



General Editor

Kate Olley, Barrister, mental health specialist at Landmark Chambers, London. Co-author of "Local Authorities and Human Rights" (OUP) and former Chair of the Free Representation Unit

Consultant Editor

Ed Mitchell, Solicitor Legal Adviser to "Community Care" Magazine (R.B.I.) and General Editor of "The Journal of Community Care Law" (Arden Davies Publishing)

Contents

Detention under the Mental Health Act 1983

- Hospital Orders – *LS v Brent Magistrates Court*: Magistrates' Courts' hospital orders should not be challenged by way of judicial review 2

Mental Health Tribunals

- Community Treatment Orders – *AA v Cheshire & Wirral Partnership NHS Foundation Trust*: tribunal proceedings not lapse because, after they begin, a patient placed on community treatment order 4
- Overriding Objective – *MHA v Secretary of State for Work & Pensions*: nature of the overriding objective under the new tribunal rules 4
- Legal Representatives – *AA v Cheshire & Wirral Partnership NHS Foundation Trust*: appointing legal representatives for patients 6
- Reviews and Appeals – *AA v Cheshire & Wirral Partnership NHS Foundation Trust*: sitting of First-tier Tribunal may review one of its own decisions 7

Mental Health – General Issues

- Autism Act 2009 – analysis of the legal effect of the Act 8
- Negligence Claims – *Johnston v Merseyside Police*: permission test for bringing claim against a person for acts done under Mental Health Act 1983 9
- Inquests – *R (Dowler) v Coroner for North London*: finding of neglect following death of a patient from side-effects of anti-psychotic medication set aside due to unfairness / Coroners and Justice Act 2009: analysis of the new legislation 10
- Self-harm in detention – *R (Sharp) v West Kent PCT*: PCT not prevented from assisting the Prisons Ombudsman's investigation into a death in prison 12
- Asylum and Immigration – *MM (Iran) v Home Secretary*: interaction between mental illness, homosexuality and conversion to Christianity 13

National Health Service

- Health Act 2009 – NHS Constitution placed on a statutory footing / quality accounts 14
- Clinicians – *Edwards v Bro Morgannwg NHS Trust*: patient not entitled to insist on being treated by a particular doctor 16

Mental Capacity

- Human Rights – *Salontaji-Drobnjak v Serbia*: the need for fairness in proceedings depriving a person of legal capacity 17
- Court of Protection – *In the Matter of LD*: the need for fairness at all stages of personal welfare proceedings in Court of Protection / *Independent News & Media Ltd & Others v A*: attendance at private hearings of the Court of Protection 18
(contents continue over page)

Contents continued

Mental Health & Criminal Justice

- Rights at Trial – *Prezec v Croatia*: representation for mentally ill defendants 20
- Diminished Responsibility – reformulation of the defence of diminished responsibility by the Coroners and Justice Act 2009 21
- Police – *R (Crosby) v IPCC*: police acted reasonably in removing all clothes of a woman held in a police who appeared likely to self-harm 22
- Parole & Related Matters – *R (Lynch) v Category A Review Team*: whether psychologist's report properly recognised prisoner's progress towards his offending behaviour targets 22
- Sentencing – *R v Airey*: sentencing a mentally ill defendant for arson 23

Equality & Discrimination

- Disability Discrimination – *Secretary of State for Work & Pensions v Alam*: the duty to make 'reasonable adjustments' for an employee with depression 23

DETENTION UNDER THE MENTAL HEALTH ACT 1983

HOSPITAL ORDERS

LS v Brent Magistrates Court – Magistrates' Courts' hospital orders should not be challenged by way of judicial review

This was an interesting decision of the High Court about the proper course to take in order to challenge a decision of the Magistrates' Court to impose an interim or full hospital order. Despite what appeared to be clear doubts as to the validity of an interim hospital order, the High Court refused to intervene saying that the patient's legal representatives had effectively chosen the wrong route of legal challenge. The Court also drew attention to an important but often-overlooked provision which it said deems a patient to be present at a Magistrates' Court simply because his/her legal representative is in court.

The first interim hospital order

36 year old LS was convicted of breach of a restraining order by a Magistrates' Court. She had a history of mental health problems, having been diagnosed variously with a "mixed personality disorder" and "affective bi-polar disorder". As LS had been convicted of an offence punishable with imprisonment, the Magistrates' Court had the power to make an interim hospital order in respect of LS if, that is, the various conditions set out in s.38 of the Mental Health Act 1983 were met.

An interim hospital order may not be made unless two registered medical practitioners give evidence to the court that the offender is suffering from mental disorder and that it may be appropriate for a full hospital order to be made (s.38(1)). Importantly for this case, s.38(3) specifies that one of these medical practitioners must be employed by the hospital in which the patient would be detained if the order were made.

Neither of the registered medical practitioners who gave evidence to the Magistrates' Court in the present case were employed at the hospital proposed for LS. A nurse of the hospital did give evidence but, of course, he was not a registered medical practitioner for the purposes of s.38(3). The Magistrates' Court was aware of this apparent failure to comply with the requirements of s.38(3). Nevertheless, they went ahead and made what purported to be an interim hospital order and the patient was duly detained in hospital in reliance on that order.

The challenge to the first interim hospital order

The patient sought the High Court's permission to claim judicial review of the Magistrates' Court's decision to make an interim hospital order. The Court noted, unsurprisingly, that there appeared to be "considerable merit" in the argument that the interim hospital order was unlawful: "section 38 empowers the court to deny the person in question his liberty. In the ordinary way therefore it should be strictly complied with. Here it was not".

However, the High Court refused to grant permission to claim judicial review. As this was a decision of a Magistrates' Court, there were other legal remedies open to LS and her legal team. Judicial review is a remedy of "last resort" for challenging the legality of decisions of public bodies and 'inferior' courts which should not be used if an alternative avenue of challenge is available. These were explained by the High Court as follows:

"the claimant enjoyed statutory rights of appeal against the decision of the Magistrates' Court to the Crown Court under Section 108 of the Magistrates' Court Act 1980 and to the High Court by way of case stated under Section 111."

The High Court also pointed out that the case stated procedure would have provided a better platform for challenging the final hospital order:

"Were there anything in the suggestion that insufficient account was taken of the lack of symptoms, I repeat, an appeal by way of case stated would have given us the magistrates' relevant findings of fact which could then have been judged against the statutory provisions. In any event, all the medical practitioners who provided reports were plainly of opinion that the claimant was suffering from a mental disorder at the relevant time."

The second interim hospital order

An interim hospital order lasts for a maximum of 12 weeks (s.38(5)). Accordingly, an application for renewal must be made if clinicians think that an interim order needs to be maintained. An application for renewal was duly made in this case. It appears that by this time the Magistrates'





Court was concerned about the fact that no registered medical practitioner from LS's hospital gave evidence in connection with the first interim hospital order. As a result, rather than renew the interim order, the Magistrates' Court decided to make a fresh interim order and to do so in reliance on medical evidence that included evidence from a registered medical practitioner employed by LS's hospital.

LS did not attend court on this occasion. This may have been because a renewal hearing was anticipated and s.38(6) provides that "the power of renewing an interim hospital order may be exercised without the offender being brought before the court if he is represented by counsel or a solicitor and his counsel or solicitor is given an opportunity of being heard". LS's legal representative argued before the High Court that the fact that LS was not present at the hearing at which the fresh interim hospital order was made rendered it unlawful. This was rejected by the High Court as follows:

"in relation to the second order, it is said that the claimant's absence from court invalidates it. Her presence was implicitly required I think that is how it must be put by Section 38. However Section 122 (2) of the Magistrates' Court Act 1980 deems a defendant not to be absent from court if she is represented at the hearing by counsel or solicitor, as the claimant was on 20 January. Section 122 (2) does not however apply in the case of an enactment expressly requiring the litigant's presence (see Section 122 (3)). But it is plain that there is no such express requirement in Section 38.

I conclude that by force of Section 122 (2), the claimant was deemed not to be absent from court on 20 January."

The legality of the patient's admission to hospital

LS also argued that the hospital in which she was detained under the first interim hospital order acted unlawfully by failing to recognise that it was invalid (for the evidential reasons discussed above). LS said that the managers of that hospital were obliged to scrutinise the order to ascertain its validity. In support of this argument, LS referred to the Mental Health Act Code of Practice which states, at paragraph 13.12 that "documents should be scrutinised for accuracy and completeness" and, at paragraph 13.11 that "It is the hospital managers' responsibility to ensure that the authority for detaining patients is valid".

The High Court said that LS's argument was "misconceived" and that "the hospital is entitled to take documents dealing with admission, including apparent orders under Section 37 or Section 38, at their face value". It went on to say:

"it does seem to me to be right that it would be unreal and counter productive for the law to require the hospital managers, in effect, to take what may amount to sophisticated legal advice as to the validity of hospital orders. Presented with an interim order, they are obliged to admit the patient pursuant to Section 43 (d) of the Mental Health Act. As regards Section 37, the existence of such an order is by statute Section 40 (1) sufficient authority for the patient's admission.

The Code of Practice is nothing to the contrary. Of course I accept that the hospital must carefully ascertain that the documentation is in order and appropriate statutory orders are in place. But it is not their role to conduct an investigation, as it were, below the surface of the validity of the order".

The High Court was referred to the case of *R (on application of Care Principles Ltd) v Mental Health Review Tribunal* [2006] EWHC Admin 3194 as an authority said to support LS's argument. The Court disagreed, saying "I accept that there may in individual cases be circumstances which would put the hospital managers on warning. I do not accept there are such circumstances here".

The rights of hospital order patients to have the continued legality of their detention reviewed

LS also put forward human rights arguments based on the fact that rights to apply to a tribunal differ as between civil and hospital order patients. Civil patients, detained for treatment under s.3 of the Mental Health Act 1983, have the right to apply for discharge within the first six months of detention. Hospital order patients, however, do not. LS argued that this difference in treatment was unlawful discrimination contrary to Article 14 of the European Convention on Human Rights. The High Court disagreed

"As for Article 14, civil and criminal patients are not in like case. Criminal patients have already been before a court for sentence. They have statutory rights of appeal. Civil patients have no analogous right. Their admission to hospital will generally only be opposed as an alternative to a custodial sentence".

LS also argued that the fact that hospital order patients have to wait 6 months before they can apply to a tribunal means that the system does not ensure that the legality of their detention is considered by a tribunal at "reasonable intervals" as required under Article 5(4) of the European Convention on Human Rights. This argument was also rejected by the High Court:

"So far as access to a court at reasonable intervals may be required by Article 5 (4) in the case of a detention of a mental patient, that applies (see *X v United Kingdom* (1981) 4 EHRR 188 paragraph 52) where the respective detention is indefinite or lengthy. That is not so here. Unless reviewed under Section 20 [of the Mental Health Act 1983], an offender detained under Section 37 is free to leave hospital six months after the order. In any event, a period of six months before access to a tribunal may be had is not an unreasonable period: compare *Herczegfalvy v Austria* (1992) 15 EHRR 437."

The High Court (Laws LJ) gave its decision (refusing permission to claim judicial review) in *LS v Brent Magistrates' Court & the Hospital Managers of Chadwick Lodge Hospital* on 14 July 2009: [2009] EWHC 2704 (Admin).





MENTAL HEALTH TRIBUNALS

COMMUNITY TREATMENT ORDERS

AA v Cheshire & Wirral Partnership NHS Foundation Trust – tribunal proceedings do not lapse because, after they began, a patient was placed on a community treatment order

As it takes time to prepare a case for a tribunal hearing, it is possible that, by the time a patient's case comes before a tribunal, s/he is no longer detained in hospital but has been discharged under a community treatment order. The Upper Tribunal recently considered what should happen to the tribunal proceedings in such a case. The answer it gave was that the application or reference in respect of the patient nevertheless continues and, when heard, will be considered against the criteria applicable to patients under community treatment orders. In the Upper Tribunal's words:

"A tribunal has the power – or, if the conditions of section 72(1)(c) are satisfied, a duty – to direct that a person subject to a community treatment order be discharged notwithstanding that that person made the application to the tribunal while liable to be detained under section 2 or 3. Therefore, an application to the First-tier Tribunal made by or on behalf of a person detained under section 2 or 3 of the 1983 Act does not lapse if a community treatment order is made in respect of that person before the application is determined".

The Upper Tribunal went on to stress that, in such cases, "parties need to co-operate sensibly with each other and the First-tier Tribunal if a patient is made the subject of a community treatment order while an application to the tribunal is pending. In particular, it will clearly be incumbent on any representative of the applicant to inform the tribunal as soon as possible whether or not the application is being withdrawn and it is also clearly incumbent on all parties to inform the tribunal whether or not a postponement of any hearing that has already been fixed will be required in the light of the change of circumstances".

The Upper Tribunal also gave guidance as to how matters should proceed where the responsible hospital for a patient under a community treatment order is not the same as the hospital in which the patient was detained when the initial application or reference to the First-tier Tribunal was made. The issue here is that the parties to the case will alter, a matter which the Upper Tribunal considered could be dealt with simply:

"where the responsible hospital for a patient made subject to a community treatment order is not the same as the hospital where the patient was formerly detained, all that is required is to substitute the managers of the responsible hospital as a party in place of the managers of the other hospital (see rule 9 of the First-tier Tribunal Rules and rule 12 of the Mental Health Review Tribunal for Wales Rules 2008)".

The Upper Tribunal also addressed the potentially more challenging problems that arise when a patient's responsible hospital is situated in a different country to that in which the detaining hospital was situated:

"Although the 1983 Act is silent as to whether, if responsibility for a patient is transferred from a hospital in England to one in Wales, the First-tier Tribunal retains jurisdiction or whether a case may, or must, be transferred from the First-tier Tribunal to the Mental Health Review Tribunal for Wales, procedure rules for the two tribunals permit transfers from one to the other (see rule 7(3)(k) of the First-tier Tribunal Rules and rule 23(2) of the Mental Health Review Tribunal for Wales Rules 2008 (S.I. 2008/2705) and, anyway, the practical problems of one of the tribunals being obliged to retain jurisdiction could be overcome, particularly when regard is had to the overlapping membership of the two tribunals".

The Upper Tribunal (Judge Rowland) gave its decision in *AA v Cheshire and Wirral Partnership NHS Foundation Trust* [2009] UKUT 195 (AAC) on 1 October 2009.

OVERRIDING OBJECTIVE

MHA v Secretary of State for Work & Pensions – nature of the overriding objective under the new tribunal procedural rules

This was a benefits case considered by the Upper Tribunal. However, the Upper Tribunal made some general findings about the nature of the overriding objective which forms part of all the new First-tier Tribunal rules, including the rules which apply to mental health cases. The Upper Tribunal also made some useful comments about the exercise of the First-tier Tribunal's power to adjourn in the light of the overriding objective.

The overriding objective

The Upper Tribunal took the opportunity presented by this case to make some general findings about the nature of the 'overriding objective' of the procedural rules for the First-tier Tribunal (FtT), which in mental health cases are the Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008.

It is convenient to reproduce here rule 2 of the Rules, which contains and gives legal effect to the overriding objective. Rule 2 reads as follows:

- "(1) The overriding objective of these Rules is to enable the Tribunal to deal with cases fairly and justly.
- (2) Dealing with a case fairly and justly includes—





- (a) dealing with the case in ways which are proportionate to the importance of the case, the complexity of the issues, the anticipated costs and the resources of the parties;
 - (b) avoiding unnecessary formality and seeking flexibility in the proceedings;
 - (c) ensuring, so far as practicable, that the parties are able to participate fully in the proceedings;
 - (d) using any special expertise of the Tribunal effectively; and
 - (e) avoiding delay, so far as compatible with proper consideration of the issues.
- (3) The Tribunal must seek to give effect to the overriding objective when it—
- (a) exercises any power under these Rules; or
 - (b) interprets any rule or practice direction.
- (4) Parties must—
- (a) help the Tribunal to further the overriding objective; and
 - (b) co-operate with the Tribunal generally.

The Upper Tribunal made three general findings about the nature and operation of the overriding objective, all of which can be considered to be of general application:

- (i) The overriding objective of the Rules is simple. As paragraph (1) of rule 2 says, it is to enable the First-tier Tribunal to deal with cases “fairly and justly”. Paragraph (2) goes on to set out some examples of what dealing with a case fairly and justly involves. In the present case, the Upper Tribunal pointed out that these are merely examples and not an exhaustive list, it said that “the use of ‘includes’ in paragraph (2) indicates that the factors listed are illustrative, not comprehensive”.
- (ii) The parties (and by implication their representatives) must prepare their cases with a view to helping the FtT to achieve the overriding objective. As the Upper Tribunal said, “the duties imposed on the parties ties them to the same considerations that must inform the tribunal’s approach to its procedure in pursuance of the overriding objective”. This means, for example, that the parties must ensure “as far as possible that their case is ready by the time of the hearing”.
- (iii) The body of case law which grew up around the operation of the tribunals which the FtT replaced may no longer be relevant. The Upper Tribunal said that “the introduction of the overriding objective into the rules of procedure governing social security cases frees tribunals from the binding effect of previous authorities. They may continue to be relevant, but only to the extent that their principles are compatible with the overriding objective (*Albon (trading as NA Carriage Co) v Naza Motor Trading Sdn Bhd (No 5)* [2008] 1 WLR 2380)”. To the extent that the earlier cases illustrate underlying principles of fairness and justice (as many do) they will remain relevant.

The overriding objective: application to adjournment decisions

The Upper Tribunal next turned to give general guidance about the operation of the overriding objective when a party applies to the FtT for an adjournment. The FtT’s power to adjourn is contained in Rule 5 and, as with any of the FtT’s powers under the Rules, must be exercised with a view to meeting the overriding objective.

The Upper Tribunal stressed that there is no template for making correct adjournment decisions:

“In the majority of cases, there will be factors pointing both for and against a proposed adjournment. The nature of the decision is likely to require the tribunal to undertake a balancing exercise between competing considerations”.

The Upper Tribunal also pointed out that there is limited scope for the Upper Tribunal to interfere with the decision of the FtT on an adjournment application. The Upper Tribunal may only find that the FtT has erred in law in its balancing exercise on the grounds of irrationality. As a result, “different tribunals might properly make different assessments of the factors” and “the Upper Tribunal will not find an error of law simply because it would have made a different assessment”.

Nevertheless, the Upper Tribunal did feel able to identify three considerations which will normally be relevant to a decision as to whether it would be fair and just (i.e. in accordance with the overriding objective) to grant an adjournment. The three considerations were as follows:

- (i) what is the reason for the adjournment?
- (ii) why is the party seeking an adjournment not ready to proceed?
- (iii) what impact will an adjournment have on the other party and the operation of the tribunal system?

The Upper Tribunal (Judge Jacobs) gave its decision in case *MHA v Secretary of State for Work and Pensions* [2009] UKUT 211 (AAC) on 28 October 2009.





LEGAL REPRESENTATIVES

AA v Cheshire & Wirral Partnership NHS Foundation Trust – appointing legal representatives for unrepresented patients

In this case, the Upper Tribunal considered its and the First-tier Tribunal's powers to appoint legal representatives to represent patients in mental health cases. It arose in a somewhat unusual case. The case came before the First-tier Tribunal (FtT) on a reference made by a (displaced) nearest relative of a patient detained under s.3 of the MHA 1983. In other words, the patient had not applied for discharge. This was because he did not want to be discharged.

The patient did have a solicitor but the solicitor thought that the Official Solicitor should be appointed as his litigation friend to enable legal arguments to be made for the patient's discharge. This was because the solicitors thought that the patient's desire to remain detained was not in his best interests. They felt unable to put this point to the FtT because they thought it would involve them acting contrary to his instructions and thus breaching their professional obligations.

The case came before the Upper Tribunal. It conducted an in-depth analysis of its and the FtT's powers to appoint legal representatives for parties to proceedings before those Tribunals.

When can a legal representative be appointed?

The Tribunal Rules set out when a tribunal may appoint a representative for a party. The relevant provisions are materially the same for both the First-tier and the Upper Tribunal. In the case of the First-tier Tribunal, the relevant rule is Rule 11 of the Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008. This provides that, in a mental health case, the tribunal has the power to appoint a representative for a patient who does not have a representative appointed to him/herself in any of the following cases:

- (i) "the patient has stated that they do not wish to conduct their own case" (rule 11(7)(a));
- (ii) "the patient has stated that they...wish to be represented" (rule 11(7)(a));
- (iii) "the patient lacks the capacity to appoint a representative but the Tribunal believes that it is in the patient's best interests for the patient to be represented (rule 11(7)(b))".

Duty to act in accordance with instructions

The Upper Tribunal in the present case pointed out that any legal representative appointed for a patient must act in accordance with any valid instructions given by the patient:

"A patient may be capable of giving valid instructions and, where valid instructions are given, a solicitor must act in accordance with them."

The Tribunal went on to point out that in order to give valid instructions a patient must be able to do more than simply express a wish:

"The distinction between valid instructions and the mere expression of a wish is important. As [counsel] succinctly puts it: "An incapable patient ... can very frequently express a wish, even if he cannot express a capable opinion." Where a patient lacks the capacity to give valid instructions, wishes that are expressed cannot bind the solicitor in the same way as instructions".

Can a legal representative draw matters to the tribunals attention which appear to be in the patient's best interests?

As mentioned above, in the present case the patient's solicitors were concerned that his instructions required them to act in a manner which was not in his best interests. This did not mean that the solicitors were entirely unable to act to further what they considered to be their client's best interests. The Upper Tribunal said as follows:

"However, even where a patient has full capacity, a solicitor may be entitled, and in some circumstances may be under a duty, to draw a tribunal's attention to significant matters – particularly points of law – that appear to be in the patient's best interests despite his or her instructions and which it appears the tribunal might otherwise overlook. A solicitor has a duty not just to his or her client but also to the tribunal or, perhaps more accurately, to the administration of justice. A distinction is to be drawn between merely drawing a matter to a tribunal's attention and fully arguing it."

Later, the Upper Tribunal added:

"Once a point is drawn to a tribunal's attention, it is the tribunal's responsibility to ensure that it is adequately considered. In many cases, the tribunal will take the view that, the point having been drawn to its attention, it can develop it for itself without the need for further argument from solicitors or counsel, even where the point is one of law. In the First-tier Tribunal, that consideration is likely to be conclusive, which may well provide an explanation for the Official Solicitor's approach of not acting in tribunals".

Particular challenges in the case of representatives appointed for patients without capacity

As we saw above, a tribunal has the power to appoint a representative for a patient who lacks the capacity to appoint a representative him/herself. The Upper Tribunal suggested that, even where an appointment is made under this head, it is possible that valid instructions may be given. This





is because some patients, while not having the capacity to appoint a representative, may have the capacity to give valid instructions to a representative appointed by a tribunal. As the Upper Tribunal put it:

“Rule 11(7)(b), [which gives power to appoint a representative for a patient without the capacity to appoint a representative him/herself] is necessarily concerned with an appointment in respect of a patient who lacks the capacity to appoint his or her own representative. However, it is implicit in [counsel's] submissions that such a patient may, in some cases, still be able to give valid instructions in respect of aspects of his or her case. That may be correct in the light of section 3 of the Mental Capacity Act 2005 and I will accept for the purposes of this decision that it is.”

The Upper Tribunal went on:

“What, then, is the position if the patient does have the capacity to give instructions on some matters but not others? The Law Society's guidance is unequivocal: a solicitor is bound to act in accordance with the instructions that have been given. Therefore, the more a patient has the capacity to give detailed instructions, the less the solicitor has complete freedom of action.”

But if valid instructions cannot be given:

“rule 11(7)(b) plainly contemplates the possibility of a solicitor being appointed to represent a patient who does not have the capacity to give any instructions at all. In such a case, the rule must, as the Law Society's guidance plainly expects, anticipate that the solicitor will ascertain any relevant wishes that the patient may be able to express, will inform the tribunal of such wishes, make such points in support of them as can properly be made and generally ensure that the tribunal has all the relevant material before it and does not overlook any statutory provision. However, in the absence of the patient's capacity to give valid instructions, the rule must, in my view, also anticipate that the solicitor will exercise his or her judgment and advance any argument that he or she considers to be in the patient's “best interests”, which, as the Law Society's guidance recognises, will not necessarily involve arguing for the patient's discharge. In those circumstances, it seems to me that the solicitor has the same freedom of action as a litigation friend in the courts.”

Can the Official Solicitor be appointed as a litigation friend in tribunal proceedings?

The Upper Tribunal was of the opinion that the suggestion of the patient's solicitor that the Official Solicitor be appointed as his litigation friend (so that, as such, he could advance arguments as to the patient's best interests) was unlikely to be possible as a matter of law, for these reasons:

“the Upper Tribunal is a creature of statute and has no statutory power to appoint a person to represent a patient's interests other than the power contained in rule 11(7) and, secondly, that the powers and duties conferred on the Official Solicitor through legislation and through directions made by the Lord Chancellor are expressed in terms of proceedings in the courts rather than in tribunals. An answer that requires more explanation is that, at least in this case, justice does not require anyone to be appointed in a role equivalent to that of a litigation friend”.

Despite that, the Upper Tribunal did say that there might be merit in empowering the Official Solicitor to act in Upper Tribunal proceedings:

“That is not to say that there might not be some purpose in extending the Official Solicitor's role to tribunals so that the Official Solicitor, rather than the Attorney General, might be invited to instruct an advocate to the tribunal. Perhaps more importantly, if it is correct that a person incapable of instructing solicitors can nonetheless give valid instructions that limit the freedom to act in the patient's best interests that a solicitor appointed by a tribunal would otherwise have, it may be desirable – now that judicial review has been replaced by a statutory appeal to the Upper Tribunal – for the Official Solicitor to be empowered to bring an appeal in the interests of a patient when the patient declines to do so. Those, however, are not matters that arise in the present case”.

The Upper Tribunal (Judge Rowland) gave its decision in *AA v Cheshire and Wirral Partnership NHS Foundation Trust* [2009] UKUT 195 (AAC) on 1 October 2009.

REVIEWS AND APPEALS

AA v Cheshire & Wirral Partnership NHS Foundation Trust – a sitting of the First-tier Tribunal is not prevented from reviewing or considering an application for permission to appeal against one of its own decisions

The Upper Tribunal recently considered whether it is fair, and thus lawful, for a First-tier Tribunal to consider an application for permission to appeal against one of its own decisions, or to carry out a review of its decision. The Upper Tribunal said that the argument that this was unfair was “completely misconceived”.

So far as applications for permission to appeal are concerned, the Upper Tribunal said:

“There cannot be anything unfair in an initial application being made to the judge who made the decision being challenged when there is an automatic right to renew the application to a superior court or tribunal. Fairness does not demand that the First-tier Tribunal be able to consider the issue at all. The advantage to a superior court or tribunal of having this kind of procedure is that it gives the judge whose decision is being challenged, who will have the relevant issues in mind, an opportunity to comment on the grounds of appeal and indicate whether he or she thinks there is anything in them”.





So far as the review of its own decisions by the First-tier Tribunal is concerned, the Upper Tribunal said:

"there is no general rule that it is unfair for a review of a decision to be carried out by the person who made the original decision. Whether or not that is appropriate depends on the context and the nature of the review. In some contexts, it will be positively desirable that the review is carried out by the person who made the original decision. In other contexts, it will be desirable that the review be carried out by a different, and perhaps more senior, person. Here, the power of review conferred by section 9 of the Tribunals, Courts and Enforcement Act 2007 is, with an immaterial exception, limited by rules 47 and 49 of the First-tier Tribunal Rules (made under section 9(3) of the Act) to cases where there has been an application for permission to appeal and the First-tier Tribunal is satisfied that there was an error of law in the decision being made. As an appeal under section 11 lies only on a point of law, a review must be seen as an alternative to granting permission to appeal and enables the First-tier Tribunal to provide a swifter remedy in obvious cases than can be provided by the Upper Tribunal. There are bound to be occasions when a judge reading grounds of appeal realises he or she has made a mistake or overlooked something and in such cases the parties should not be put through an appeal. It is not unfair for this limited power to consider reviewing a decision to be exercised by the judge who gave that decision for the same reason that it is not inappropriate for him or her to deal with the application for permission to appeal. Considering whether to review a decision is merely part of the process for dealing with an application for permission to appeal against the substantive decision in which it is always open to the applicant to take the case to the Upper Tribunal".

The Upper Tribunal (Judge Rowland) gave its decision in *AA v Cheshire and Wirral Partnership NHS Foundation Trust* [2009] UKUT 195 (AAC) on 1 October 2009.

MENTAL HEALTH – GENERAL ISSUES

AUTISM ACT 2009

The Autism Act 2009 received Royal Assent on 12 November 2009. The lynchpin of the Act is the requirement for Secretary of State (for Health) to publish an "autism strategy" by 1 April 2010 (s.1(3)) but the Department of Health have said that they aim to publish a strategy before then. By s.1(1) this is a:

"strategy for meeting the needs of adults in England with autistic spectrum conditions by improving the provision of relevant services [NHS services and social services] to such adults by local authorities, NHS bodies and NHS foundation trusts".

As that provision says, the Act applies to England only.

Legal effect of the autism strategy: the Secretary of State's guidance

Section 2 of the Act is what gives the autism strategy some legal force. S.2(1) provides that the Secretary of State must, for the purpose of securing implementation of the strategy, by 31 December 2010 issue guidance to local authorities (with social services functions) and NHS bodies (other than NHS Foundation Trusts). The Department of Health is committed to carrying out a consultation exercise prior to finalising its guidance. In legal terms, this is strong policy guidance because it is treated as if given under s.7 of the Local Authority Social Services Act 1970. The Explanatory Notes say:

"Section 7 of the Local Authority Social Services Act 1970 ("the LASS Act") requires local authorities, in exercising their social services functions, to act under the general guidance of the Secretary of State ("section 7 guidance"). Case law has established that complying with this requirement involves more than simply taking account of the guidance. Rather, local authorities must "follow the path charted by the guidance, with liberty to deviate from it where the authority judges on admissible grounds that there is good reason to do so, but without freedom to take a substantially different course" (*R v Islington Borough Council, ex parte Rixon* (1998 ICCLR 119)). A local authority which failed to comply with section 7 guidance without a compelling reason for doing so would be acting unlawfully and could find itself subject to judicial review or default action by the Secretary of State".

Section 2 specifies certain matters about which guidance must be given to local authorities and the NHS (the Secretary of State is free to issue guidance about additional matters):

- (a) the provision of relevant services for the purpose of diagnosing autistic spectrum conditions in adults;
- (b) the identification of adults with such conditions;
- (c) the assessment of the needs of adults with such conditions for relevant services [footnote on how this not accompanied by an amendment to s.47 1990 Act];
- (d) planning in relation to the provision of relevant services to persons with autistic spectrum conditions as they move from being children to adults;
- (e) other planning in relation to the provision of relevant services to adults with autistic spectrum conditions;
- (f) the training of staff who provide relevant services to adults with such conditions;
- (g) local arrangements for leadership in relation to the provision of relevant services to adults with such conditions.





The definition of 'autistic spectrum conditions'

The Explanatory Notes to the Act explain why it contains no definition of the term "autistic spectrum conditions":

"Autistic spectrum conditions are lifelong conditions which affect how a person communicates with, and relates to, other people and the world around them. The word "spectrum" is used because the characteristics of the condition vary from one person to another. As research and experience refines the understanding of autism, so the range of characteristics will change. It is because of this that no definition of the term "autistic spectrum condition" has been included in the Act. The intention is that definitional issues will be dealt with in the autism strategy, which, as it has to be kept under continual review, will allow for changes to be made much more quickly in response to new developments than if the definition were to be included in primary legislation".

NHS Foundation Trusts

The guidance will not apply to NHS foundation trusts in the same way as they apply to other NHS bodies such as NHS Trusts and PCTs. Although the Secretary of State is required by section 2(1)(b) to issue guidance to NHS foundation trusts, they are not required by section 3(1) to act under the guidance. The effect of and rationale for this is described as follows by the Act's Explanatory Notes:

"This means that NHS foundation trusts will be expected to take the guidance into account in planning and providing services for adults with autistic spectrum conditions, but they will not have the same duty to act under it as local authorities and NHS bodies (the definition of NHS bodies in section 4(1) does not include NHS foundation trusts). This reflects the greater autonomy of NHS foundation trusts."

Links – www.opsi.gov.uk/acts/acts2009/ukpga_20090015_en_1 – the Autism Act 2009 is available here.

www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/LocalAuthorityCirculars/DH_109715 – the letter explaining the Department of Health's timetable for preparing an autism strategy.

NEGLIGENCE CLAIMS

Johnston v Chief Constable of Merseyside Police – High Court modifies the test for deciding whether a person will be granted permission to claim against a person for acts done under the Mental Health Act 1983

In this case, the High Court modified the test to be applied when deciding whether to grant permission for a civil claim to be brought against a person acting in pursuance of the Mental Health Act 1983. The result is that, where an application for permission is made, the focus is likely to be on whether the claim has a realistic prospect of success.

The facts

Mr J had a history of mental health problems, including schizophrenia. In 2006 an ambulance with police back-up was called to Mr J's residence because the person with whom he was staying became concerned about his behaviour. An incident occurred during which a police officer sprayed CS gas on Mr J's face which caused serious chemical burns. The police then detained Mr J and took him to hospital. No criminal proceedings were brought. Mr J argued that the police officer's actions were wholly unnecessary and, as a result, wished to bring a civil claim for false imprisonment and assault against the officer's police force, Merseyside police.

Mr J's claim faced two obstacles:

- (i) the first arose because of the mental health context to this case. The police officer alleged that he was acting under s.136 of the Mental Health Act 1983, which is the police's power to remove mentally disordered persons found in a public place to a place of safety. A claim made against a person purportedly acting in pursuance of the Mental Health Act 1983 may not be brought without the permission of the High Court (s.139 of the 1983 Act);
- (ii) the second obstacle was of a more general nature. It was whether Mr J's claims were barred as having been issued too late under the Limitation Act 1980.

S.139 of the Mental Health Act 1983: the test to be applied

The first issue on this aspect of the claim was for the High Court to identify the relevant test to be applied under s.139 of the Mental Health Act 1983 in deciding whether to give permission for civil proceedings to proceed. The leading case has been that of the Court of Appeal in *Winch v Jones* [1986] 1 QB 296, where it was held that the test for deciding whether permission to proceed with a claim should be granted is whether the matter "deserves the fuller investigation which will be possible if the intended applicant is allowed to proceed". In the present case, the High Court said that it would be wrong significantly to modify the *Winch v Jones* test in the light of the fact that, since that decision was given, a new set of Civil Procedure Rules have come into operation. However, it did decide that one modification was called for given the Rules' "new emphasis on allowing claims to go to trial only where they have a real prospect of success". As a result, the High Court held:

"a court faced with an application for permission under section 139 (2) of the Act must strive to apply the test...in *Winch v Jones*...with the proviso that the court should also consider whether, in all the circumstances, the proposed claim has a real prospect of success".





Why did the High Court grant leave under s.139?

Applying that modified test described above, the High Court gave leave for the civil claim against the police to proceed. The Court concluded that it did have a real prospect of success for the following reasons:

- (i) the woman in whose home Mr J was staying gave a witness statement which supported Mr J's account that, when sprayed with CS gas, he was submissive and offering no resistance to the police;
- (ii) a witness statement from a consultant dermatologist said that, in the light of Mr J's injuries, over half a can of CS gas must have been discharged only a short distance away from his face. While there was evidence from the police which countered that of the consultant dermatologist, the High Court said that this conflict of evidence was of little significance for the purpose of determining whether the claim had a real prospect of success because Mr J's severe injuries "make it at least arguable that the force used was excessive";
- (iii) there was "legitimate debate" as to whether the PC who sprayed the CS gas informed Mr J at the time of the incident that he was acting under s.136 of the Mental Health Act 1983.

The Limitation point

Civil claims are subject to time limits; sometimes, as in this case, the limit varies according to the type of claim. Mr J brought a civil claim for false imprisonment and a civil claim for assault. The limitation period for false imprisonment claims is 6 years and so there was no limitation problem with that claim. The assault claim, however, was subject to a 3 year limitation period. Mr J brought his claim outside that limit (he was 2 months late). As he was out of time, he had to persuade the court to exercise its discretion under s.33 of the Limitation Act 1980 to allow his late claim to proceed.

The High Court decided to allow the assault claim to proceed. Its principal reason for doing so was that the delay in this case was relatively short and had not been the fault of Mr J. The major part of the delay was caused by a misunderstanding on the part of his legal advisers in that an initial claim form was issued before permission under s.139 of the Mental Health Act 1983 had been obtained. Where a claim which requires s.139 permission is issued before the permission is granted, the claim is a nullity. That explains why Mr J had to issue fresh proceedings just after expiry of the 3 year time limit for bringing the assault claim. In allowing the claim to proceed out of time, the High Court also relied on the fact that the delay had not caused the police any prejudice in defending the claim.

The High Court (Coulson J) gave its decision in *Johnston v Chief Constable of Merseyside Police* on 20 November 2009: [2009] EWHC 2969 (QB).

INQUESTS

[R \(Dowler\) v Coroner for North London](#) – finding of neglect following death of a patient from side-effects of anti-psychotic medication set aside due to unfairness

Most legal challenges to inquests with a mental health context involve the assertion that there was insufficient investigation of the health care which the deceased did or did not receive. However, other parties have a legitimate interest in the conduct of an inquest. In this case, a General Practitioner challenged the verdict of an inquest which criticised the care she gave to a patient who died from a side-effect of anti-psychotic medication. The High Court was highly critical of the conduct of the inquest which did not safeguard the Practitioner's interests at all.

The death and the inquest

The deceased had a diagnosis of paranoid schizophrenia and was taking anti-psychotic medication, olanzapine. A known but rare side effect of that medication is diabetic ketoacidosis.

The deceased saw a General Practitioner on 27 May 2008. The GP concluded that the deceased needed an "urgent" fasting blood sugar test for diabetes; the requirement for 'urgency' being subsequently said to mean that it should be performed within 4 to 5 days. Two days later, however, the deceased died of diabetic ketoacidosis without the test having taken place.

An inquest was held and clearly went badly wrong. The GP was not given notice of the inquest and so was denied the opportunity to participate in it. She should have been given notice under the Coroners Rules. Those Rules also gave the GP, as a person whose conduct was likely to be called into question, the right to examine witnesses in person or by an advocate but, as she was unaware of the inquest, the GP was unable to exercise those rights.

The inquest concluded that the deceased had died of a recognised side-effect of his medication, contributed to by "neglect". In the inquest context, this was a strong and highly adverse finding so far as the GP was concerned. The meaning of neglect in this context was provided by the case of *R v H.M. Coroner for North Humberside and Scunthorpe, ex parte Jamieson* (1995) QB 1 as follows:

"Neglect in this context means a gross failure to provide adequate nourishment or liquid, or provide or procure basic medical attention or shelter or warmth for someone in a dependent position (because of youth, age, illness or incarceration) who cannot provide it for himself. Failure to provide medical attention for a dependent person whose physical condition is such as to show that he obviously needs it may amount to neglect. So it would be if it is the dependent's mental condition which obviously calls for medical attention."





The coroner went on to say that the GP should have recognised that the deceased required a fasting blood sugar test as an "emergency".

The legal challenge

Where an inquest has been held, s.13 of the Coroners Act 1988 provides the High Court with the power to order another inquest to be held where that is "necessary or desirable" on various grounds such as "irregularity of proceedings", "insufficiency of inquiry" or "discovery of new facts or evidence". The GP (having obtained the authority of the Attorney General to bring the application) applied to the High Court for it to exercise its powers under section 13 to order another inquest and for it to be conducted by a different coroner.

The High Court granted the GP's application. The threshold for making an order under s.13 was met because there were serious procedural irregularities in the original inquest, in which the GP had been unable to participate. The GP had also obtained new evidence in the form of expert evidence about the standard of competence expected of a GP faced with a patient such as that which faced this GP on 27 May 2008. This expert expressed the opinion that the GP had provided the deceased with a high standard of care and that competent care did not call for the deceased to have been given a fasting blood sugar test before his death. Given the defects in the original inquest, the Court concluded that it was necessary or desirable in the interests of justice for a new inquest to be conducted at which the GP will, of course, have the opportunity to participate or be represented in accordance with the Coroners Rules.

The High Court also ordered that the new inquest should be conducted by a different coroner. The original coroner had shown a surprising disregard for the Coroners Rules which clearly required the GP to have been given notice of the inquest. This suggested that the coroner had "closed his mind" to the possibility that the GP had acted properly. As a result, the interests of justice required the new inquest to be held by a different coroner.

The High Court, Divisional Court (Dobbs J) gave its decision in *R (Dowler) v Coroner for North London* on 6 November 2009: [2009] EWHC 3300 (Admin).

CORONERS & JUSTICE ACT 2009

Analysis of the new legislation governing coroners and inquests

The Coroners and Justice Act 2009 was enacted on 12 November 2009. When the Act is brought into force, it will repeal the existing legislation governing the work of coroners, the Coroners Act 1988. Most of the differences between the two legislative systems are organisational rather than substantive changes to the operation of the coronial system. There are, however, some important points of difference with the current legislation which are relevant to deaths of detained person as a result of self-harm and so will be of interest to some readers.

Key points are as follows:

- (i) Under section 1 of the 2009 Act, a "senior coroner" must investigate certain deaths in his/her area. This includes a death in "custody" or "state detention". "State detention" is defined in section 42(2) as follows: "a person is in state detention if he or she is compulsorily detained by a public authority within the meaning of section 6 of the Human Rights Act 1998". Accordingly, it is clear that a person who dies while detained in hospital under the Mental Health Act 1983 is in state detention.
- (ii) A large body of case law has developed since the enactment of the Human Rights Act 1998 as to how the current legislation, the Coroners Act 1988, should be operated so as to ensure an investigation into a death in state detention is compliant with the investigative obligation under Article 2 of the European Convention on Human Rights (see the article below for further details of the underlying issues). That case law culminated in the decision of the House of Lords in *R (Middleton) v West Somerset Coroner & Another* [2004] 2 AC 182 where the Law Lords held that, in considering the statutory question of "how" a person died, an inquest should in an Article 2 case consider "by what means and in what circumstances" a person came by his/her death. The 2009 Act converts this key case law finding into a statutory provision. Subsection (1)(b) of section 5 of the 2009 Act sets out the matters to be ascertained by an investigation under the Act as including "how, when and where the deceased came by his death". Subsection (2) of that section goes on to provide that:

"Where necessary in order to avoid a breach of any Convention rights (within the meaning of the Human Rights Act 1998), the purpose mentioned in subsection (1)(b) is to be read as including the purpose of ascertaining in what circumstances the deceased came by his or her death."

Accordingly, the body of case law about when an 'expanded' investigation is required in order to secure compliance with Article 2, and what it should comprise, remains applicable. For a full details, see our analysis of *R (Lewis) v HM Coroner for the Mid and North Division of Shropshire* [2009] EWHC 661 (Admin) in issue 57.

- (iii) Section 7 of the Act sets out when a jury inquest should be held as part of an investigation under the Act. Amongst the cases in which a jury inquest is required are those where a senior coroner has reason to suspect:

"(a) that the deceased died while in custody or otherwise in state detention, and that either—

- (i) the death was a violent or unnatural one, or
- (ii) the cause of death is unknown" or

"(b) that the death resulted from an act or omission of—

- (i) a police officer, or





(ii) a member of a service police force,

in the purported execution of the officer's or member's duty as such"

Accordingly, the most commonly encountered unnatural deaths of persons in poor mental health who are being subject to coercive powers of the state, whether through being detained in prison or hospital or during the arrest process, will require jury inquests.

- (iv) Where an inquest is held, the jury (or coroner in non-jury inquests) must make determinations as to how, when and where the deceased came by his death, including determinations as to the circumstances of death where that is necessary to ensure Article 2 compliance.
- (v) The current restrictions on the determination of an inquest determining any question of criminal liability on the part of a named person or civil liability are maintained.
- (vi) Section 51 of the Act extends the availability of publicly-funded legal representation for families of deceased persons at inquests. The Explanatory Notes to the 2009 Act describe this section as follows:

"Section 6(6) of the Access to Justice Act 1999 states that the Legal Services Commission may not fund, as part of the Community Legal Service, any of the services specified in Schedule 2 to that Act. Paragraph 2 of Schedule 2 states that the Legal Services Commission may not fund advocacy, except in the circumstances listed in that paragraph.

Section 51 amends the list in paragraph 2 of circumstances where advocacy can be made available by adding...inquests into the deaths of persons who die while in the custody of the State, or those who die in the course of a police action or arrest. The Legal Services Commission will be authorised to fund advocacy for family members to be represented at such inquests, subject to the funding criteria in the Funding Code made under section 8 of the Access to Justice Act 1999 being met. Funding would also be subject to a means test."

- (vii) Schedule 5 to the 2009 Act provides, in paragraph 7, that in certain cases a senior coroner must, at the end of an investigation, make reports to authorities or organisations with a view to preventing similar deaths in the future (currently, the coroner merely has the statutory power to make such reports). The person or organisation to whom the report was made must respond in writing to that report. Further provision may be made in regulations enabling reports and responses to be published.
- (viii) The office of Chief Coroner is created, to lead the coroners service. Amongst the functions of the Chief Coroner will be that over presiding over a new appeals process. Therefore the High Court will no longer hear challenges to inquests, or failures to hold inquests, such as that considered in the previous article in this issue.

SELF-HARM IN DETENTION

R (Sharp) v West Kent PCT – PCT not prevented from assisting the Prisons Ombudsman's inquiries into a death in a prison for whose healthcare arrangements the PCT was responsible

In this case, a challenge was brought to the arrangements whereby the NHS is involved in Prison Ombudsman investigations into an apparent suicide in prison custody. Here are the relevant background facts:

- (i) Mr S died in HMP Maidstone in September 2008, to which he had been admitted 15 days previously. He had a well-documented history of mental illness;
- (ii) the circumstances suggested that Mr S may have committed suicide, in that he was found hanging;
- (iii) in accordance with the policy of the Secretary of State for Justice, the Prisons Ombudsman commenced an investigation into Mr S's death. Under that policy, the Ombudsman was expected to ask the NHS to investigate in accordance with "existing procedures" the health care provided to Mr S;
- (iv) the Ombudsman duly asked the Primary Care Trust in whose area HMP Maidstone is situated, the West Kent PCT, to investigate. That PCT was also responsible for commissioning health care services for HMP Maidstone;
- (v) the PCT arranged for one of their officers to carry out an investigation. That officer had not been involved in the provision of health care services within HMP Maidstone;
- (vi) an investigation by the coroner will also be carried out, as required by the Coroners Act 1983, because Mr S died in prison custody.

The nature of the legal challenge

The European Court of Human Rights (ECtHR) has decided that the obligation to protect life under Article 2 of the European Convention on Human Rights requires State bodies to ensure that an effective independent investigation is carried out where certain deaths occur, including deaths in State custody (*Jordan v UK* (2001) 37 EHRR 52). In England and Wales, the inquest is usually the vehicle by which this obligation is discharged. In such cases, the inquest must result in a verdict which "can and should address the chain of events relevant to and leading to the death in question": *R (Lewis) v HM Coroner for the Mid and North Division of Shropshire* [2009] EWHC 661 (Admin): see issue 57.

As the High Court observed in the present case, investigation of that chain of events leading to Mr S's death is likely to involve consideration of the NHS mental health treatment provided for Mr S in prison. The Prisons Ombudsman will therefore be relying on a body which is potentially





implicated in the death to assist in his investigation of it. The deceased's family argued that such a body could not possibly produce a report which could be considered independent.

The legal argument next pointed out that the Prisons Ombudsman's report would be seen by the coroner conducting the inquest and would be likely to affect the coroner's decisions about the matters to be investigated and which witnesses to call to give evidence. Mr S's family, who brought this claim for judicial review, argued that the involvement of the NHS in producing that report would mean that an essential aspect of the circumstances of the death would not be independently investigated. Accordingly, it was argued, the coroner's investigation would be tainted by association if it were to rely on the Prison Ombudsman's report and it would not amount to an effective and independent investigation such as is required to ensure discharge of the Article 2 investigative obligation. In order to prevent that happening, it was claimed that the Prisons Ombudsman was required not involve the NHS in investigating the mental health treatment provided to Mr S prior to his death.

The High Court's view

The High Court refused to grant permission to bring a claim for judicial review. The Court was not convinced that the involvement of the NHS in the Ombudsman's investigation would necessarily prevent the subsequent inquest from discharging the Article 2 requirement for an effective and independent investigation. The Court said:

"In advance of the inquest it is extremely difficult in this class of case to reach any provisional conclusions as to whether any part of investigation has been inadequate, and certainly it is impossible in this case where the report of the officer of the PCT is not before the court and will be, in due course, available to those participating in the inquest".

It can be seen, therefore, that the Court rejected the argument that, as a rule, a PCT should not in cases such as this be involved in investigating the prison health care for which it was responsible. The High Court judge went on to say:

"I do not accept that, in this case, on the information presently available to the court, there is an obligation of complete independence in the sense of no person playing a role in the investigative process having any connection at all with the health care authority that provided the health care to the prison. I do not accept that that proposition is an absolute and invariable requirement of the provisions of Article 2".

The Court also pointed out that the deceased's family will have the opportunity at the inquest to "participate, to pose questions, to make submissions to the coroner as to what should be investigated, and in particular to enable the adequacy of any investigation to be examined in an appropriate degree of critical detail". So, even if there is some defect in the PCT and Ombudsman's report there will be an opportunity for those matters to be further considered at the inquest itself. As the Court went on to say, "that assessment [by the PCT] is not a final assessment. It is capable of challenge and investigation. If that assessment proves flawed, doubtless there will be the opportunity for the coroner and/or a jury to say so".

Might PCTs be prevented from investigating in some cases?

It should also be recorded that the High Court accepted the possibility that in some cases the possible role of a PCT in a death in prison custody would be so central to the events under investigation that some other NHS body should assist the Prisons Ombudsman in his investigation. Here are the High Court judge's views on this topic:

"I would accept that, since these questions are fact sensitive, one can never be prescriptive as to what the requirements of investigation into a death in custody may amount to in terms of independence and adequacy by reason of the first acts not being performed by someone outside the employment of the Trust. It may well be that cases arise where the Ombudsman, making a reference to the NHS as required to do by the terms of the Secretary of State's policy, the Trust to whom the reference is made must recognise that their own actions may be so critical, and their own policy judgments of such importance to the outcome of the particular investigation, that the only appropriate course of action is to sub delegate any investigation that is required by the Ombudsman to an independent part of the NHS outside the Primary Care Trust concerned".

The High Court (Blake J) gave its decision in *R (Sharp) v West Kent PCT and the Secretary of State for Justice* on 25 September 2009: [2009] EWHC 3243 (Admin). Since this decision was given on an application for permission to claim judicial review, it may not be cited in court; it is offered here for information only.

ASYLUM AND IMMIGRATION

MM (Iran) v Home Secretary – interaction between mental illness, homosexuality and conversion to Christianity for the purposes of resisting deportation to Iran

In many mental health immigration cases, the key issue is the sufficiency of available treatment and other forms of support in the state to which attempts are being made to return a person with a mental illness. In this case, there was an additional factor namely whether an Iranian's mental health would heighten the risk that he would bring other factors to the unwelcome attention of the Iranian authorities, namely his homosexuality and conversion to Christianity.

The background

M, who is now aged 37, claimed asylum in 2007. He relied on three matters:

- (i) the fact that he was a homosexual;
- (ii) the fact that he had converted to Christianity;





(iii) his poor mental health.

The claim had a complicated procedural history. On the first judicial consideration of the claim, an immigration judge accepted that M was a homosexual and that his conversion to Christianity was genuine. However, the judge went on to find that, provided M was discreet about practising Christianity and homosexuality, there was no reason to suppose he would be subject to mistreatment by the Iranian authorities. As regards M's mental health, the immigration judge accepted the following medical evidence given about M:

"[he] suffers from PTSD, depression, auditory hallucinations, and persecutory ideas of reference of modest severity; it could be an indication of early schizophrenia. He has been on medication of varying intensity but needs psychological intervention. His attitude is one of hopelessness and returning him to Iran would be likely to worsen his PTSD and depression. He thinks about suicide, which is a real possibility although he has no plans at present. It is imperative [MM] has access to psychiatric services to review his safety and ensure his access to, and compliance with, medication."

However, applying the factors identified in the Court of Appeal's decision in *J v the Home Secretary* [2005] EWCA Civ 629, the immigration judge concluded that Article 3 of the European Convention on Human Rights (prohibition of inhuman or degrading treatment) did not prevent M's deportation on mental health grounds. As we looked at in-depth in issue 56, the decision in *J* identifies a number of factors to be considered by a body charged with deciding whether Article 3 of the Convention prevents the deportation of a person who may commit suicide upon his/her return. One of these is whether there are available in the receiving state effective mechanisms, including family support, to reduce the risk of suicide. The immigration judge concluded that there were effective mechanisms in this case due to the fact that anti-psychotic medication is now widely available in Iran and that M's Iranian family had "not said they would not help him".

M appealed against that decision and his appeal was allowed on two bases. First, that the Immigration Judge had not considered whether the interaction of M's mental illness with his homosexuality and Christianity might heighten the risk he faced of maltreatment by the Iranian authorities, i.e. whether his mental illness might cause him to be brazen in his practice of Christianity or homosexuality. Second, that it was arguable that the immigration judge had not properly considered whether there were "effective mechanisms" available in Iran to prevent M from committing suicide. It was arguable that reliance on the fact that M's family had 'not said they would not help him' was an insufficient investigation of this important aspect of the case.

The case was then reconsidered by two immigration judges. They did not accept the genuineness of M's purported conversion to Christianity. They also went on to find that Article 3 did not prevent M's deportation. They referred to the availability of psychiatric services for M in Iran and said that they did not think that M's mental state was such that he was likely voluntarily to being a homosexual. M brought a further appeal against that finding to the Court of Appeal.

The Court of Appeal's decision

The Court of Appeal allowed the appeal. The immigration judges had not been entitled to re-open the question of whether M's conversion to Christianity was genuine. This had not been disputed by the Secretary of State and so the judges should have made their decision on the basis that M had genuinely converted to Christianity. Their failure to do so was an error of law. It meant that they had not properly assessed the risks which M would face if he were returned to Iran. The matter must now be considered afresh on the basis that M is a genuine Christian.

In addition, the Court of Appeal found that M had still not had a judicial determination of whether there were effective mechanisms in Iran to prevent him committing suicide. What was in particular required was a reasoned finding as to the level of support available to M in Iran from his family. However, it should be noted that the Court of Appeal went on to express doubt as to whether M's claim would succeed even if, as he alleged, his Iranian family wanted nothing to do with him. This is because it is particularly difficult to rely on suicide risk to prevent deportation taking place. In the words of one of the Court of Appeal judges:

"I have significant doubts whether, even in the absence of family support, MM's appeal can sustain the difficulties of the jurisprudence ranged against him. Nevertheless, particularly in the light of the history of these proceedings whereby the second issue on which second stage reconsideration was required has not been specifically answered, I am just persuaded that I cannot find that MM's appeal on this ground must inevitably be decided against him. Therefore I would remit it as well".

The Court of Appeal gave its decision in *MM (Iran) v Secretary of State for the Home Department* on 10 November 2009: [2009] EWCA Civ 1167. The Court was comprised of Rix, Moses and Rimer LJ.

NATIONAL HEALTH SERVICE

HEALTH ACT 1999

The NHS Constitution – contents and legal effect

Chapter 1 of Part 1 of the Health Act 2009, which received Royal Assent on 12 November 2009, places the NHS Constitution on a statutory basis and gives it a degree of legal force. The Constitution itself is already in existence, having been published in January 2009 (see 'links' below).

The duty to 'have regard' to the NHS Constitution

NHS bodies in England, such as NHS Trusts and Primary Care Trusts, are required by s.2(1) of the Act to "have regard" to the NHS Constitution in performing their NHS functions. This means that the Constitution is more than a set of legally ineffective aspirations. The fact that various bodies are statutorily required to "have regard" to it gives it a particular legal status. By analogy with the existing case law on duties to have regard to





something, NHS bodies must (a) take the Constitution into account when performing their functions and (b) if they decide to depart from it, give clear reasons for doing so (*Newham LBC v Khatun* [2004] EWCA Civ 55).

General duties such as this, which apply to all, or a wide range, of a public body's functions, are easy to enact but less easy to comply with. This is illustrated by the numerous successful challenges that have been made as a result of non-compliance by public authorities with general equality duties. In order to comply with the duty to "have regard" to the NHS Constitution, a NHS body in England must ensure that the Constitution is embedded into its decision-making structures. Only then can a body be certain that, whenever a function is performed, it is performed "having regard" to the Constitution.

Bodies and persons subject to the Convention

Section 2 requires a range of bodies providing services for the NHS in England also to have regard to the Constitution, for example General Practitioners and independent healthcare providers.

The content of the Constitution: the guiding principles

The NHS Constitution has an entrenched element to it. These are the seven "principles that guide the NHS". The principles may only be revised by the Secretary of State if regulations setting out the revisions are laid before both Houses of Parliament, either of which may decide to reject the regulations. Here are the seven guiding principles:

1. The NHS provides a comprehensive service, available to all.
2. Access to NHS services is based on clinical need, not an individual's ability to pay.
3. The NHS aspires to the highest standards of excellence and professionalism.
4. NHS services must reflect the needs and preferences of patients, their families and their carers.
5. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population.
6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.
7. The NHS is accountable to the public, communities and patients that it serves.

Other parts of the NHS Constitution

The other provisions of the NHS Constitution are not protected from alteration save that consultation must be carried out with a range of persons and groups, such as NHS staff and patients' organisations, before any change is made. The other provisions include the following which are particularly relevant to mental health service users in England:

- "You have the right to access NHS services. You will not be refused access on unreasonable grounds".
- "The NHS also commits to provide convenient, easy access to services...to make decisions in a clear and transparent way, so that patients and the public can understand how services are planned and delivered; and to make the transition as smooth as possible when you are referred between services, and to include you in relevant discussions".
- "You have the right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality".
- "You have the right to be treated with dignity and respect, in accordance with your human rights."
- "You have the right to accept or refuse treatment that is offered to you, and not to be given any physical examination or treatment unless you have given valid consent. If you do not have the capacity to do so, consent must be obtained from a person legally able to act on your behalf, or the treatment must be in your best interests".
- "You have the right to be given information about your proposed treatment in advance, including any significant risks and any alternative treatments which may be available, and the risks involved in doing nothing".
- "You have the right to privacy and confidentiality and to expect the NHS to keep your confidential information safe and secure".
- "You have the right of access to your own health records. These will always be used to manage your treatment in your best interests".
- "The NHS also commits...to share with you any letters sent between clinicians about your care".
- "You have the right to make choices about your NHS care and to information to support these choices. The options available to you will develop over time and depend on your individual needs. Details are set out in the Handbook to the NHS Constitution".
- "You have the right to be involved in discussions and decisions about your healthcare, and to be given information to enable you to do this".
- "The NHS also commits...to work in partnership with you, your family, carers and representatives".





Other points about the NHS Constitution

Other points to note about the Constitution are:

- (i) the Constitution must be reviewed every 10 years. The Constitution may be revised following a review or at other times;
- (ii) as well as continuing to make the NHS Constitution available, the Secretary of State must also make available a handbook to the NHS Constitution. The handbook must be reviewed by the Secretary of State every 3 years;
- (iii) regulatory bodies, such as the Care Quality Commission, must also have regard to the Constitution in performing their NHS functions.

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093419 - the NHS Constitution is available here.

www.opsi.gov.uk/acts/acts2009/ukpga_20090021_en_1 - the Health Act 2009 is available here.

Quality Accounts

Chapter 2 of Part 1 of the Health Act 2009 requires NHS bodies to produce what are termed "quality accounts". These have nothing to do with financial accounts. Rather, they are published information about the quality of the NHS services provided by a NHS body during the period running from April to April, referred to by the Act as a "reporting period". The first reporting period, and thus the first period in respect of which an account of quality must be produced, runs from 1 April 2009 to 31 March 2010.

Much of the detail concerning the production of quality accounts is to be set out in regulations, for example matters such as the form and content of accounts and the process by which they are to be produced.

Other points to note concerning quality accounts are:

- (i) the Act requires contractors such as General Practitioners or independent providers providing services for the NHS also to produce quality accounts. However, the Secretary of State does have the power to exempt providers and services from the duty, where, for example, the provision made is on such a small scale as to make the production of a quality account a disproportionate effort;
- (ii) the Care Quality Commission and Strategic Health Authorities have the power to direct NHS bodies to correct errors in their quality accounts. The corrected account, together with an explanation, must be published within 21 days;
- (iii) the accounts must be sent to the Department of Health who intend to publish them on the NHS Choices website;
- (iv) hard copies of quality accounts must be made available to members of the public in accordance with section 9(6) of the 2009 Act.

Links – www.opsi.gov.uk/acts/acts2009/ukpga_20090021_en_1#Legislation-Preamble – Health Act 2009 is available here.

CLINICIANS

Edwards v Bro Morgannwg NHS Trust – patient not entitled to insist on being treated by a particular doctor

A patient was pleased with the psychological treatment he had received from a particular doctor. The doctor then moved jobs so that she was working from a clinical unit which formed part of a different NHS Trust. The clinic was a tertiary level forensic facility which did not take referrals direct from General Practitioners. For that reason, if no other, it appears that the patient was unable to carry on being treated by his preferred doctor. The patient, however, said that the clinical director of that unit was preventing the doctor from carrying on working with him. The patient sought permission to bring a claim for judicial review of the doctor and the NHS Trust by whom he was employed.

The claim was first considered in 2005 when it was rejected by Hughes J for the following reason:

"It can be very disappointing for patients when Doctors who have been treating them, and in whom they have developed confidence, move to a different job. But they do. There is nothing illegal, or irrational in the legal sense, in a decision that because of the move the Doctor is no longer available to continue treating the patient. Additionally, in this case, the Caswell Clinic, where Dr H now works, is a specialist unit dealing with offenders or potential offenders. The Claimant rightly says that he is not in that category. The Court has no power to interfere."

A long period of delay set in before there was a hearing of the patient's renewed application for permission to claim judicial review. In the intervening period, the Director of the clinic wrote to the patient saying that, if he wished to access mental health services, he should begin by making an appointment to see his GP. That Director also wrote to the patient's GP to say that the Director's clinic could not provide a service to the patient. The patient also challenged these actions.

When the renewed application for permission came before the High Court, the judge said that "in the course of the hearing before me, it became plain that what [the patient] wanted was freedom from any further interference by, in particular, [the Director] in his efforts to seek whatever medical treatment might be appropriate to his condition". The NHS Trust then agreed, at the suggestion of the High Court judge, to offer an undertaking to the Court in these terms:





"Upon the defendant [NHS Trust] by its counsel indicating to the court that [the Director] nor any other member of his clinical or administrative staff will obstruct the complainant in obtaining medical treatment in any other NHS Trust area."

Upon that undertaking being given, the Court formally refused the application for permission to claim judicial review. In so doing, the judge said he agreed with the views expressed by Hughes J on the earlier refusal to grant permission to claim judicial review.

The High Court (HHJ Milwyn Jarman QC, sitting as a Deputy High Court judge) gave its decision in *Edwards v Bro Morgannwg NHS Trust* on 29 May 2009: [2009] EWHC 2868 (Admin).

MENTAL CAPACITY

HUMAN RIGHTS

Salontaji-Drobnjak v Serbia – the need for fairness in proceedings depriving a person of legal capacity

Below, we consider a case before the domestic Court of Protection in which one party to the proceedings was treated unfairly. The case considered here is therefore a timely decision of the European Court of Human Rights because it reiterates the importance of fairness in proceedings connected with a person's capacity to take decisions.

Background to the decision of the European Court of Human Rights

Mr S had a history of mental illness. In 2002, legal proceedings were begun under Serbian law for an assessment of his legal capacity. This appears to have been prompted by the large number of civil claims for damages that he had instituted. A psychiatric examination was ordered which concluded that Mr S suffered from "litigious paranoia (*paranoia querulans*)" and recommended that his legal capacity be restricted.

The Serbian court accepted that recommendation and directed that Mr S be deprived of legal capacity to take part in legal actions, decide about his own medical treatment, and deal with large amounts of money. A lawyer was appointed to represent Mr S but the lawyer never met him and Mr S was not even aware of the appointment. The court also refused to hear Mr S in person, saying that this would serve no useful purpose because all the evidence needed by the court was contained in the psychiatric reports.

For the next four years, Mr S tried without success to have his deprivation of capacity reviewed by the Serbian courts. He then brought a complaint to the European Court of Human Rights in Strasbourg.

The fairness of the initial hearing at which Mr S was deprived of his legal capacity

The European Court held that the initial proceedings to deprive Mr S of his legal capacity in relation to various matters were subject to Article 6 of the European Convention on Human Rights. Article 6 provides that "in the determination of his civil rights and obligations ... everyone is entitled to a fair ... hearing ... by an independent and impartial tribunal established by law". Accordingly, Mr S was entitled to a fair hearing. He did not, however, receive a fair hearing for the following reasons:

- (i) Mr S had been excluded from the final hearing and so had been unable personally to challenge the experts' reports recommending the partial deprivation of his legal capacity;
- (ii) the court's reasons for excluding him from that hearing were inadequate, merely stating that his attendance would not be "purposeful";
- (iii) although Mr S had been provided with a State-appointed lawyer to represent him at the hearing, he had had no opportunity to meet with her or give her instructions as to how the case should be conducted.

Mr S's attempts to have the incapacitation decision reviewed

Mr S's attempts to reverse his deprivation of capacity were blocked by the Serbian courts. This did not necessarily mean that his rights under the Convention were violated. The right of access to a court inherent within Article 6 is not absolute but may be subject to limitations (*Ashingdane v. the United Kingdom*, 28 May 1985, § 57, Series A no. 93). However, *Ashingdane* also establishes that the limitations applied must not restrict or reduce the access left to the individual in such a way or to such an extent that the very essence of the right is impaired. Furthermore, a limitation will not be compatible with Article 6(1) if it does not pursue a legitimate aim and if there is not a reasonable relationship of proportionality between the means employed and the aim sought to be achieved.

Were, then, the limitations on Mr S's access to a court acceptable under the Convention? The European Court held that they were not. Even if the restrictions were in accordance with Serbian domestic law and in pursuit of a legitimate aim, the Court held that they were disproportionate and amounted to a separate violation of Mr S's Article 6 rights, for the following reasons:

- (i) Although Mr S and his guardian had lodged numerous requests over four years for reconsideration of the restrictions on his legal capacity no court of law had yet considered on the merits the question of full restoration of his legal capacity;
- (ii) During those four years, "there has been no comprehensive psychiatric examination of the applicant undertaken in this context"; and



(iii) "the applicable domestic legislation does not seem to provide for a periodical judicial re-assessment of the applicant's condition". Instead, it appeared that a social services authority had the discretionary power to decide whether to refer a case to court.

Application of Article 8 – right to respect for private and family life

Mr S also argued that the way in which he had been deprived of legal capacity and his inability to require that decision to be reviewed amounted to a separate violation of his rights under Article 8 of the Convention. Article 8 provides that "everyone has the right to respect for his private and family life...". This is not an absolute right. The European Court held that in the present context an interference with the right would be justified in the following circumstances:

"any interference with an individual's right to respect for his private life will constitute a breach of Article 8 unless it was "in accordance with the law", pursued a legitimate aim or aims [such as the protection of health or the rights of others], and was "necessary in a democratic society" in the sense that it was proportionate to the aims sought....In particular, the authorities must strike a fair balance between the interests of a person of "unsound mind" and the other legitimate interests concerned".

The Court also reiterated that "whilst Article 8 of the Convention contains no explicit procedural requirements, the decision-making process involved in measures of interference must be fair and such as to ensure due respect of the interests safeguarded by Article 8" (see *Görgülü v. Germany*, no. 74969/01, § 52, 26 February 2004).

The Court proceeded to apply those principles to the circumstances of Mr S's case. The restriction of Mr S's legal capacity "undoubtedly" amounted to an interference with his private life. And even assuming that the interference was 'in accordance with the law' and pursued a 'legitimate aim', "the means employed were not proportionate to the aims sought to be realised". Therefore, Mr S's Article 8 rights had been violated. The reason why the interference was disproportionate was explained by the European Court as follows:

"whilst the limitation of the applicant's legal capacity (involving his inability to independently take part in legal actions, file for a disability pension, decide about his own medical treatment, or even get a loan) has been very serious, the procedure on the basis of which the domestic courts had so decided had itself been fundamentally flawed [as explained above] Moreover, some four years later and despite repeated requests to this effect, the applicant's legal capacity has yet to be re-assessed on the merits by a court of law...Finally, the Court acknowledges that a legal system must be allowed to protect itself from vexatious litigants, but considers that it is up to the domestic authorities to set up an effective judicial mechanism of dealing with such litigants' claims, without necessarily having to resort to additional measures affecting their legal capacity".

Compensation

The Court awarded Mr S 12,000 Euros in non-pecuniary damages, as well as 3,000 Euros in costs.

The European Court of Human Rights gave its decision in *Salontaji-Drobnjak v Serbia* on 13 October 2009 (application no. 36500/05).

COURT OF PROTECTION

In the Matter of LD – the need for fairness at all stages of personal welfare proceedings before the Court of Protection

The Court of Protection has the power radically to interfere in family life by, for example, making a decision which requires an adult without capacity to live apart from family members. The seriousness of such decisions heightens the need for fairness in the conduct of the proceedings leading up to the decision. Such fairness was noticeably absent in this case.

The background

This case concerned a 21 year old man with very severe physical and learning disabilities(a). For some time, his mother had found it difficult to care for him. While his care needs would have challenged the most experienced of carers, the man's mother had difficulties of her own to the extent that she has received in-patient mental health treatment.

In early 2009, the man was staying at a local authority-run residential respite care centre. The authority became very concerned about the level of care that the mother was able to offer the young man. She was in their opinion resistant to any local authority input. The authority wanted to be able to prevent the mother from removing her son from the home and to be able to make plans for an alternative long-term residential placement. Accordingly, the local authority applied to the Court of Protection seeking orders and declarations permitting them to keep the man at the respite care unit and to transfer him to another named unit for assessment. An interim order was made declaring that the young man lacked capacity to make decisions about his residence contact or care and that it was lawful and in his best interests for him to remain in the interim at the respite placement and to be deprived of his liberty there. The Official Solicitor was appointed to represent the young man in the proceedings.

The parties, including the mother's counsel, attended what they thought was going to be another interim hearing in April 2009. However, the District Judge of the Court of Protection who took the hearing said that she intended to make a final order there and then. She duly made an order that the young man was to remain in his current facility or any other unit considered suitable by his local authority, to authorise the man to be deprived of his liberty there, and for his mother to have contact with him on dates agreed with the local authority. The parties, including the local authority, were surprised at this summary determination of the proceedings which none of them had expected. An appeal was made to a circuit judge of the Court of Protection.

Why was the order requiring placement at the residential care unit flawed?

The Appeal was allowed. The district judge had made a wrong decision which had to be set aside. The main points of interest made by the circuit judge who allowed the appeal were as follows:



- (i) The Court of Protection does have the power under rule 27 of the Court of Protection Rules to make summary orders on its own initiative. However, the current case was clearly not suitable for summary determination. The judge said the rule 27 power was to be reserved for cases "such as an emergency or where there is little or no apparent contest anticipated to the exercise of the court's powers".
- (ii) At an earlier stage in the proceedings, the district judge had ordered an expert report which was designed to assist the court in deciding what course of action would be in the young man's best interests. The judge did not wait for this report to be completed before making her decision. The judge also failed to recite or engage with the statutory best interests considerations contained in s.4 of the Mental Capacity Act 2005. This was an error of law and undermined the district judge's conclusion that the orders that were made were in the young man's best interests.
- (iii) "I accept [counsel's] submission that there was a breach of procedural fairness and of Article 6 of the European Convention on Human Rights [right to a fair hearing in the determination of civil rights]. The fact that the mother had not visited and was not in attendance and unable to deal with the course proposed put her through her advocate's difficulties at a disadvantage in that he was deprived of an opportunity to advance a case or explain her position. That unfairness was aggravated when [counsel] on her behalf told the Court that there was a distinct possibility that she lacked litigation capacity – an accurate forecast. That was a clear amber if not red light to the Court".
- (iv) "It was simply no answer to that actual and potential difficulty to allow the mother in due course to bring parallel proceedings by way of the application to vary. [counsel] lists the procedural difficulties which would have followed some of which he was able briefly to put before the Court. They include delay and other difficulty where there was a question as to capacity, delay and a real question as to the availability of funding".
- (v) The district judge should not have authorised the man to be deprived of his liberty at an unspecified place which the judge did by authorising placement at the named nursing home or such other establishment as was to be decided by the local authority. The circuit judge said "such a sweeping unfettered delegation of future management power should not have been made. It was particularly wrong to do so without proper warning or examination any of the parties might have wished to bring to bear to what was proposed".
- (vi) The district judge also appointed the local authority as the young man's personal welfare deputy (and thus empowered to make decisions about his care on his behalf). This was done in a procedurally unfair manner as his mother had no opportunity to make representations about why this should not happen. In addition, the Guidance in the Code of Practice provides at paragraphs 8.38 and 8.39 that deputies for personal welfare decisions will only be required in the most difficult cases. There was no indication that the district judge had considered this section of the Code.

(a) These were described by the Court as follows:

"He suffers from spastic quadriplegia and cerebral palsy, Microcephaly and has a moderate to severe learning disability and epilepsy. He lacks capacity for intelligible word communication and can express only limited wants, for example, regarding drinks and food items through facial expression. He is doubly incontinent and additionally has a severe swallowing difficulty which necessitates a special diet of thickened fluids to avoid the risks of aspiration and choking either of which might prove fatal. He is wheelchair-bound."

The Court of Protection (Judge Horowitz QC) gave its decision in *In the Matter of LD* on 19 October 2009: Case No: 1144 8388 /03.

Independent News & Media Ltd & Others v A – attendance at private hearings of the Court of Protection

This was the first in-depth consideration of the application of the rules governing attendance at and reporting of proceedings in the Court of Protection. In a useful decision, the High Court judge who was nominated to sit in the Court of Protection to hear this case set out the applicable legal framework and identified the factors to be weighed in the balance in order to determine whether media representatives should be allowed to attend private hearings in the Court of Protection.

The background

The case concerned a young man who, in the words of the Court, while "severely disabled" with "severe learning difficulties which render him incapable of making decisions as to any significant issue in his life" also "possesses remarkable gifts and the practice of those have brought him to public, indeed international, attention". It was those gifts which led to the interest of the media in Court of Protection proceedings concerning the man. The media wanted to be able to attend hearings and report their outcome, including the man's name.

The legal framework

The relevant legal framework is contained in Rules 90 to 93 of the Court of Protection Rules. Those Rules, in so far as relevant in this case, and their proper operation as described by the High Court judge who sat in the Court of Protection to decide this case were as follows:

- (i) There is a "general rule" that a hearing is to be in private (Rule 90). Rule 90 also identifies a list of persons who are always entitled to attend a private hearing, such as the parties and their legal representatives. Unsurprisingly, representatives of the media are not included on this list.
- (ii) The Court of Protection has the power to permit a hearing to be held in public, but an application for such a hearing was not made in this case. What was made was an application under Rule 90(3) for media representatives to be permitted attend the hearing. The Court said that such application would not be agreed to readily because "real weight must be given to Rule 90(1) that the general rule is that these matters are dealt with in private attended only by those who are listed in rule 90(2)".
- (iii) There are two stages on an application under Rule 90(3) for permission to attend a private hearing. The first stage requires the person who wishes to attend to show "good reason" for the making of an order permitting attendance.
- (iv) If 'good reason' is shown that is not the end of the matter. The Court still has a discretion as to whether or not to permit attendance, this is the second stage. As the Court said in the present case "if 'good reason' is found that should not automatically entitle an applicant to an order under Rule 91". The Court must go on to consider two potentially opposing human rights under the European Convention on Human Rights. First, the Article 8 rights (right to respect for private and family life) of the person whom the proceedings concern. Second, the Article 10 rights (right to freedom of expression) of the media. The Court must balance these rights against each other in order to decide whether or not to permit attendance. In so doing, the Court should follow the decision of the House of Lords in *Re S (a Child) (Identification: Restrictions on Publication)* [2005] 1 AC 593. In that case, Lord Steyn summarised the legal position as follows:



"First, neither article has as such precedence over the other. Secondly, where the values under the two articles are in conflict, an intense focus on the comparative importance of the specific rights being claimed in the individual case is necessary. Thirdly, the justifications for interfering with or restricting each right must be taken into account. Finally, the proportionality test must be applied to each".

Application of the law: attendance of media representatives permitted

The Court of Protection proceeded to apply the relevant legal framework to the circumstances of this case. The judge began by concluding that the media had shown good reason for attending the hearing because: (1) "all these issues in principle are already within the public domain and the questions which they raise are readily apparent"; (2) the court is equipped with powers to preserve privacy whilst addressing the issues in the case; (3) "the decision of the court will have major implications for the future welfare of 'A' and it is in the public interest that there should be understanding of the jurisdiction and powers of the court".

The Court then proceeded to conclude that the second stage balancing exercise also came down in favour of media attendance. In so deciding, the judge was heavily influenced by the fact that the court retained power to control dissemination of information revealed during any hearing(a).

(a) Unauthorised publication would be a contempt of court under s.12 of the Administration of Justice Act 1960.

The Court of Protection (Hedley J) gave its decision in *Independent News & Media Ltd & Others v A* (by the Official Solicitor, his litigation friend) on 12 November 2009: [2009] EWHC 2858 (Fam).

MENTAL HEALTH & CRIMINAL JUSTICE

RIGHTS AT TRIAL

Prezec v Croatia – representation for mentally ill defendants

The main point of interest for domestic purposes arising in this human rights case was the European Court of Human Rights' confirmation that, to some extent, the quality of legal representation provided for a mentally ill defendant should be monitored by the court before which the defendant is being tried.

The facts

A prisoner (P) in a Croatian jail had a long history of mental illness(a). P was charged with a criminal offence of assaulting a prison guard, but was not legally represented at his trial. P was found guilty and sentenced to five months' imprisonment together with a compulsory psychiatric treatment condition. He brought a complaint to the European Court of Human Rights.

P argued that, because he had not been legally represented, his rights under Article 6(3) of the European Convention on Human Rights had been breached. Article 6(3) provides:

"everyone charged with a criminal offence has the following minimum rights...

(c) to defend himself in person or through legal assistance of his own choosing or, if he has not sufficient means to pay for legal assistance, to be given it free when the interests of justice so require."

Had P waived any right to free legal assistance at his criminal trial?

The Croatian government first argued that P had waived his rights under Article 6(3), by refusing the lawyer appointed for him by the Croatian court. It is true that these rights may be waived, as the Court said:

"neither the letter nor the spirit of Article 6 of the Convention prevents a person from waiving of his own free will, either expressly or tacitly, entitlement to the guarantees of a fair trial. However, such a waiver must, if it is to be effective for Convention purposes, be established in an unequivocal manner; it must not run counter to any important public interest (see *Sejdovic v. Italy* [GC], no. 56581/00, § 86, ECHR 2006-...), and it must be attended by minimum safeguards commensurate with its importance (see *Poitrinol v. France*, 23 November 1993, § 31, Series A no. 277-A)."

To assess whether P had effectively waived his rights, it was necessary to consider what happened in connection with his legal representation when he was tried before the Croatian criminal court. Prior to the hearing, he submitted a written request for a lawyer. However, this request was not included in the case file for the final hearing at which P said he did not want representation and that he would defend himself in person. His defence did not appear effective because on a number of occasions during the hearing P said that he could not understand anything. In those circumstances, the European Court held that P had not waived his rights under Article 6(3):

"In view of the applicant's mental state...and his express request to have a legal aid lawyer appointed during the trial proceedings, the Court concludes that it cannot be accepted that the applicant waived his right to be represented by a lawyer during the trial proceedings".

Did the interests of justice require a lawyer to be appointed for P?

The next issue was whether the interests of justice required P to be given free legal assistance (it was accepted that he did not have the means to pay for a lawyer himself). The European Court has pointed out on a number of occasions that Article 6(3) does not guarantee free legal representation to any defendant who cannot afford to pay for his/her own legal representation. In P's case, however, it was quite clear that the interests of justice required that he have legal representation at trial:



"In the Court's view, the applicant's mental state and the fact that as a convicted prisoner he was charged with an offence against a prison employee warranted his legal representation in the proceedings at issue. Furthermore, the Court's case-law is clear on the principle that where deprivation of liberty is at stake, the interests of justice in principle call for legal representation (see *Quaranta v. Switzerland*, 24 May 1991, § 34; *Benham v. the United Kingdom*, 10 June 1996, § 61, *Reports of Judgments and Decisions* 1996 III; and *Talat Tunç v. Turkey*, no. 32432/96, § 56, 27 March 2007)".

The Croatian court's failure to appoint a lawyer for S meant, therefore, that his rights under Article 6(3) were breached.

P's representation during appeal proceedings

P appealed against his conviction by the Croatian court. A lawyer was appointed for him at the appeal stage. However, P argued that the legal service he provided was so inadequate that, at this stage, there was also a breach of his Article 6(3) rights.

The European Court first set out the State's (limited) responsibilities under Article 6(3) to supervise the competence of the legal service provided by a lawyer that it has appointed for a defendant:

"a State cannot be held responsible for every shortcoming on the part of a lawyer appointed for legal aid purposes or chosen by the accused. It follows from the independence of the legal profession from the State that the conduct of the defence is essentially a matter between the defendant and his counsel, whether counsel be appointed under a legal aid scheme or privately financed (see *Cuscani v. the United Kingdom*, no. 32771/96, § 39, 24 September 2002). The competent national authorities are required under Article 6 § 3 (c) to intervene only if a failure by legal aid counsel to provide effective representation is manifest or sufficiently brought to their attention in some other way (see *Kamasinski v. Austria*, 19 December 1989, Series A no. 168, § 65, and *Daud v. Portugal*, 21 April 1998, *Reports* 1998-II, § 38)."

The European Court went on to find that the legal service provided to P at the appeal stage was deficient so that at this stage there was also a breach of his Article 6(3) rights. Two different lawyers were said to have been appointed for P. However, he was given neither a telephone number or address for either of them and so could not contact them. Further, neither of the lawyers visited P in prison or contacted him in any other way and so could not, in the circumstances, have provided him with effective representation during the appeal proceedings.

Compensation

The European Court declined to order that compensation be paid to P. It considered that the finding that his rights under the Convention had been violated was itself "just satisfaction".

(a) His condition was described as follows in reports placed before the Court:

"a person suffering from serious and permanent personality disorder with a prevalence of paranoia [paranoid personality disorder], schizophrenic disorder and a pronounced narcissistic pathology, as well as a strong tendency towards destructive and self-destructive behaviour."

The European Court of Human Rights gave its decision in *Prezec v Croatia* on 15 October 2009 (app'n no. 48185/07).

DIMINISHED RESPONSIBILITY

Coroners and Justice Act 2009: reformulation of the defence of diminished responsibility

Section 52 of the Coroners and Justice Act 2009 modernises the terminology used to describe the defence to a charge of murder of diminished responsibility. Currently, the defence, contained in s.2 of the Homicide Act 1957, is made out the following two elements are proven:

- (i) a defendant was suffering from an abnormality of mind ("whether arising from a condition of arrested or retarded development of mind or any inherent causes or induced by disease or injury"); and
- (ii) that abnormality was such as to substantially impair the person's mental responsibility for the killing.

Section 52 of the 2009 Act will, when in force, substitute a modernised definition for that described above. The new defence is available where a person (D) charged with a killing suffers from an "an abnormality of mental functioning" which satisfies all of the following conditions:

- (i) the abnormality arises from a "recognised medical condition";
- (ii) the abnormality substantially impaired D's ability to do any of the following:
 - understand the nature of D's own conduct;
 - form a rational judgment;
 - exercise self-control,
- (iii) the abnormality provides "an explanation" for the person's involvement in the killing. The new defence specifies that "an abnormality of mental functioning provides an explanation for D's conduct if it causes, or is a significant contributory factor in causing, D to carry out that conduct."

As now, under section 2(2) of the 1957 Act, if the defence is made out, the person will be convicted of the offence of manslaughter instead of murder.



R (Crosby) v Independent Police Complaints Commission – police acted reasonably in stripping a woman held in a police who appeared likely to self-harm

In this case, the High Court analysed the obligations of police officers towards persons detained in police cells who exhibit signs of mental distress. A complaint was made that the police treated a mentally ill woman in a humiliating and degrading manner. This is what happened:

- (i) Ms C was arrested on suspicion of criminal damage at 7.30 p.m. following a neighbour dispute. She was heavily intoxicated and "had a history of depression and suicidal feelings" (as the High Court put it);
- (ii) Ms C was taken to a police station. At around 8 p.m. she was examined by a Force Medical Examiner (FME) who recorded that she was on anti-depressants and had self-harmed in the past. The FME recommended "watch re SH (unlikely)". The custody record stated that Ms C also said that she had tried to kill herself 4 times previously. She was placed in a cell with CCTV and the decision taken by the custody sergeant that she should be checked every 30 minutes;
- (iii) at 8.25 p.m. Ms C was seen trying to strangle herself with her tracksuit bottoms. Those were removed from her as was her bra;
- (iv) at 11.15 p.m. Ms C said that she was unwell and the FME was called with a request that he attend the police station to examine her;
- (v) at 11.20 p.m. Ms C tried to strangle herself with a blanket and her blouse. All her clothing was then removed from her as was the blanket;
- (vi) the FME did not arrive until 2 a.m. at which time Ms C refused to let him examine her;
- (vii) Ms C was released from custody (unharmd) the following day.

Ms C made a complaint to the police about her treatment. It was rejected. She appealed to the Independent Police Complaints Commission which rejected her appeal. She claimed judicial review of the Commission's decision in the High Court.

The approach the High Court took was to examine whether the conduct of the police breached the requirements of Code C of the Police and Criminal Evidence Act 1984, the *Code of Practice for the Detention Treatment and Questioning of Persons by Police Officers*. The Court concluded that the Commission had lawfully concluded that, on a balance of probabilities, there was no breach of Code C in this case. The Court made the following findings in arriving at this conclusion:

- (i) Code 3(10) provides that "a risk assessment is an ongoing process, and assessments must always be subject to review if circumstances change". In Ms C's case, this meant that "each of the claimant's attempts at self harm in the present case should be considered as a change in circumstances" so as to trigger a review of the previous risk assessment. Having noted that "the absence of an exactly contemporaneous record does not mean that a reassessment was not carried out", the Court was satisfied that there were proper risk assessment reviews in Ms C's case:

"In some respects the response was a reactive one: for example, on each occasion when the claimant had attempted to harm herself, the progressive removal of the physical means by which she might do so. In other respects it was proactive: for example, the placing of the claimant in a cell with CCTV installed in it once it was known she had tried to commit suicide in the past, and the efforts made to reach the doctors by telephone and to get them to come to the police station to see her".

- (ii) "When the claimant tried to harm herself at 8.25pm, by placing her tracksuit bottoms around her neck and attempting to strangle herself, the officers removed that garment and her bra from her. I do not believe it is arguable that this was other than an appropriate response, sensibly intended to reduce the claimant's opportunities to harm herself".
- (iii) "When the claimant tried to harm herself at 11.18pm by tying her blanket and her blouse around her neck, the officers took these away from her. Again, in my judgment, this was an appropriate response aimed at reducing the claimant's opportunities for selfharm".
- (iv) "The steps [the police] found it necessary to take could only be taken with the consequence that the conditions in which the claimant was held became undignified and somewhat uncomfortable. But the officers clearly gave priority to her safety, and, in my judgment, they were plainly right to do so".
- (v) "Although Code C does not provide a definition of "appropriate clinical attention", there is nothing to indicate that the medical attention the claimant received while in police custody was other than appropriate in the circumstances. She was assessed on three occasions by [three doctors]. Nothing seems to have been said by her at the time to suggest the need for an appropriate adult to be present, or for an immediate assessment under the provisions of the Mental Health Act 1983. There was no indication that the claimant was physically ill or injured. In my judgment, the custody officers did what they reasonably could to keep in touch with the doctors on whose timely help they reasonably assumed they could rely if they had to".

The High Court (Keith Lindblom QC, sitting as a Deputy High Court judge) gave its decision in *R (Crosby) v IPCC* on 1 July 2009: [2009] EWHC 2515 (Admin).

PAROLE & RELATED MATTERS

R (Lynch) v Category A Review Team – whether psychologist's report properly recognised prisoner's progress towards his offending behaviour targets

A prisoner serving a life sentence for murder was seeking to be downgraded from a category A to a category B prisoner, a necessary step towards his ultimate goal of release on parole. As the High Court put it, the prisoner had "committed an extremely serious, deliberate act of violence with



a firearm which will mean that his case is considered presumptively as dangerous unless and until he has demonstrated that that assessment has been diminished by the way he has reacted to his sentence". In fact, the prisoner's Lifer Manager has expressed the opinion that the prisoner had done sufficient work to be downgraded to category B. The Category A Review team, however, have refused to downgrade.

The prisoner first challenged the refusal to downgrade him in a claim for judicial review in 2008. The claim was successful. The High Court held that the decision maker had erred in law by failing to take into account evidence of positive progress made by the prisoner in addressing his offending behaviour. As a result, the decision had to be re-taken. In that connection, a prison psychologist reported unfavourably on the prisoner and, once more, the Category A Review team refused to downgrade. The prisoner argued that the psychologist's report was flawed and, therefore, so was the decision refusing to downgrade him. The prisoner sought permission from the High Court to claim judicial review of the refusal. The Court granted permission, observing as follows:

"Given the history of this case and a number of particular features highlighted in this renewed application as to how the claimant is recorded as behaving by the authorities, the claimant may well have the sense that he has at the least addressed all that he has been asked to do in the course of his rehabilitation in prison, but the achievement of those targets has not been sufficiently acknowledged by the authorities. I conclude that this is a challenge that deserves a more detailed examination by this court. Therefore I would grant permission".

The High Court (Blake J) gave its decision in *R (Lynch) v the Category A review Team* on 28 October 2009: [2009] EWHC 2880 (Admin). Since this decision

SENTENCING

[R v Airey – sentencing a mentally ill defendant for arson](#)

46 year old Ms A had a recurrent depressive disorder and alcohol dependency. She was estranged from her parents. While her parents were out, she broke into their house when intoxicated and set fire to some clothing before leaving the scene. Minimal damage was caused because the parents returned soon after the fire was started and extinguished it.

Ms A pleaded guilty to the offence of arson being reckless as to whether life was endangered. A psychiatric report before the Crown Court said that Ms A's "mental state was so disordered that she had not considered the risks of her actions" and that "her risk of suicide was significantly above that of the general population". The psychiatrist added that if Ms A "was able to maintain abstinence from alcohol and an effective management plan could be provided in the community, consideration should be given to a community order". The Crown Court did not implement this recommendation. Instead, the Court said that for this very serious offence "the court could not take the exceptional course of not passing a custodial sentence". It sentenced Ms A to 3 years and nine months' imprisonment.

Ms A appealed to the Court of Appeal against her sentence. It allowed the appeal. While the Crown Court had been right to consider Ms A's offence as "very serious" and "save in the most exceptional circumstances an immediate prison sentence should be imposed for this offence", this was an exceptional case. The Court of Appeal took into account Ms A's lack of intent to cause injury and her mental condition which it noted was "treatable in the community". It substituted a supervision order with a number of requirements attached including an alcohol treatment requirement of 12 sessions to be completed within 2 years.

The Court of Appeal (Criminal Division) gave its decision in *R v Airey* on 10 September 2009: [2009] EWCA Crim 2106. The Court was comprised of Elias LJ and Simon and Coulson JJ.

EQUALITY & DISCRIMINATION

DISABILITY DISCRIMINATION

[Secretary of State for Work & Pensions v Alam – the duty to make 'reasonable adjustments' for an employee with depression](#)

The identification of the duty to make reasonable adjustments for a disabled person must be carried out in a structured way in accordance with the (somewhat complex) provisions of the Disability Discrimination Act 1995. In this case, the Employment Appeal Tribunal criticised an Employment Tribunal which allowed the 'reasonable adjustments' claim of a man with depression. The Appeal Tribunal suspected that the Tribunal below had been swayed by "sympathy" for the man, rather than a dispassionate application of the law. The upshot was that the employer was found to have been entitled to discipline the man for leaving work early without permission.

The facts

A man, Mr A, with depression was employed as an administrative officer by the Department for Work and Pensions (DWP). His symptoms, as described by his GP who had prescribed him anti-depressant medication, were a tendency to lose his temper and concentration and to suffer occasional severe headaches. In March 2008, Mr A turned up late for work, at midday. He also asked his line manager if he could leave early to attend an interview for a second job. The line manager refused permission as did her superior. In any event, Mr A left work without permission at 5 p.m, informing his line manager of his departure as he was leaving.

A disciplinary hearing took place which concluded that Mr A was guilty of "minor misconduct of a more serious nature" and imposed a 12 month written warning (upheld on internal appeal). The man brought a claim to the Employment Tribunal in which he claimed that the DWP had failed to comply with their duty under s.4A of the Disability Discrimination Act to make 'reasonable adjustments'.

The Employment Tribunal held that, due to the effects of his depression, Mr A was disabled within the meaning of the Disability Discrimination Act 1995. The Tribunal went on to find that Mr A's disability meant that he "could not control himself sufficiently to clearly ask for permission to leave work early and wait for an answer". Flowing from that, the Employment Tribunal held that the DWP had failed to comply with its duty to make reasonable adjustments to take account of that effect of Mr A's disability. The DWP appealed to the Employment Appeal Tribunal (EAT).



The EAT allowed the appeal. As explained below, it was critical of the Employment Tribunal's decision for its failure to relate its conclusions to the relevant statutory provisions.

The duty to make reasonable adjustments: identifying the thing that needs adjusting

Under s.4A of the DDA, the duty to make reasonable adjustments under consideration in this case arises where an employer's "provision, criterion or practice" places a disabled employee at a "substantial disadvantage". If there is this substantial disadvantage, the employer must take such steps as are reasonable to take in order to prevent the provision, criterion or practice having that effect.

It is clear, therefore, that the provision, criterion or practice must be precisely identified. As the EAT said in the present case, "no conclusion can be reached as to the nature and extent of what adjustments can reasonably be expected without first identifying the PCP". In this case, the Employment Tribunal appeared to hold that the DWP had a practice of imposing a sanction of a 12 month written warning for anyone who left the workplace without permission. This was unsustainable in the light of the evidence about what actually went on at the DWP because it did not have a fixed sanction for this type of disciplinary offence. The evidence suggested that the practice to be analysed was simply the requirement to seek permission before leaving work early.

Disapplication of the duty to make reasonable adjustments

In some cases, an employer's state of knowledge means that under s.4A of the DDA 95 the employer is not obliged to make any adjustments. In the present case, the EAT took the opportunity to clarify the case law. Disagreeing with the approach taken by another sitting of the EAT (in *Eastern and Coastal Kent PCT v Grey* [2009] IRLR 429), the present EAT said the legal test was as follows:

"to ascertain whether the exemption from the obligation to make reasonable adjustments...applies, two questions arise. They are:

1. Did the employer know both that the employee was disabled and that his disability was liable to affect him in the manner set out in section 4A(1) [i.e. place him at a substantial disadvantage in relation to a practice of the employer]? If the answer to that question is: "no" then there is a second question, namely,
2. Ought the employer to have known both that the employee was disabled and that his disability was liable to affect him in the manner set out in section 4A(1)?

If the answer to that second question is: "no", then the section does not impose any duty to make reasonable adjustments. Thus, the employer will qualify for the exemption from any duty to make reasonable adjustments if *both* those questions are answered in the negative".

Determination of the appeal

The EAT proceeded to determine for itself the correct disposal of Mr A's claim:

- (i) the DWP did not know that Mr A was disabled, nor of course did they know that his disability was likely to have any effect on his compliance with their practices as an employer. This meant the second question identified above had to be answered to determine the claim;
- (ii) The EAT concluded that, due to their receipt of a letter from Mr A's GP, the DWP ought to have known that Mr A was "disabled to the extent that he had symptoms of depression comprising difficulty at times in concentrating and with keeping his temper and severe headaches at times". However, the DWP could not reasonably have known that Mr A's disability put him at a substantial disadvantage as compared to a non disabled person in relation to a practice applied by the DWP, that practice being a requirement for employees to ask permission before leaving work early. This was because there was no evidence that difficulty in asking for permission to leave work early was a feature of Mr A's disability. The EAT went on to say that this did not mean that the DWP were under no duty to make reasonable adjustment, but that the adjustment contended for (exemption from the requirement to seek permission before leaving work early) was not required in this case because there was no evidence that the features of Mr A's depression "amount to or imply difficulty in asking for permission when it was required".

The Employment Appeal Tribunal (presided over by the Hon. Lady Smith) gave its decision in *Secretary of State for Work and Pensions v Alam* on 9 November 2009: [2009] UKEAT 0242_09_0911.

All Arden Davies Journals are published ten times per annum by Arden Davies Ltd, who are registered as a company in England and Wales (Company No. 436 4132). An annual subscription to each publication is £165 for organisations and £75 for individuals and the voluntary sector (including postage and packing). Back issues cost £15.

To order:

- call the subscription line on **0800 783 3656**
- fax us on **0800 783 6871**
- subscribe on line at **www.ardendavies.com** (you may pay by credit/debit card in a totally secure environment). A recent issue is also displayed at the site.
- write to us at Arden Davies Publishing Ltd, 27 Old Gloucester Street, LONDON, WC1N 3XX

The contents of this publication are offered for information only. It does not constitute legal advice. Legal advice can only be given by a solicitor or barrister in light of the factual matrix applicable to a particular issue.

The contents of this publication are copyright Arden Davies 2003, all rights reserved. If you are reading a photocopy of this publication, please call 0800 783 3656 to check you have permission to do so.

