criminal responsibility) could still be deployed in the context of the public confidence principle, considered further below.

Second, there was said to be an inconsistency within the civil law that it was clearly established by case-law that the claimant's insanity would be no defence to any action in tort that his victims' families might bring. However, Underhill LJ considered, "[t]*he question of the liability of the Claimant to his victims for the injury which he caused them is self-evidently different from the question of the liability of the Appellants for the loss which they have caused him. In the former case justice requires that the interest of the victim in receiving compensation comes before any question of moral culpability … In the latter it is the Claimant who is the victim of wrongdoing and the question whether he should nevertheless be denied recovery because his loss was the result of a criminal act has to be considered in that quite different context. Again, I am not saying that it has to be answered in his favour, only that to allow recovery would not be inconsistent with the rule that his insanity does not preclude his liability to his victims*."

Third, Underhill LJ considered the public confidence principle, identified in the *Henderson* case as being the potential that allowing a claimant to be compensated for the consequences of his own criminal conduct would risk bringing the law into disrepute and diminishing respect for it because that is an outcome of which public opinion would be likely to disapprove. He noted at paragraph 103 that:

> *In my view it is this principle which is at the heart of this appeal, as it was for Santow JA in* [the Australian case of] *Presland, and I have not found it easy to decide whether it should operate in this case. I do not doubt that it would – at least as a first reaction – stick in the throats of many people that someone who has unlawfully killed three innocent strangers should receive compensation for the loss of liberty which is a consequence of those killings, however insane he was and however negligent his treatment had been. To the extent that that reaction reflects, in Santow JA's language, "considered community values", we should be very slow to*

> *disregard it: the law ought so far as possible to give effect to such values.*

However, Underhill LJ came to the conclusion that:

> *104.* […] *although that first reaction is entirely understandable, the values of our society are not reflected by debarring a claimant from seeking compensation in this kind of case. It is necessary, as Santow JA accepted, to go beyond "instinctive recoil" and to consider what justice truly requires in a situation which most humane and fair-minded people would recognise as far from straightforward. Taking that approach, although of course those who are killed or injured must always be treated as the primary victims, it is fair to recognise that the killer also may be a victim if they were suffering from serious mental illness and were let down by those responsible for their care. I rather suspect that some such view underlies the observations of the jury at the Claimant's trial which I quote at para. 11 above.*[3] *But, whether it does or not, I believe that the considered view of right-thinking people would be that someone who was indeed insane should not be debarred from compensation for the consequences of their doing an unlawful act which they did not know was wrong and for which they therefore had no moral culpability. As we have seen, the law does not generally apply the illegality defence where the claimant does not know that what they are doing is wrong and has no moral culpability; and in my view that reflects ordinary and comprehensible principles of fairness. I do not believe that it is rational, or would accord with community values, that the position should be different where the claimant's lack of knowledge or culpability was the result of insanity. In short, I would align myself with the approach taken by Spigelman CJ at para. 95 of his judgment in Presland: see para. 55 above.*

Two further potential anomalies were pointed out by the public bodies in support of their argument that the law would be brought into disrepute. The general one was that claimants would be entitled to claim compensation from their doctors for what they had lost as a result of not being prevented from committing their unlawful acts, the victims of those acts (or their estates or dependants) would have no claim against the doctors. Underhill LJ was:

> *107.* […] *prepared to assume that at least in the generality of cases victims in a situation such as the present would have no right to recover against the authorities whose negligence had allowed the attack to take place. But I do not accept that that gives rise to an anomaly. Victims may not have a right to compensation against the doctors, but they have a straightforward claim against their assailant, whose insanity would be no defence to a civil claim for assault. It is true that, unlike a doctor or health authority, the assailant may not be in a position to meet a substantial award of damages. However, as we have seen, one of the heads of damage claimed by the Claimant in this case is an indemnity against any liability to his victims. I can see no reason why that would not be an admissible head of claim; and, if it is, it would afford a route by which victims could be assured of payment of any damages that they were awarded. However, Ms Ayling did not accept that a claim for such an indemnity would lie, though she did not advance any developed reason for that*

[3] The jury sent a note to the judge during the trial in the following terms: "*We the Jury have been concerned at the state of psychiatric health service provision in our county of Devon. Can we be reassured that the failings in care for* [the Claimant] *will be appropriately addressed following this trial*."

> *position. In the absence of full argument I am not prepared definitively to decide the point. But even if the claimant were not entitled to such an indemnity, the fact that they might not be able to meet any award of damages to the victim does not seem to me to be a principled reason for denying them recovery for their own loss.*

The more specific anomaly would arise in the case where the victim of the claimant's unlawful act was also the defendant – for instance where a mentally ill patient attacked the negligent doctor. Underhill LJ fully accepted that:

> *110.* […] *seems unjust that someone who has suffered unlawful injury at the hands of another can be required to pay damages to them for the consequences that they have suffered as a result of inflicting that injury. Of course the victim would have a cross-claim, but even if that exceeded the value of the claimant's claim, so that there was no net liability, their net recovery would necessarily be less than the full compensation for their loss. The position would be worse still if the claimant, as in this case, claimed an indemnity against any such liability: that would on the face of it reduce the victim's recovery to nil while still leaving them liable for the claimant's loss. (It is true that they might be insured against their liability to the claimant – in my two examples, both the doctor and the driver would almost certainly be insured – but that ought not to affect the position in principle.)*
>
> *111. I do not, however, believe that the problems that would arise in that scenario are a reason for barring a claim in the typical case where, as here, the defendant is not a victim of the claimant's unlawful act. I ought not to seek to determine in advance how the Court would address such a situation; but since we are concerned with questions of public policy, it would have the tools to produce a just outcome.*

Fourth, Underhill LJ considered two other considerations that had also been raised in *Henderson*: (a) the impact on NHS funding of allowing a claim of the present kind; and (b) deterring unlawful killing and providing protection to the public, there being no more important right to protect than the right to life. Whilst Underhill LJ agreed that they appeared to be in play, he considered that the question was whether it was proportionate to treat them as outweighing the public interest in claimants in insanity cases receiving due compensation for the wrong that they have suffered. He did not believe that it was:

> *116. The balance is quite different from in the diminished responsibility cases because the claimant has no moral culpability. That point is clearly made if one looks at how Lord Hamblen struck the balance at paras. 138-143 in Henderson. In those paragraphs he emphasises the importance of the fact that the claimant knew that what she was doing was legally and morally wrong: see paras. 139 and 142. In the absence of that element, and where, essentially for that reason, the consistency and public confidence principles are, as I would hold, not engaged, I do not believe that either the impact on NHS resources or the general deterrent effect of a rule against recovery could justify the denial of the claim in these proceedings.*

A final consideration was the fact identified by the appellant public bodies that there was no sharp distinction between a finding of diminished responsibility and a finding of insanity: the distinction is one of degree only:

> *117.* […] *That may be so, but the criminal*

> *law proceeds on the basis that the distinction is nevertheless real and that in any given case it will be possible to say on which side of the M'Naghten line the defendant falls. That being the case, there is nothing irrational about the application of the illegality defence depending on the selfsame distinction. If I had any unease about this aspect, it would, rather, be about the possibility that in some cases the distinction may reflect not a finding by a court but a forensic choice by the defendant or their advisers. Pleas of not guilty by reason of insanity are in practice rare; and there must be cases where a defendant tenders, and the Crown accepts, a plea of manslaughter by reason of diminished responsibility where the facts might arguably have justified a special verdict (Henderson may be an example). But if that results in the illegality defence being unavailable in some cases where it might have been available if the defendant had made a different choice I do not think that can affect the decision in principle which we have to make.*

Whilst Underhill LJ identified (at paragraph 119) that he did not consider the question as an easy one, he therefore allowed the appeal.

Dame Victoria Sharp P gave a shorter judgment explaining her reasoning for allowing the appeal, her central reasoning being that each of the key English cases:

> *161.* […] *draws a coherent and bright line distinction for the purposes of the ex turpi causa doctrine, between those who are criminally responsible for their acts whether fully or partially, and those who are not responsible for their acts because they do not know what they are doing is morally and legally wrong. In my judgment, this common thread running through the criminal and civil law, is consistent with principle, a proper understanding of the true implications of acute mental illness and is one that would not offend the sensibilities of ordinary right-thinking members of the public or undermine public confidence in the law.*

Andrews LJ dissented, finding herself unable to agree with the majority that:

> *122. […] a lack of knowledge or understanding by a person who intentionally takes the life of another human being that what he was doing was wrong is a sound and principled basis for allowing that person to make a claim in negligence against someone for putting them in a position which enabled them to commit an act which was both deliberate and tortious.*
>
> *123. I agree with Underhill LJ that in an era where there is much greater understanding of mental health issues, it is fair to recognise that, as well as the primary victims, the killer also may be a victim, if they were suffering from serious mental illness and were let down by those responsible for their care. However, I am not persuaded that an absence of the state of knowledge of wrongdoing, which would afford the mentally ill perpetrator of a deliberate fatal assault a complete defence to criminal liability for murder or manslaughter, justifies drawing a bright line between the present case and similarly tragic cases such as Clunis, Gray and Henderson.*
>
> *124. There are all kinds of reasons why a defendant suffering from a serious mental illness who faces a charge of murder might prefer to opt for running the partial defence of diminished responsibility rather than pleading insanity, even though it may be open to them to do so. The most obvious of these is the prospect of indefinite incarceration in a secure mental health*

> *unit. Moreover, it is not difficult to conceive of examples of situations where a person who is guilty of the criminal offences of murder or manslaughter, or causing death by careless driving, might be regarded by the public as less blameworthy for the death than a person in the position of the Claimant, who intended to kill his victims. Yet such a person would be precluded by their conviction from making a claim of this nature even if they were seriously mentally unwell at the time.*
>
> […]
>
> *137. I have not reached this conclusion lightly. However it does seem to me that there is nothing disproportionate about precluding someone who intended to kill, and did so, from bringing a claim in negligence in reliance on that deliberate and unlawful act, and that the policy rule preventing such claims from being made should not rest on nice distinctions between having little or no personal responsibility for the killing because of the state of the claimant's mental health at the time. For those reasons, I would have allowed this appeal.*

Comment

It is very important to make clear that the decision of the Court of Appeal is not that the public authorities did, in fact, fail in their duties towards the claimant. Rather, it was whether, as a matter of principle, the claimant could even bring his claim. Further, as Underhill LJ identified, there also remains in play issues such as whether his contributory negligence should eliminate in whole or in part any obligation on their part to pay him damages. Furthermore, it is important to remember in any commentary or discussion of the case that underpinning it is a tragedy where three entirely innocent older people were killed.

However, given the wider implications of the analysis of the law in play, the determination of the majority to carry through the logical implications of the meaning of a finding of not guilty by reason of insanity – i.e. that a person is truly to be taken not to be responsible for their actions – stands out at a time of considerable media interest (to put it neutrally) in the implications of a person being found not guilty by reason of insanity as a result of the Valdo Caldocane case. It is perhaps not surprising that that all three of the judges found the case a difficult one, and that Underhill LJ identified that the approach that underpinned it would – at least by way of first reaction – stick in the throats of many.

For those steeped in matters of mental health law from the disability rights angle, one striking feature of the case was the absence of discussion of the UN Convention on the Rights of Persons with Disabilities. Even if not part of English law, the CRPD is part of the modern context within which the approach to mental illness is considered,[4] and which appears to have played a part in the thinking of the majority. And, given that the Court of Appeal were grappling with principles, the CRPD might be thought to have provided a useful stress-test of those principles.

On one view, it might be thought that, albeit perhaps unknowingly, Andrews LJ's dissent reflects the most CRPD-compliant approach to the difficult question before the court. Put shortly, if a central tenet of the right to equal

[4] See, for instance, the part that it played in shaping the thinking of the independent Review of the Mental Health Act 1983.

recognition before the law in Article 12 CRPD[5] is that those with disabilities should not be denied agency on the basis of their impairments, then it might be said that it flows that they should not be identified as lacking responsibility for their actions when they act upon that agency: no matter the consequences. That would, in turn, seem to point to a conclusion that the illegality defence should be available in all cases where the person's actions were both intentional and wrongful (even if that 'intention' was based upon delusional beliefs).

In saying this, I should say that I am aware that some might contend that: (1) none of the public authorities should have had the power to detain the claimant prior to his attacks on the basis of his mental ill-health, such that his claim should fail at the very first base; and (2) the CRPD would dictate the abolition of the very concept of a defence of not guilty by reason of insanity, such that he should, in fact, have been convicted of their murders. Both of these points show the complexities of the CRPD in this regard, especially as interpreted by the Committee on the Rights of Persons with Disabilities. And they arguably also show the limits of the 'abolitionist' arguments advanced by the Committee.[6] But if the current case does go further (as it is possible to imagine it might given the finely balanced nature of the judgments, and the absence of prior binding authority), it is to be hoped that the CRPD can get at least a walk-on part in testing the proposition whether it is right to expand the range of circumstances in which English law identifies that that a person with cognitive impairments is not to be seen as seen as responsible for their own actions.

[5] For those unfamiliar with this, this reading list may be useful: Legal and mental capacity – a reading list – Mental Capacity Law and Policy.

[6] See for a nuanced discussion of the CRPD and criminal law, Jill Craigie, Against a singular understanding of legal capacity: Criminal responsibility and the Convention on the Rights of Persons with Disabilities. *International Journal of Law and Psychiatry*, *40*, 6-14.

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Conferences

Members of the Court of Protection team regularly present at seminars and 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.

Adrian will be speaking at the following open events: the Royal Faculty of Procurators of Glasgow Private Client Conference (14 March, details here), the World Congress of Adult Support and Care in Buenos Aires (August 27-30, 2024, details here) and the European Law Institute Annual Conference in Dublin (10 October, details here).

Peter Edwards Law has announced its spring training schedule, here, including an introduction – MCA and Deprivation of Liberty, and introduction to using Court of Protection including s. 21A Appeals, and a Court of Protection / MCA Masterclass - Legal Update.

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 April. 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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