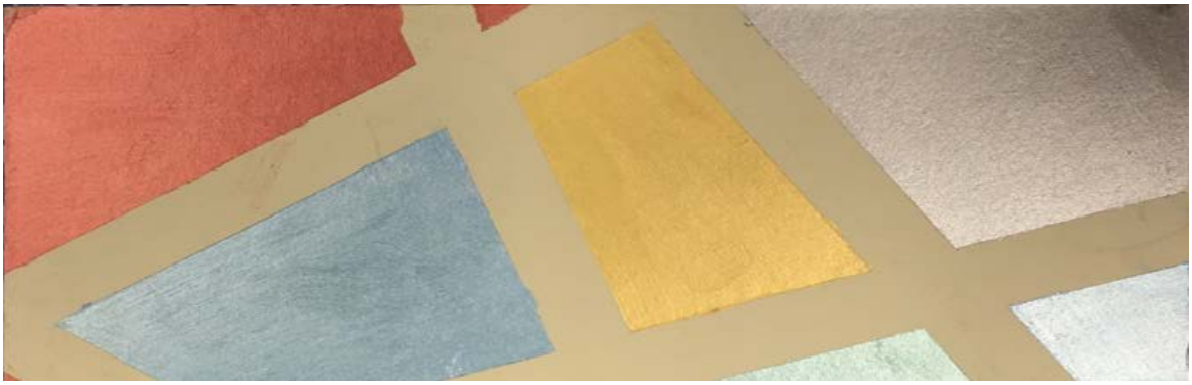
MENTAL CAPACITY REPORT:
MENTAL HEALTH MATTERS
May 2024 | Issue 140



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

(1) In the Health, Welfare and Deprivation of Liberty Report: a rare successful capacity appeal, evicting someone from P's house and holistically approaching hoarding;

(2) In the Practice and Procedure Report: when you can remove deputies, and publishing judgments in serious medical treatment and closed material procedure cases;

(3) In the Mental Health Matters Report: when not to rely on capacity in the mental health context;

(4) In the Wider Context Report: capacity, autonomy and the limits of the obligation to secure life, and the European Court of Human Right raises the stakes for psychiatric admission for those with learning disabilities;

(5) In the Scotland Report: licence conditions and deprivation of liberty, and Executor qua attorney – a few steps back?

In the absence of relevant major developments, and on the basis people have enough to do without reading reports for the sake of reports, we do not have a property and affairs report this month. But some might find of interest the blog by Alex prompted by a question in the property and affairs context of whether you need to have capacity to consent to having your capacity assessed.

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.

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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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Deaths in custody – the MHA problem

The Independent Advisory Panel on Deaths in Custody has published an updated report analysing deaths in custody for the period between 2017 and 2021. The report concludes that:

- People in state custody are at a significantly elevated risk of death, both natural and unnatural, compared with the general population. These deaths are often preventable.
- Greater transparency is needed to understand who is dying in closed institutions and why.
- Prisons have the highest number of deaths, with an average of 322 annually during the period analysed.
- Mental health detention had an average of 263 deaths annually in the period analysed, or 1314 per 100,000 people detained. This figure jumped starkly higher to 15,770 when it was adjusted for the fact that the average period of detention was one month.
- Even on the average, unadjusted rate, when rates are considered, the mortality rate of individuals detained under the Mental Health Act is three times higher than prisons and the highest across all places of custody.
- Despite the frequency with which deaths of people detained under the MHA occur, a lack of timely and high-quality data limits learning to prevent further deaths in secure health settings.
- Deaths among men and women were roughly equal in mental health settings when measured relative to the number of male and female detainees.
- The majority of unnatural deaths across all settings – which includes suicides, accidents and homicides – occurs in those under the age of 40.
- For deaths in mental health detention, deaths by 'natural' causes were significantly higher than deaths by 'external' causes, though high numbers of deaths were considered to be 'awaiting classification' pending a coroner's inquest.

The report makes clear recommendations for how data should be kept on deaths in mental health detention.

> *Data on deaths in mental health detention is still not good enough.*
>
> - *Data on deaths in MHA detention remains poor quality in terms of comprehensive and timeliness. As the IAPDC has found for a number of years, we cannot identify the proportion or rate of deaths by race*

or ethnicity due to the lack of available data.

- *The same remains true for identifying rates of death for both men and women within MHA detention: it is currently not possible due to the poor data quality.*

- *It remains the case that a large number of deaths in MHA detention in each new year are reported as "awaiting classification". This is because those reporting the data wait for coroners' verdicts before determining whether a death was self-inflicted or 'nonnatural'.*

- *However, this issue does not pose a problem for the other detention settings, such as prisons or police custody, with the relevant bodies using other, provisional methods for reporting apparent self-inflicted deaths before a coroners' verdict to ensure timely and potentially actionable data. This should be changed for data on deaths in MHA detention.*

When (not) to rely upon capacity

Lukes v Kent & Medway NHS & Social Care Partnership Trust & Anor [2024] EWHC 753 (KB) High Court (King's Bench Division) (Julian Knowles J)

Other proceedings – civil

In this case, Julian Knowles J had to consider whether Mr Lukes had a viable claim for damages for personal injury against either the police or a mental health Trust. Mr Lukes had jumped from height in August 2020 onto railway tracks and sustained serious injuries. In the year or so before this incident, and especially in the days leading up to it, there had been concerns about his mental health, and he had been detained twice the year before under the Mental Health Act 1983. He had also been arrested by police officers for assaulting members of his family. Both the police and the Trust sought to shut the claim down at an early stage, in effect on the basis that there could be no proper basis for a claim against them. The police succeeded in essence because they persuaded the judge that there could be no argument that they had failed to fulfil their duty of care by ensuring that Mr Lukes received appropriate clinical attention (see paragraph 149).

The position of the Trust, however, was different. One striking submission made on the Trust's behalf and recorded at paragraph 95 was that the claimant that at no point in August 2020 lacked capacity (to decide what is not set out in the judgment). The Trust also emphasised that Mr Lukes was not cooperative. At paragraph 179, Julian Knowles J observed that:

> *179. I next turn to the complaint that Mr Parish [a community psychiatric nurse] wrongly determined that he was unable to speak with C's mother, or write to his GP, to find out more information about his mental health because of C's lack of consent. The note made by Mr Parish on 12 August 2020 was, 'I am unable to speak with his mother or write to his GP without his consent, which he is clearly not going to give to me.'*
>
> *180. Initially, I was sceptical about this argument, and ventured during the hearing the possible view that whilst C's lack of consent might not have absolutely prevented Mr Parish from speaking to C's mother or GP, the reality is that any conversation would have been a short one of little value. I noted the absence of any clear pleading about what such a conversation could have revealed which would have been of assistance.*

Having reflected, however, I consider that there is force in Mr Woolf's submission that if he had spoken to C's mother or GP, Mr Parish could have asked – without breaching confidentiality - about what they had witnessed about C's state of mind over the previous two years and whether there had been in their mind concerns about his risk of self-harm and, if so, why.

Julian Knowles J found Mr Lukes had a reasonable prospect of showing that the Trust failed properly to ascertain his mental health history and so failed to carry out a proper screening assessment (paragraph 186). The question, though, was what flowed from that arguable breach.

187. […] I acknowledge the strength of the points made by Mr Trusted that: C had capacity; he repeatedly refused to engage with Mr Parish, which he was entitled to do; and that there is little to show that he was psychotic around 12 August 2020, or during the subsequent week when he dealt with Ms Hatfull, or when was assessed in Kings College Hospital in early September 2020 following his accident, and hence there was no basis for him being detained on any view.

188. However, the conditions for compulsory detention under the MHA 1983 for either assessment or treatment are not limited to cases of psychosis. Section 2(2) (admission for assessment) provides:

"(2) An application for admission for assessment may be made in respect of a patient on the grounds that -
(a) he is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and
(b) he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons."

189. Having capacity is also not a bar to being compulsorily detained. In the notes for 8 September 2019 following C's detention there was this from the duty psychiatrist:

"…Capacity Fully capacitous. Diagnosis Drug induced psychosis. Plan he needs antipsychotic medication. No indication for his prescribed citalopram. Not ready for section 17 leave yet prn medication."

190. I also cannot ignore the fact that C's detention in September 2019 took place despite C denying that he had 'any problems and reported that he actually feels quite clear in his head'.

191. It therefore seems to me that there is a triable issue as to whether a properly conducted screening by Mr Parish would have led to a further mental health assessment – or assessments - and compulsory detention in light of C's presentation, his extensive mental health history, and his MHA 1983 detention a year earlier. Whilst, as Mr Trusted said, it was not possible for Mr Parish himself to have conducted an assessment given C's refusals, there were other options open to him by way of referring the case upward to others who could have assessed C.

Julian Knowles J also found that there was a triable issue as regards the conduct of a Ms Hatfull, in the single point of access team:

192. Turning to the alleged breaches by Ms Hatfull, the gist of these is that she

failed to gather a proper history and failed to carry out a proper screening, despite apparent evidence of psychosis being relayed to her colleague Ms Pinduke, and wrongly discharged C. This is evidenced by her erroneous completion of the screening form.

193. I also consider that there is a triable issue that there were also breaches of duty by Ms Hatfull. As pleaded in [16] of the PoC, she was arguably wrong to state on the form she completed on 15 August 2020 that C was not known to local mental health services or other agencies; that there was no history of mental illness in the family; and that C had never attempted suicide. As to the last, whether what happened in January 2019 was properly an 'attempt' seems less important than the history of suicide threats by C which I outlined earlier. As to this, the box 'Client Risks (protective factors, self-harm, risk to others, risk from others, etc)' was left blank and no reference made to these earlier suicide concerns. Also, given that C had been arrested in the days before for assaulting his father and sister (and was then on bail), and had assaulted his grandfather the previous year, the fact no reference was made to this (as 'risk to others') is surprising. Whilst not said to be a breach of duty, this omission is perhaps indicative of the incomplete way in which Ms Hatfull conducted her assessment of C.

194. Again, I understand D1's case that circumstances were difficult in August 2020 because of COVID; that days earlier he had been fit for a PACE interview; and that he had capacity on 15 August 2020; that there is no evidence around that date he was at imminent risk of self-harm, or suffering from a mental illness, such that an urgent MHA 1983 assessment was then required.

195. However, all these matters seem to me to relate to triable issues. As I have already said, lack of capacity is not of itself a bar to compulsory detention. The risk of suicide was arguably not properly assessed by Ms Hatfull. And whether C was suffering from a mental illness requiring an urgent MHA 1983 assessment on 15 August 2020 is a matter of expert evidence. It is relevant that just four days later on 19 August 2020 he was found to require just such an urgent assessment and was said to be possibly psychotic.

It is very important to emphasise that the judge did not find that the Trust did breach its duty of care towards Mr Lukes – all he said was that Mr Lukes must have the chance to seek to establish his case at trial. However, his clear rejection of the assertion that 'having capacity' is sufficient to alleviate the need to consider detention under the MHA 1983 is very helpful. For those who want to think more about this issue, we recommend this video discussion with Dr Chloe Beale, a champion of critical thinking in this area.

MHA reforms, autism and learning disability

The always useful Parliamentary Office of Science and Technology has published the most recent of its POSTnotes on the proposed reforms of the Mental Health Act 1983, this time summarising the key reforms relevant to and including research evidence and stakeholder views on the impacts on autistic people and people with a learning disability.

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

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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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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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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:

1. Adults with Incapacity at the Horizon Hotel, Ayr on 22 May 2024, organised by Ayr Faculty (contact Claire Currie claire@1stlegal.co.uk)
2. Adults with Incapacity Conference in Glasgow on 10 June 2024, organised by Legal Services Agency (contact SusanBell@lsa.org.uk)
3. The World Congress on Adult Support and Care in Buenos Aires (August 27-30, 2024, details here)
4. The European Law Institute Annual Conference in Dublin (10 October, details here).

Advertising conferences and training events

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

Our next edition will be out in June. 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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