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# DETENTION UNDER THE MENTAL HEALTH ACT 1983

## CONDITIONAL DISCHARGE

### JLG v Managers of Llanarth Court – further in-patient treatment needed before patient could safely be treated in the community

Often a tribunal's refusal to direct discharge will principally be based on its assessment of the risk posed by the patient. It is difficult to mount a successful challenge to a tribunal's decision in such a case, especially where it involves a restricted patient. This case is an example of that.

#### The patient with whom this case was concerned

An individual became a restricted patient following his conviction for indecent assault. He applied to the Mental Health Review Tribunal for Wales ("the Welsh Tribunal"). His aim was to secure a conditional discharge to his parents' home where he could be assisted by community mental health support services.

The patient's diagnosis was paranoid schizophrenia with erotomania. The Welsh Tribunal refused to direct the patient's discharge. The medical evidence was that his condition was relapsing and he still harboured obsessive thoughts about the victim of his index offence. The Tribunal also concluded that he posed a risk to other women whom he might meet and develop a further obsession. He was responding to in-patient treatment but his clinicians considered that he required another 6 to 12 months of in-patient treatment before he would be suitable for community living. So, in terms of the detention criteria in sections 72 and 73 of the Mental Health Act 1983, the Welsh Tribunal must have been satisfied that they were all met. In other words it was satisfied that:

- (i) the patient had a mental disorder and it was of a nature or degree which made it appropriate for the patient to be detained in hospital for medical treatment; and
- (ii) it was necessary for the protection of other persons that the patient should be detained in hospital for medical treatment; and
- (iii) appropriate medical treatment was available for the patient.

Arguing that the Welsh Tribunal's decision involved an error of law, the patient challenged its decision before the Upper Tribunal.

#### What is an error of law?

The Upper Tribunal only has power to set aside a tribunal decision if it involves an error of law (s.12 Tribunals, Courts and Enforcement Act 2007). In this case, the Upper Tribunal Judge set out his understanding of what an error of law is. While not containing any new law, the Judge's comments are a useful reminder of the limited grounds on which the Upper Tribunal can interfere with a decision of the First-tier Tribunal (or Mental Health Review Tribunal for Wales). This is what the Judge said:

"3...The essence of the legal requirement for a tribunal's decision is that: (i) the tribunal asked itself the correct legal questions; (ii) it made findings of fact that were rationally based in the evidence; and (iii) it answered the legal questions appropriately given its findings of fact. Additionally, the tribunal must: (iv) give the parties a fair hearing; and (v) provide adequate reasons. In simple terms, the issue is whether the tribunal did its job properly".

The Upper Tribunal also made the point that a tribunal does not make an error of law by failing to refer to such everyday legal matters as the burden and standard of proof in tribunal proceedings. A tribunal is assumed to know and apply such basic aspects of its role (unless the contrary is shown). The Upper Tribunal's comments were made in response to the assertion that the Welsh Tribunal's decision was flawed because it did not state upon whom the burden of proof lay and what the standard of proof was.

#### Why was the Welsh Tribunal's decision upheld?

The Upper Tribunal held that the Welsh Tribunal's decision did not involve any error of law. The appeal was dismissed. This is what the Upper Tribunal said:

"13. I consider those conclusions [of the Welsh Tribunal, as set out above] are soundly and rationally based in the evidence and the nature of the patient's condition. They explain why the conditions for the patient's continued detention were satisfied. They identify the existence of a disorder and make clear why it is appropriate that he remain detained for treatment. The risk to his previous victim is clear, even if it is only indirect through contact with her parents. The availability and suitability of the treatment was clear from the impact it was starting to have. Detention was required because at the present stage of his treatment it could not reliably be provided outside the control of detention".

The Upper Tribunal (Judge Jacobs) gave its decision in *JLG v Managers of Llanarth Court & Secretary of State for Justice* on 9 February 2011: [2011] UKUT 62 (AAC).





## COMMUNITY TREATMENT ORDERS

### **MP v Mersey Care NHS Trust – Community Treatment Order recommendation pointless if tribunal's findings require patient's discharge**

A Community Treatment Order is not an alternative disposal for a patient in respect of whom the detention criteria are not met. Such a patient must be discharged, it is as simple as that. That was the message of this case.

#### What happened before the First-tier Tribunal?

A detained patient's case came on before the First-tier Tribunal (FtT). The FtT considered whether it was satisfied that all the detention criteria in s.72(1) of the Mental Health Act 1983 were met. The FtT decided that:

- (i) it was not satisfied that the patient's mental disorder was of a nature or degree which made it appropriate for him to be liable to be detained in hospital for medical treatment; and
- (ii) it was not satisfied that it was necessary for the health or safety of the patient or the protection of others that the patient should be detained in hospital for medical treatment.

In simple terms, the FtT considered that the patient posed such a low risk to the public that his detention in hospital could not be justified.

If just one of the detention criteria are not met, the FtT must direct a patient's discharge. Accordingly, the FtT in this case was obliged to direct the patient's discharge. It directed that he be discharged in 6 weeks' time (the delay being to allow the authorities to make suitable discharge planning arrangements).

The FtT then proceeded to take the step that muddied the waters in this case. It said that it was "inviting" the patient's clinical team to consider "implementing" a Community Treatment Order (CTO) for the patient. Under a CTO, the patient would be discharged from detention but remain liable to recall to hospital.

#### The decision to impose a Community Treatment Order

In response to the FtT's comments, the patient's responsible clinician purported to impose a CTO. This was a few days before the patient was required to be discharged under the FtT's decision.

At this point, we should point out why the FtT's CTO recommendation was odd. Section 17C of the Mental Health Act 1983 lists cases in which a CTO ceases to be in force. It includes where "(c) the application for admission for treatment in respect of the patient otherwise ceases to have effect". That appears to be why the parties agreed that, if the FtT's discharge decision stood, the patient's CTO would cease to have effect. Accordingly, it was odd for the FtT to suggest that a CTO was appropriate when the discharge direction it had just given would have nullified any CTO upon the direction's implementation six weeks after it was given. It seems likely that the FtT simply misunderstood the law relating to CTOs.

#### The parties' arguments

How did the parties respond to the above sequence of events? Their stances were as follows:

- (i) The patient thought the FtT's discharge direction should stand. The effect would be (a) his discharge, and (b) the CTO ceasing to have effect (for the reason explained above).
- (ii) The detaining hospital authority, however, wanted the patient to remain on a CTO so that he could be recalled to hospital in the event of a deterioration in his condition. To achieve that result, they had to get rid of the FtT's discharge decision (because, as explained above, upon the discharge decision have effect it would nullify the CTO). Therefore, the hospital argued that the FtT's decision it was unlawful.

The matter came before the Upper Tribunal.

#### What did the Upper Tribunal decide?

The Upper Tribunal found in favour of the patient. The FtT clearly stated that it was not satisfied that the discharge criteria were met. That required it to direct the patient's discharge, which is what it did. The FtT's misconceived comments about CTOs could not alter its clear and rational conclusion that the detention criteria were not met. So as from the date on which the FtT directed the patient's discharge his CTO would be of no effect.

The FtT is given an express power by s.72(3A) of the Mental Health Act 1983 to recommend that a responsible clinician consider making a CTO. But, as the Upper Tribunal pointed out, such a recommendation would be pointless in a case such as this where the FtT has given a direction for discharge. The Upper Tribunal said that "it is only a consideration in a case where the tribunal is not under a positive duty to discharge".

The Upper Tribunal (HHJ Pearl) gave its decision in MP v Mersey Care NHS Trust on 15 March 2011: [2011] UKUT 107 (AAC).

#### KEY POINT

- If the First-tier Tribunal is not satisfied that one of the detention criteria are met, it must direct discharge
- If the Tribunal directs discharge (deferred or otherwise) there is no point in inviting the patient's responsible clinician to impose a Community Treatment Order (CTO)
- A Tribunal's misconceived CTO recommendation did not undermine its conclusion that the detention criteria were not met





# MENTAL HEALTH TRIBUNALS

## SECTION 2 APPLICATIONS

### **R (Modaresi) v Secretary of State – 14 day time limit for making s.2 applications applies even if the 14th day is a weekend day or public holiday**

As soon as an appropriate opportunity arises after a patient's admission under s.2 of the Mental Health Act 1983, s/he must be given clear information about the time limits for making a tribunal application. This should inform the patient that the 14 day time limit includes weekends and public holidays. The patient should also be told whether that means that the patient has to make an application on the final working day before expiry of the time limit. This will depend on whether the hospital has the facilities to allow applications to be made on non-working days.

The above steps were not taken by the NHS Trust responsible for the hospital in which the claimant who brought this case was detained. However, at the time of the relevant events that was understandable. Nowadays, it would not be. This is because all hospitals should now be aware that the First-tier Tribunal (and the Welsh Mental Health Review Tribunal) cannot accept an application that is made more than 14 days after a patient's s.2 detention began. The previous practice of accepting late applications if they were made on the next working day after expiry of the 14 day period is no longer being followed.

#### What happened?

The relevant events in this case were as follows:

- (i) Ms M, who was diagnosed with schizophrenia, was compulsorily admitted to hospital for assessment under s.2 of the Mental Health Act 1983 (MHA 83).
- (ii) The admission occurred on 20 December 2010. Under s.66 of the MHA 83, Ms M therefore had 14 days from the beginning of 20 December 2010 to apply to the First-tier Tribunal (FtT) for it to consider the lawfulness of her detention. If calendar, rather than working, days were counted, that 14 day period expired on 2 January 2011 which was a Sunday.
- (iii) If Ms M had made a valid application within that 14 day period, the FtT would have been obliged to hear it within 7 days: Rule 37(1) of the Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 ("the Tribunal rules"). By contrast, the evidence before the High Court was that, in other cases, there is normally a delay of about 6–8 weeks before the FtT hears an application.
- (iv) On 31 December, the patient completed a form for making an application to the FtT for discharge from s.2 detention.
- (v) Also on 31 December, the patient handed the form to a member of staff on her ward. At 4.30 p.m. the staff member faxed it to the NHS Trust's Mental Health Act Administration Office, which was responsible for liaising with the Tribunals Service in relation to patients' applications for discharge.
- (vi) The Administration Office should have sent the form on to the Tribunals Service. However, there were no staff in the Office and so the patient's application form simply lay in the fax machine until it was discovered when the office re-opened on 4 January 2011.
- (vii) By the time the fax was discovered, if calendar days counted, the patient's 14 day window for applying as of right to the FtT had expired.
- (viii) The patient's application form was faxed on to the Tribunals Service on 4 January 2011. However, the Tribunals Service informed the hospital staff that the patient's application was invalid and out of time.
- (ix) On 6 January 2010, the legal basis for the patient's detention altered. On that date, she began to be detained for treatment under s.3 of the MHA 1983.
- (x) On 7 January the patient's solicitors asked the Secretary of State to exercise his discretionary power to refer the patient's case to the First-tier Tribunal. By this time, the patient was detained under s.3 of the MHA 1983 for treatment and so had her own fresh right to apply to the FtT within the first 6 months of her s.3 detention. But she wanted to preserve this right, which was why the Secretary of State was asked to make a reference. However, the Secretary of State refused to make a s.2 reference. In refusing, the Secretary of State relied on the fact that the patient now had the fresh right to make a s.3 reference to the FtT.
- (xi) Ms M brought a claim for judicial review in the High Court which challenged the lawfulness of the various decisions taken by the public bodies involved in her case and the FtT.

#### KEY POINTS

- All calendar days are to be counted in calculating the 14 day period for bringing a s.2 tribunal application
- An application is to be treated as received by the tribunal on a non-working day if it is faxed to it on that day
- The tribunal cannot extend the 14 day period for bringing a s.2 application
- Where a patient missed the deadline because an administrator failed to fax an application to the tribunal in time, the Secretary of State was not obliged to make a compensatory tribunal reference
- Patients should be informed if their deadline for applying to a tribunal falls on a non-working day
- Hospitals are not required to make arrangements so that applications may be faxed to the tribunal on non-working days





## Issue 1 – how is the 14 day period for applying to the tribunal for discharge from detention for assessment to be calculated?

As we saw above, if calendar days were counted this patient's application to the FtT was out of time: her application was received by the FtT on 4 January when it should have been received by 2 January. If, however, only working days were counted the application was in time.

The High Court held that all calendar days counted and it made no difference if the last day of the 14 day period was a non-working day such as a weekend day. In the Court's words:

"47. Since the Tribunal's rules do not require the Tribunal to perform any administrative act upon receipt of an application in order to validate its delivery, there is no reason to construe the time period in section 66(2)(a) as extending to the next working day if the expiry of the time limit would otherwise fall on a weekend or bank holiday."

Accordingly, the patient's application to the FtT was out of time and the Tribunals Service had correctly refused to accept.

The High Court went on to reject the argument that the FtT had the power to extend time. The FtT's general power to extend time, contained in Rule 12 of the Tribunal Rules(a) only applies in relation to time limits specified in the Rules. It does not apply to time limits set out elsewhere such as the 14 day period for applying to the FtT in s.2 detention for assessment cases which is set out on the face of the Mental Health Act 1983 (section 66).

## Issue 2 – Did the Secretary of State lawfully refuse to refer the patient's case to the tribunal?

This aspect of the case involved arguments based on both principles of domestic public law and the patient's rights under Article 5(4) of the European Convention on Human Rights to "be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court". But the patient's arguments had a common rationale which was simply that the Secretary of State should have exercised his power of referral to 'compensate' for the hospital having deprived her of her right under the Tribunal Rules to a very speedy (within 7 days) consideration of the lawfulness of her detention. It was, the patient argued, either irrational under public law principles for the Secretary of State to have refused or it amounted to a breach of Article 5(4) because that Article implies an obligation on the Secretary of State to take steps to remedy the disappearance of Ms M's right to a very speedy hearing of the lawfulness of her s.2 detention.

In beginning its analysis of this aspect of the case, the High Court pointed out that, due to the administrative error by the hospital's Mental Health Act administration office, the patient had lost her right to a very speedy FtT consideration of her case. As set out above, patients' s.2 applications, if made within the 14 day time limit, must be heard by the FtT within 7 days. In other cases, however, the evidence before the High Court was that it takes 6-8 weeks for the FtT to hear a case. What this meant was that the patient's right to a very speedy FtT determination had been lost for ever. Even if the Secretary of State had agreed to make a reference, it would not have resulted in the FtT considering the patient's case within 7 days. The significant point was that the Secretary of State was unable effectively to restore the patient's right to a very speedy (7 days) FtT consideration of the lawfulness of her detention.

The Court's conclusion was to reject the patient's challenge to the Secretary of State's refusal to refer the patient's case to the FtT. In fact, the Secretary of State said that he would reconsider referral in the event that the patient (a) exercised her right to apply to the FtT for consideration of the lawfulness of her s.3 detention for treatment, and (b) the FtT refused to direct the patient's discharge. This undertaking undermined the patient's case which was put, as we saw above, on the basis that the Secretary of State was obliged to exercise his referral powers so as to in some way minimise the adverse affect on the patient of the hospital's failure to get the patient's s.2 application to the FtT in time. This is how the High Court expressed the point:

"62. It seems to me that it was well within a proper exercise of the Secretary of State's discretion to decline to make a referral on behalf of the Claimant for so long as she had the right to make that application herself. If the application was unsuccessful and circumstances subsequently changed, the Secretary of State could always be asked to make a referral on the Claimant's behalf at that stage. The Secretary of State had specifically said that he would consider any such application if and when it was made."

## Issue 3 – Why was the claim against the hospital rejected?

The claim against the hospital argued that it was obliged to put in place effective systems to assist patients in exercising their rights to put their cases before the FtT. The High Court did not appear to depart from that as a matter of principle. The argument appears sound. Otherwise, a patient's Article 5(4) right to take proceedings for a speedy determination of the lawfulness of s.2 detention would be undermined.

At this point, we should explain a recent relevant change of practice by the FtT in relation to s.2 applications. According to the hospital's evidence, the FtT used to accept a patient's application as being in time if it was signed by the patient within the first 14 days of detention. For example, if the 14 day period ended on midnight on Saturday an application would be accepted by the FtT if (a) it was signed by a patient on Saturday, and (b) faxed to the Tribunals Service on the next working day normally Monday.

But the FtT altered its practice so as to require, in accordance with the Tribunal Rules, s.2 applications to be received within the 14 day window. According to the hospital, this happened "sometime in around September or October 2010". At the time of the relevant events in this case, Ms M's detaining hospital were unaware of the FtT's change of stance. Accordingly, they had assumed that Ms M's application was in time because she made it (signed the form) within 14 days of her s.2 detention commencing.

It was for the above reasons that the hospital did not have a system in place for forwarding applications on to the Tribunals Service over the weekend and on other non-working days. However, that did not explain the errors made in this case. Ms M's application was received in the





hospital's Mental Health Act administration office at 4.40 p.m. on New Year's Eve which is a working day. Someone should have been on duty there until 5 p.m. but they were not. If someone had been on duty, the application would have been faxed on to the Tribunals Service and thus would have been received by them within the 14 day time limit. So, the problem was simply that a staff member was not where s/he should have been whether by oversight or by him/her having left early (it was New Year's Eve). The Court held that this one-off conduct by a member of staff was not sufficient to make good the claim against the hospital. The claim was that the hospital's systems were defective. But one-off unauthorised behaviour by a member of staff cannot amount to a defective system. This aspect of the patient's claim was based on her assertion that the hospital's system was defective. Accordingly, her claim had to fail.

### What are the practical implications of this case for detaining hospitals?

Despite the patient's claim having failed, this decision remains of wider practical significance. The Court accepted the argument that detaining hospitals are obliged to put reasonable systems in place to assist patients in exercising their rights to apply to a tribunal. It went on to give guidance as to how those systems should operate in s.2 cases.

As it should now be well known that the First-tier Tribunal will not accept applications received outside of the 14 day time-limit, hospitals should inform s.2 patients that they may submit an application on a weekend or bank holiday and that, if they wait until the next working day, their application will be rejected if that falls outside the 14 day period. In practice, what is important is to ensure that patients whose deadline for applying expires on a non-working day are aware of that fact.

But the Court did not seem to think that hospitals are legally obliged to put in place facilities so that applications can be transmitted to the tribunal on weekends or public holidays. It said that, even if the hospital in the present case was aware that late applications would not be accepted by the tribunal, the hospital "would not have been acting unreasonably in adopting the system that it did provided that it explained to patients on admission that any application would have to be made during normal working hours".

The High Court (Edwards-Stuart J) gave its decision in *R (Modaresi) v Secretary of State for Health, First-tier Tribunal (Mental Health) and the West London Mental Health NHS Trust* on 3 March 2011: [2011] EWHC 417 (Admin).

## PUBLIC HEARINGS

### AH v West London Mental Health Trust – patients' rights to public hearings

If a patient wants a Tribunal to sit in public to consider his/her application for discharge, the patient should be taken seriously. As the Upper Tribunal's decision in the present case shows, in some cases patients are entitled to public hearings. It is true that the Upper Tribunal expressed the view that only rarely would a patient be entitled to a public hearing. But that does not dilute the requirement for a tribunal to consider each application for such a hearing on its merits.

#### Why did the patient want a public hearing?

A restricted patient was in his 23rd year of detention under the Mental Health Act 1983. While detained in Broadmoor high security hospital, he made a routine application to the First-tier Tribunal (FtT) for it to consider the lawfulness of his detention. Less conventionally, he also applied for the hearing of the application to be in public under Rule 38(1) of the Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 ("the Tribunal Rules").

The patient wanted a public hearing for two reasons. First, to educate members of the public about life as a Broadmoor patient. Second, to draw attention to what he considered to be his doctors' inaccurate diagnosis of psychopathic disorder. The hospital managers opposed a public hearing. They thought it might harm the patient's mental health, make the proceedings difficult to manage and be disproportionately expensive given that all of the expert evidence was that the patient did not meet the statutory criteria for discharge. The managers were also concerned that the patient might misuse the tribunal hearing by using it publicly to air his grievances about Broadmoor.

While the FtT accepted that the patient had the mental capacity to make a valid request for a public hearing, it went on to refuse his application. The patient appealed to the Upper Tribunal.

#### The course of the patient's appeal

The Upper Tribunal considered the patient's appeal in two stages. First, it considered the general legal framework about public hearings of FtT mental health cases. But it did not at that first hearing feel able to determine the patient's appeal. It adjourned so that more information could be obtained about the practicalities of holding public hearings and the approach taken in other jurisdictions. So a second hearing was convened to determine the appeal taking into account the new information.

#### KEY POINTS

- The Tribunal Rules' lawfully adopt a presumption that mental health hearings should be held in private
- The Upper Tribunal identified four considerations to be taken into account by the First-tier Tribunal in deciding whether to grant an application for a public hearing
- Subsequently, the Upper Tribunal described those considerations as containing a 'threshold test' for granting an application for a public hearing
- Special factors in favour of granting a patient's application for a public hearing were his 25 year detention history and his recent change of diagnosis
- In arriving at its decision, the Upper Tribunal took into account the Convention on the Rights of Persons with Disabilities





## Is the presumption of a private hearing in mental health cases lawful?

Rule 38(1) of the Tribunal Rules contains a general rule that all mental health hearings must be in private. It then provides that this does not apply and that a public hearing may be held where "it is in the interests of justice for the hearing to be held in public". Initially, the Upper Tribunal considered whether this presumption of a private hearing is compatible with the European Convention on Human Rights. It held that it was, reasoning as follows:

- (i) Article 6 of the Convention generally requires a public hearing in the determination of a person's civil rights. However, it does permit exclusion of the press and public "in the interests of morals, public order or national security in a democratic society, where the interests of juveniles or the protection of the private life of the parties so requires, or to the extent strictly necessary in the opinion of the court in special circumstances where publicity would prejudice the interests of justice."
- (ii) The Convention's stance is mirrored by the domestic courts which are suspicious of private judicial hearings. Public hearings are considered important, principally to (a) deter inappropriate behaviour on the part of a court or tribunal, (b) to maintain public confidence in the legal system by demonstrating that justice is administered impartially and (c) to encourage the exposure of previously unknown evidence (*Scott v Scott* [1913] AC 417).
- (iii) Despite the provisions of Article 6 of the Convention, as the Upper Tribunal pointed out in the present case, the European Court of Human Rights has held that, in relation to some categories of case, a presumption in favour of private hearings is compatible with Article 6.
- (iv) In its first decision on the patient's appeal, the Upper Tribunal held that mental health cases were a "special category" in which it is legitimate to adopt a presumption, as in Rule 38(1) of the Tribunal Rules, in favour of a private hearing. In fact, this accords with a decision of the High Court in relation to the similar approach taken under the old Mental Health Review Tribunal Rules (see *R (Mersey Care NHS Trust) v Mental Health Review Tribunal* [2004 EWHC 1749 (Admin); [2005] 2 All ER 820).

## How should the First-tier Tribunal respond to an application for a public hearing?

While the Tribunal Rules adopt a presumption in favour of private hearings, as we have seen they do permit a hearing to be held in public. Rule 38(1) of the Tribunal Rules states that a hearing may be held in public where "it is in the interests of justice for the hearing to be held in public".

Despite Rule 38(1)'s focus on the interests of justice, the Upper Tribunal in its initial decision in this case held that "the principal consideration remains the protection of the interests of the patient". However, that factor seems to have been downplayed in the Upper Tribunal's second decision which simply considered whether the considerations referred to below called for a public hearing.

What, then, are those considerations? Drawing the jurisprudence together, the Upper Tribunal gave the following guidance for FtTs which are faced with requests for public hearings:

"29. To summarise, it seems to us that the principal issues for the tribunal considering an application for an open hearing in a case such as the present are:

- Is it consistent with the subjective and informed wishes of the applicant (assuming he is competent to make an informed choice)?
- Will it have an adverse effect on his mental health in the short or long term, taking account of the views of those treating him and any other expert views?
- Are there any other special factors for or against a public hearing?
- Can practical arrangements [including adequate security arrangements] be made for an open hearing without disproportionate burden on the authority?"

Will application of this guidance lead to most applications for public hearings being granted? The Upper Tribunal thought not. In its second decision in this case, it expressed the view that "it is unlikely that a public hearing will be ordered other than in a relatively few cases". It seems that the basis for this opinion is the assumption that only rarely will there be special factors in favour of a public hearing (the third set of considerations referred to by the Upper Tribunal). We say this because in many cases it will be relatively straightforward for a patient to show that the other considerations operate in his/her favour. The first consideration, wishes of the patient, simply involves a matter of fact as does the second consideration namely the affect on the patient's mental health. As regards the remaining consideration, disproportionate resource burdens, the Upper Tribunal's ultimate disposal of the present case seems to suggest that only rarely will this be decisive especially in the case of a patient who does not pose a security risk.

## What role do these factors play when a Tribunal is considering whether to grant an application for a public hearing?

As just mentioned, in its initial decision the Upper Tribunal set out four considerations to be taken into account when determining a patient's application for a public hearing. But in its second decision these considerations had been transformed into what the Upper Tribunal described as "threshold tests". This shift in the terminology used to describe the role played by the list of matters poses challenges for those who will need to apply the Upper Tribunal's decision. A threshold test, being a qualitative standard, is not the same thing as a list of factors to be taken into account. So it is not clear what role the list of factors are really supposed to play.





It is possible that the answer is found by looking more closely at the list of factors. When that is done it can be seen that they are in fact a series of questions, the answers to which are either 'yes' or 'no'. So what the Upper Tribunal may mean is that if each of the questions is answered 'yes' then the FtT may well be bound to grant a request for a public hearing. On this approach, by reference to the matters listed by the Upper Tribunal, the threshold for a public hearing would be met where:

- (i) a public hearing is consistent with the subjective and informed wishes of a patient; and
- (ii) a public hearing will not have an adverse effect of a patient's mental health; and
- (iii) further special factors in support of a public hearing are present; and
- (iv) practical arrangements for a public hearing can be made without imposing a disproportionate burden on the detaining authority. This implies that the tribunal should explore different modes of holding a public hearing with a view to identifying one which does not impose a disproportionate burden. So in the present case the Upper Tribunal did not reject the patient's application once it became clear that a traditional public hearing at Broadmoor hospital was not feasible. It considered whether other venues and types of hearing could be used to meet the patient's desire for the FtT to hear his application in public.

### Why did the FtT err in law when refusing to grant the patient a public hearing?

We can now proceed to consider why the FtT's refusal of a public hearing was flawed. The Upper Tribunal identified three main defects in the FtT's reasoning:

- (i) The FtT identified part of the rationale for the open justice principle, such as the need to deter inappropriate behaviour on the part of a tribunal. But, in refusing the patient's application, it found that these reasons did not apply because there was no suggestion that the FtT would act inappropriately. The Upper Tribunal held that this demonstrated that the FtT had misunderstood the law:

"42. [The FtT's] approach also seems to have diverted their attention from the fundamental principle that open justice is a right, which does not require justification on a case by case basis. On the contrary it is the exceptions which need to be justified."
- (ii) The FtT had also not paid close enough attention to what should have been a key issue, the effect of a public hearing on the patient's future mental health.
- (iii) Finally, some of the additional factors relied on by the FtT to refuse the patient's application were legally irrelevant to the task before it. The fact that the patient's evidence might be "amateurish" or not "objectively sensible" were not considerations to which it was legitimate to have regard. Nor was it legitimate to have regard to the "possibility that some visiting members of the public might find the hearing "disagreeable and uninformative".

For the above reasons, the FtT's decision was flawed and would be set aside.

### Why was the patient's application for a public hearing granted?

At its second hearing, the Upper Tribunal granted the patient's application for a public hearing. It is clear that the Upper Tribunal was satisfied that the 'threshold test' discussed above was met in this patient's case (otherwise it would not have ordered a public hearing). To identify why, it is necessary to piece together findings made by the Upper Tribunal on both occasions on which it considered the patient's application for a public hearing. When that is done, it seems that the Upper Tribunal considered that the four elements of the threshold test were met for the following reasons:

- (i) **Patient's wishes.** The parties agreed that the patient wanted a public hearing and that he had the mental capacity to make such a decision. This element of the test was therefore clearly met.
- (ii) **Effect on patient's mental health.** The Upper Tribunal noted that the psychiatric evidence in this respect was finely balanced. One psychiatrist thought a public hearing might improve the patient's mental health because public airing of his grievances might lead to more productive engagement with his rehabilitation plans. The patient's consultant psychiatrist, however, considered that the negative publicity that would be likely to follow would be harmful for the patient. When it first considered the patient's application, the Upper Tribunal said that, given the state of the psychiatric evidence, "it seems to us that the views of the patient himself, supported by his own expert, should carry considerable weight, in the absence of other countervailing factors". As it ultimately directed a public hearing, it seems that the Upper Tribunal concluded that a public hearing would be unlikely to have an adverse effect on the patient's mental health.
- (iii) **Special factors in favour of public hearing.** A particularly significant element of this case appears to have been the weighty special factors in favour of granting the patient's application. These were described as follows by the Upper Tribunal:

"The patient has been kept in detention at public expense for over 23 years, often in conditions of high security, and it is only recently that there has been a change in his diagnosis from mental illness and personality disorder to personality disorder. We agree that this potentially gives the case some heightened public significance, although whether it will attract public attention is a matter of speculation".
- (iv) **Public hearing without disproportionate resource burden.** The Upper Tribunal decided that a public hearing could be held without imposing





a disproportionate burden on public resources. It cast doubt on the detaining hospital's assertion that the patient might be difficult to control in a public hearing, saying that they had "overstated" that possibility. In itself this is a useful finding. It shows that if a tribunal can be persuaded that a patient would be difficult to control a public hearing is less likely to be ordered on the basis that to hold it would impose a disproportionate resource burden. But in this case that was not a factor to which much weight could be attached. Given that, it seems that the Upper Tribunal felt that there was no basis for denying the patient's application for a public hearing. In relation to this element of the threshold test, the Upper Tribunal made it clear that different forms of public hearing ought to be explored – some public hearings will be simpler and cheaper to arrange than others. For example, it is possible that the public could view a hearing by way of live link (although see the views expressed below on this point).

### What form will the patient's public hearing take?

The parties agreed that it was not feasible for the patient's public hearing to take place in Broadmoor hospital itself. This left two options. A standard open-access public hearing off-site or a hearing in Broadmoor the proceedings of which would be relayed by live link to a publicly viewable TV screen.

The patient's counsel strongly argued that the patient had the right to a typical public hearing, one to which members of the public would have free physical access. The Upper Tribunal seemed to agree, stating in its second decision, that "considerations of cost must reach a high threshold before they can be regarded as sufficiently disproportionate to permit a restriction of a public hearing". It is worth noting that in making this finding the Upper Tribunal took into account the provisions of Article 13 of the Convention on the Rights of Persons with Disabilities (CRPD), which the UK ratified in June 2009. Article 13 provides that States should ensure "effective access to justice for persons with disabilities on an equal basis with others. This is how the Upper Tribunal expressed its conclusion on this point:

"22. It seems to us that once the threshold tests in paragraph 8 above for establishing a right to a public hearing have been satisfied, article 6 of the European Convention on Human Rights (re-enforced by article 13 of the CRPD) requires that a patient should have the same or substantially equivalent right of access to a public hearing as a non-disabled person who has been deprived of his or her liberty, if this article 6 right to a public hearing is to be given proper effect. Such a right can only be denied a patient if enabling that right imposes a truly disproportionate burden on the state." (a)

The Upper Tribunal directed that the patient was entitled to a full off-site public hearing. However, this was not a recognition that the patient was in law entitled to such a hearing. The Upper Tribunal said that its decision was partly based on a desire not further to delay the case by investigating the possibility of a live-link hearing at Broadmoor. At this point the Upper Tribunal's decision again becomes somewhat confusing. It seemed to suggest that normally a live-link could be used in order to give effect to a Broadmoor patient's right to a public hearing. But it did not explain why it thought that the 'truly disproportionate' condition as referred to in the quotation above (which justifies something less than a typical public hearing to which the public have free access) was likely to be met on a general basis in Broadmoor cases. This is what the Upper Tribunal said:

"On the evidence provided to us by the Broadmoor Hospital Clinical Director, it seems likely that if similar cases arise in the future, it should be possible for arrangements to be made between the hospital and the Tribunals Service for a hearing at the hospital with a video-link to suitable premises off-site where any interested members of the press or public can view the proceedings."

The Upper Tribunal (Carnwath LJ, Senior President of Tribunals, and Upper Tribunal Judges Levenson and Cooper) gave its decision in *AH v West London MHT* on 29 July 2010: [2010] UKUT 264 (AAC). The appeal was heard by 3 judges on the basis that it involved an important point of principle.

The Upper Tribunal gave its decision in *AH v West London MHT* on 17 February 2011: [2011] UKUT 74 (AAC). The Tribunal was comprised of Carnwath LJ, Senior President of Tribunals and Upper Tribunal Judges Levenson and Cooper.

### **RB v Nottinghamshire Healthcare NHS Trust – Tribunal erred by too hastily deciding not to reconvene in the light of slow progress towards its transfer recommendation**

It may be tempting for a tribunal to give up on a statutory recommendation that it has made in the light of implementation difficulties. But it should not do so. In this case, the Upper Tribunal informed First-tier Tribunals that the making of a recommendation carries with it a certain obligation to monitor the response to the recommendation.

#### What happened?

The sequence of events in this case was as follows:

- (i) A patient was detained for treatment under s.3 of the Mental Health Act 1983 (MHA 83). He was detained in Rampton Hospital. The patient's case came before the First-tier Tribunal (FtT). The FtT did not direct the patient's discharge. But it did

#### KEY POINTS

- A tribunal should give its reasons for making a statutory recommendation as to, for example, transfer to a different hospital
- In deciding whether to make a recommendation, a tribunal should take into account the fact that its recommendations are unenforceable
- The Upper Tribunal said that, while a recommendation is unenforceable, it operates by 'moral authority' – this may not have been the most appropriate description to have used
- A tribunal may not be justified in making a completely obvious recommendation or a recommendation that it knows will not be complied with
- A tribunal should monitor progress being made in complying with its recommendation
- A tribunal was too ready to abandon its recommendation in the face of delays in a 'gatekeeping' assessment about transfer to the recommended hospital





make a recommendation under its statutory power contained in s.72(3) of the MHA 83.

- (ii) The recommendation was for the patient's transfer to a different hospital. Importantly, however, the FtT did not explain why it made this recommendation. It simply said that it considered that the patient was "ready" for transfer to a particular named hospital.
- (iii) The FtT went on to state that, if the recommendation was not complied with by a certain date, 12 December 2009, it would decide whether to reconvene taking into account any representations of the parties.
- (iv) That date came and went without the patient having been transferred. The detaining hospital said that a 'gatekeeping' assessment, used to decide whether to permit the patient's transfer, had yet to be completed.
- (v) The patient's solicitors argued that the FtT should wait until the gatekeeping assessment was completed before deciding whether or not to reconvene. But the FtT refused to wait saying that it would not be "proportional" to do so and noting that the patient had the right to make another FtT application once the gatekeeping assessment was available. The question of whether the FtT had erred in law in taking that course came before the Upper Tribunal.

### What is the legal effect of a Tribunal's recommendation?

The Upper Tribunal first considered the legal framework governing the giving of statutory recommendations by the FtT. It found as follows:

- (i) The purpose of the power was described as "to assist in identifying the best way forward for the patient". In fact, this probably goes too far. The purpose of a recommendation is given on the face of the MHA 83 s.72(3) of which states that the recommendation is to be given "with a view to facilitating [the patient's] discharge on a future date". But whatever is the precise purpose of the power, it is clear that its exercise may be rendered pointless if no reasons for it are given. It follows that reasons for a recommendation should be given. Otherwise, no real assistance may be being given in either identifying the 'best way forward' for the patient or facilitating his/her discharge.
- (ii) In deciding whether or not to make a recommendation, the FtT should bear in mind that it has no power to enforce its recommendation: "it operates by moral pressure and moral authority, not by order. The tribunal must be mindful of that limitation when deciding whether to make a recommendation in the first place." So if it is clear that a recommendation would not be complied with the FtT should ask itself whether it should make a recommendation at all. As the Upper Tribunal said, "it is surely undesirable to give a patient false hope".
- (iii) The FtT should also guard against giving obvious recommendations. That may just waste everyone's time:

"16...The more obvious the recommendation, the more likely it is that the authority will consider it anyway. So recommendations are likely to be made in those cases where the authority has not considered the possibility or would be unlikely to do so."

- (iv) If the power to make a recommendation is exercised it carries with it an assumption of some degree of responsibility in relation to implementation of the recommendation. What the Upper Tribunal said was that "once begun, it [the recommendation] must be followed through fairly". It seems therefore that the FtT is expected to monitor the progress being made in responding to its recommendation. The Upper Tribunal gave this guidance:

"16...If the tribunal does make a recommendation, it has to take account of the tenuous nature of its control. This makes it essential to consider very carefully the timescale and the directions that the tribunal might give in order (i) to apply its moral pressure on the authority and (ii) to be fully informed by the time it has to decide whether to reconvene. It may, for example, be appropriate for the tribunal to direct that a progress report be provided shortly before a specified date so that it can decide if there is any practical purpose in reconvening."

- (v) S.72(3) of the MHA 83 says that the FtT may (a) make a recommendation and (b) further consider the patient's case in the event of the recommendation not being complied with. The Upper Tribunal was of the opinion that the FtT does not have to reconvene to consider the patient's case if the recommendation is not complied with. But it must at least consider whether to do so:

"16...the tribunal has to decide whether to reconvene. In making that decision, it has to decide what practical value this would serve. It has no power to enforce the recommendation and is not reconvening for that purpose. It has the power to embarrass the authority into explaining its thinking or, possibly, into compliance. But it has to make a judgment on what it can practically achieve, if anything. That is where the issue of proportionality comes in."

### Is it correct to describe a recommendation as having 'moral authority'?

As we saw above, the Upper Tribunal said that a First-tier Tribunal's recommendation carries 'moral authority' and exerts 'moral pressure'. It could be argued that using the language of morality in this context is inappropriate. It suggests that a failure to comply with a recommendation is an action lacking in morality. But in reality what this topic is really concerned with is differences in clinical opinion and it is well known that reasonable disagreement on clinical matters is quite possible. So it is not really fair to describe one clinical viewpoint as possessing an inherent morality which the other does not possess. Nevertheless the import of what the Upper Tribunal judge meant was clear. A recommendation is not binding but it can exert considerable pressure because it is given by a body whose opinions clearly merit respect.

### What did the Upper Tribunal decide?

The FtT did not give reasons for its recommendation. As a result, the recommendation was of limited benefit to the patient. As it was not clear





why the recommendation was made, it would have been difficult for the patient to hold the detaining NHS Trust accountable in the event that it failed to follow the recommendation. This is what the Upper Tribunal Judge said on the point:

"13...the tribunal did not explain why it made its recommendation. It may be that that was clear to all concerned from the evidence and submissions before the tribunal, but I do not know. It would certainly assist those responsible for the patient's care and detention to know the tribunal's reasoning and it may not be wise to rely on that information being conveyed by those present at the hearing. The reasons may also provide a basis for considering how to proceed if the recommendation is not complied with, although they will of course be known to the tribunal."

Also, the FtT did not fairly follow through on its recommendation. It was too ready to wash its hands of the recommendation once delays in carrying out the gatekeeping assessment were encountered. This is what the Upper Tribunal Judge said:

"15...I do not understand the tribunal's reasons for refusing to reconvene. In short, the tribunal was saying that the assessment was not ready so it would not reconvene. It knew that the gate-keeper assessment was not yet ready, but it did not know why. That knowledge was surely essential. If the assessment had been delayed for some reason, that would not indicate that the authority was unwilling or unlikely to comply with the tribunal's recommendation. Indeed, finding out what had happened and why might be a useful exercise of the tribunal's moral pressure on the authority to take its recommendation seriously. Given the tribunal's lack of information, it was not possible to decide that it would be disproportionate to reconvene whether on the fixed date or later. I consider the tribunal's reasons inadequate."

As the FtT's decision was legally flawed, the Upper Tribunal proceeded to consider for itself whether the FtT should reconvene. It is relevant to note that, by this point, the gatekeeping assessment had been completed and the decision taken not to transfer the patient to the recommended hospital. Largely for that reason, the Upper Tribunal decided that there would be no point in reconvening:

"17. The authority has made its decision. There is nothing to suggest that the authority might be persuaded to change its mind. Any hearing would realistically be limited to obtaining an explanation. After so long, applying moral pressure is unlikely to have any effect. The claimant's solicitor says that the patient's condition appears to be unchanged, so a discharge does not seem a possibility. In those circumstances, the most appropriate order would be to identify the error in the tribunal's decision but to make no order on the appeal."

### The position of the detaining hospital as respondent

A final point of interest in this case concerned the involvement of the NHS Trust in which the patient was detained. It applied to be removed as a party to the proceedings before the Upper Tribunal. The application was made on the basis that it was neutral and the issue was between the patient and the FtT. The Upper Tribunal refused the Trust's application, saying as follows:

"11...I understand the authority's position, but that does not justify removing it as a party. A respondent is not required to respond, but a lack of formal interest in the decision is not a reason for removing the respondent as a party. The authority's removal might have the effect that it was not bound by the Upper Tribunal's decision, which would be an inappropriate result."

The Upper Tribunal (Judge Jacobs) gave its decision in *RB v Nottinghamshire Healthcare NHS Trust* on 11 February 2011: [2011] UKUT 73 (AAC).

## MENTAL CAPACITY & COURT OF PROTECTION

### Care Quality Commission's Annual Report – analysis

The Deprivation of Liberty Safeguards (DOLS) scheme, contained in the Mental Capacity Act 2005, contains an unusual mix of precision and imprecision. The core concept is itself vague – what is a deprivation of liberty. But the processes that flow from an application to authorise deprivation of liberty are set out precisely in some bureaucratic detail. In March 2010, the Care Quality Commission (CQC) published a report entitled *The Operation of the Deprivation of Liberty Safeguards in England 2010*. This collates the CQC's inspection findings in so far as they relate to the operation of the DOLS in England and makes recommendations for improvement in practice. The report shows that some PCTs and, to a lesser extent, councils, are still struggling to get to grips with DOLS. Both its imprecise and precise features continue to pose compliance challenges for many councils and PCTs.

#### KEY POINTS

- In some areas, DOLS has yet adequately to bed in
- Joint working between PCTs and councils in the exercise of DOLS functions is encouraged
- Location of DOLS officers within adult safeguarding units should not lead to a dilution of the least restrictive intervention principle
- Excessive restraint in care homes is causing the Care Quality Commission (CQC) concern
- The CQC have provided an illustrative list of cases in which a deprivation of liberty might be occurring





## Key general points in the report

- (i) **Joint-working.** The CQC is of the view that it is often desirable for councils and PCTs to work closely in discharging the functions as DOLS supervisory bodies (in England councils are the supervisory body for care homes, PCTs for hospitals). The report states that "many PCTs and councils have worked effectively together, and established joint teams to fulfil their supervisory role"
- (ii) **Staff awareness.** The CQC are concerned about lack of awareness of DOLS amongst many hospital and care home staff. The report states that there were "too many examples of managers and staff in hospitals and care homes who were unaware of the Safeguards or who had received no training on them, even towards the end of 2009/10".
- (iii) **Bureaucracy.** The CQC acknowledge that many professionals view DOLS as being over bureaucratic. It recommends that the Department of Health "consider whether it may be possible to reduce the amount of paperwork needed to use the Safeguards."
- (iv) **Care Planning.** The report stresses the importance of good care planning in avoiding a deprivation of liberty in the first place. For example, close liaison and involvement of family members in fixing care arrangements may avoid a deprivation of liberty. It could inhibit a person from trying to leave a care home or avoid a situation in which a care home provider feels to need to prevent family members from making visits.
- (v) **Statistics.** The report includes some interesting findings about the make-up of the DOLS population. 75% of DOLS applications have been made to councils (i.e. in respect of care home residents). And the most frequently encountered cause of lack of capacity within the DOLS population was dementia.
- (vi) **Regional variations.** The report identifies significant regional variations in use of DOLS. For example, DOLS authorisations were three times more likely to be sought in the East Midlands than in the region with the lowest DOLS use, the South West.
- (vii) **Under-use of DOLS.** Concern has previously been expressed about the low use of DOLS in some areas. In August 2010, the Department of Health wrote to councils and NHS bodies about the suspiciously low use of DOLS in some areas saying that "Chief executives are reminded that they have a statutory responsibility for ensuring that no NHS care or treatment is offered without the necessary DOL safeguards in situations which amount to a deprivation of liberty". These concerns are reflected in the CQC report which states that 5 PCTs and 3 local authorities received no DOLS applications whatsoever in 2009/10. However, the report does note a steady general increase in the use of DOLS.

## Key points for councils

- (i) **Safeguarding services.** The CQC observes that within councils the DOLS function is part of the council's adult safeguarding service. It strikes a note of organisational caution in this respect:

"While this may appear sensible, it also raises some concerns. These designated teams may be considering the Deprivation of Liberty Safeguards as an extension of the safeguarding role, potentially leading to staff not being mindful of the requirement for the least restrictive practice. Furthermore, staff may also be unaware that it is inappropriate for someone to be deprived of their liberty as part of a safeguarding plan unless they are also subject to Deprivation of Liberty Safeguards assessments and authorisation".
- (ii) **Restraint.** The report expresses concern that in some care homes staff unthinkingly use restraint upon residents. Two particular problems are identified. First, whether restraint is being used in accordance with the Mental Capacity Act 2005 – only to prevent harm and as a proportionate response to the likelihood and seriousness of the harm. Second, a failure to appreciate that regular use of restraint might mean that a resident is being deprived of liberty so that a DOLS authorisation is required in order for it lawfully to continue

## Key points for PCTs

- (i) **PCT concerns.** Generally, it seems fair to say that the CQC is more concerned about the discharge of DOLS functions by PCTs than by local authorities. More PCTs than councils failed to provide information to the CQC about their DOLS activities and, where they did, on average they showed lower levels of understanding.
- (ii) **Mental Health Act 1983.** PCTs tend to reject more applications than councils. The report thinks this might be because in some cases the PCT concludes that the individual is ineligible under DOLS because Mental Health Act 1983 powers should be used instead. The interface between the two regimes is complex and was something that we considered in depth in issue 62 when analysing the decision of Charles J in *GJ v the Foundation Trust; the PCT and the Secretary of State for Health* [2009] EWHC 2972 (Fam), (2009) 12 CCL Rep 600, [2010] Fam Law 139, [2010] 1 FLR 1251.
- (iii) **Informal mental health patients.** The report raises concerns about the position of informal patients on locked wards. In some cases, a situation of de facto deprivation of liberty seems to have occurred. This is what the report says:

"On some visits, we found that informal patients in these units were not free to leave and locked doors or keypads were used to restrict entry and exit to and from the units for all patients.

This raises concerns that some informal patients in such facilities are at risk of 'de facto' detention, or a deprivation of liberty without legal authority, and this is not acceptable practice. To ensure that the rights of informal patients on these units are protected, all staff in these units must be trained appropriately to ensure that they are aware of the Mental Capacity Act and the Deprivation of Liberty Safeguards and the impact of these on the care they provide".





## Does the report help in identifying what amounts to a deprivation of liberty?

The DOLS safeguards operate by reference to the concept of deprivation of liberty under Article 5 of the European Convention on Human Rights. This creates a difficulty for those who are subject to, and charged with operating, DOLS. Under European Court of Human Rights case law there is no precise definition of what amounts to a deprivation of liberty and no clear demarcation between deprivation of and mere restriction of liberty (to which DOLS does not apply). For example, in *Guzzardi* [1981] 3 EHRR 333, the Court said that "the difference between deprivation of and restriction upon liberty is nonetheless merely one of degree or intensity, and not one of nature or substance".

The CQC report acknowledges that the inherent lack of precision as to what amounts to a deprivation of liberty has made it difficult for some professionals to know whether a DOLS authorisation should be sought. To assist care professionals to recognise a deprivation of liberty, the CQC recommend that the Department of Health "consider developing clear and concise briefings [on the topic] that are accessible and easily applied to practice".

The report also provides some assistance in this respect. It has distilled from the case law certain features which tend to show that a deprivation of liberty is occurring (so that a DOLS authorisation should be sought). These are as follows:

- Restraint was used to admit a person to a hospital or care home when they were resisting admission.
- Medication was given forcibly, against a patient's will.
- Staff exercised complete control over a person's care and movements.
- Staff made all decisions on a person's behalf, including choices relating to assessments, treatment, visitors and where they could live.
- Hospital or care home staff took responsibility for deciding if a person could be released into the care of others or allowed to live elsewhere.
- When carers requested that a person be discharged into their care, hospital, or care home staff refused.
- A person was prevented from seeing friends or family because the hospital or care home restricted access to them.
- A person was unable to make choices about what they wanted to do and how they wanted to live, because hospital or care home staff exercised continuous supervision and control over them.

Links – [www.cqc.org.uk/\\_db/\\_documents/20110304\\_DoLS\\_Report\\_v4\\_201103144159.pdf](http://www.cqc.org.uk/_db/_documents/20110304_DoLS_Report_v4_201103144159.pdf) – the full report is available here.

## BEST INTERESTS

### **AH v Hertfordshire Partnership NHS Foundation Trust – not in adult's best interests to move from rural campus-style accommodation to urban supported housing**

Community living has changed the lives of thousands of persons with learning disabilities for the better. But it should not be assumed that it suits everyone. To do so comes close to the paternalistic mindset which for many years left persons with learning disabilities languishing in long-stay hospitals. Instead, the guiding principle should be an adult's welfare. That is the message from this case.

#### What happened?

In rural Hertfordshire an NHS Trust ran a self-contained campus-style residential facility for adults with autism and severe learning disabilities. Department of Health national policy is to promote the migration of adults from facilities such as this to supported living projects in the community.

One of the adults at the facility, who had lived there for about 20 years, was placed by Ealing council. In pursuit of the national policy, Ealing proposed that the adult should move to a supported housing project in London. Ealing contended that such a move would be in the adult's best interests as it would promote his independence.

Ealing's proposal was strongly objected to by the adults' parents. The adult lacked the mental capacity to decide where to live. It fell to the Court of Protection to decide whether a move to the London supported house would be in the adult's best interests.

#### What did the Court of Protection decide?

Having heard expert evidence, the Court decided that it would not be in the adult's best interests to leave the campus-style facility and move into supported housing. The adult's severe form of autism meant that he was highly sensitive to changes in his routine. In itself that mitigated against a move. But in addition the rural setting of the Hertfordshire unit was a much more suitable environment for him than a busy, built-up urban area of London.





The Court ended its decision by criticising the assumption that the optimum caring environment for all adults with severe learning disabilities must be a supported housing project in the community. Insightfully, the Court pointed out that this runs counter to the personalisation philosophy that guides national care policy:

“guideline policies cannot be treated as universal solutions, nor should initiatives designed to personalise care and promote choice be applied to the opposite effect. The very existence of [the Hertfordshire facility], after most of the institutional population had been resettled in the community, is perhaps the exception that proves this rule. These residents are not an anomaly simply because they are among the few remaining recipients of this style of social care. They might better be seen as a good example of the kind of personal planning that lies at the heart of the philosophy of care in the community.”

The Court of Protection gave its decision in AH (by his litigation friend RH) v Hertfordshire Partnership NHS Foundation Trust & Ealing Primary Care Trust on 17 February 2011: [2011] EWHC 276 (CoP).

## MENTAL HEALTH – GENERAL ISSUES

### SELF-HARM

#### Coroners' Rule 43 reports on reducing risks of death – themes from the latest reports

Rule 43 of the Coroners Rules 1984 provides for a coroner to issue a report where the evidence heard during an inquest “gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future”. The report is to be issued to the person who could take action to reduce the risk. The Ministry of Justice has collated a summary of the 175 Rule 43 reports, and the responses to them, given between 1 April and 30 September 2010.

#### Legal relevance of Rule 43 reports

The summary report is of legal interest. It reveals what could be done to prevent deaths. Accordingly, its contents may well be relevant if a claim is made that a hospital or prison authority failed to comply with its duty under Article 2 of the European Convention on Human Rights to protect life, or if a death in detention resulted in a negligence claim on the basis that the suicide-prevention steps taken in a particular case fell below that which could reasonably be expected. In both cases, publicly available information about avoidable risks of death could be relied on in support of an Article 2 or a negligence claim.

#### Main points made in Rule 43 reports

For the purposes of this publication, the key points made in the summary report were as follows:

- (i) 26% of reports concerned hospital deaths. The major issues identified in hospital death reports are described as “staff training, absence of procedures and protocols or failing to follow such procedures and protocols, deficiencies in record keeping, and concerns about communication”;
- (ii) the report goes on to identify in more detail the main communication concerns in hospital deaths as follows:

“Communication concerns are raised in a number of areas:

- between different hospital departments or specialities;
- between different staff involved in the patient's care, including when they change shifts;
- with patients and their families, and
- with community healthcare providers about follow-up treatment after discharge from hospital.”

- (iii) 16% of reports concerned deaths in custody. As regards themes revealed, the summary report states:

“The main issue in these reports is medical care of prisoners, particularly those with mental health concerns. Problems with communication and prison procedures and protocols also feature in many of the reports in this category of deaths.”

Links – <http://www.justice.gov.uk/publications/docs/rule-43-coroners-report-march2011.pdf> - the full report is available here, which includes in its Annexes details of the individual Rule 43 reports divided according to category. There is a mental healthcare category.





# MENTAL HEALTH & THE CRIMINAL JUSTICE SYSTEM

## HOSPITAL ORDERS

### **R v O – hospital order substituted for life sentence for reasons which included facilitating access to welfare benefits**

In 1998 sixteen year old O pleaded guilty in the Crown Court to raping his six year old brother. At the time, the possibility of a Mental Health Act disposal was investigated but ultimately not pursued, in part due to difficulties in identifying an available bed. Instead, O was given a life sentence with a minimum term of 30 months.

In 1999, O was transferred from a YO1 to a secure hospital by a transfer direction given under s.47 of the Mental Health Act 1983. O has remained detained in hospital ever since. O recently appealed against his life sentence (upon a reference made by the Criminal Cases Review Commission under s.9 of the Criminal Appeal Act 1995).

#### **Why was a hospital order not originally imposed?**

When O came before the Crown Court in 1998, a Mental Health Act disposal was actively considered. But the Court could not obtain any clear undertaking that, if a hospital order were made, a bed would be available for O. It seems that, due to these difficulties, the Crown Court had no real alternative but to impose a custodial sentence rather than a Mental Health Act disposal. This is because, under s.37 of the Mental Health Act 1983, the Crown Court may not make a hospital order unless it is satisfied that arrangements have been made for the defendant to be admitted to a particular hospital within 28 days of an order being made. As the Crown Court could not be satisfied that such arrangements had been made, it considered that it had no power to make a hospital order. The Court of Appeal's analysis of what happened in 1998 was that there was "confusion" about the availability of a bed, the Crown Court judge felt "boxed in" and had no real alternative but to impose a prison sentence.

#### **Why was the appeal allowed and a hospital order imposed?**

The fact that the Crown Court did not think it had the power to make a hospital order was not a bar to the Court of Appeal making such an order on appeal. The Court of Appeal referred to the case of *R v De Silva* (1994) 15 Cr App R(S) 296 as authority for the proposition that a hospital order may be made on appeal in a case where the satisfaction of the s.37 criteria at the time of sentencing only came to light after a prison sentence had been imposed. The Court proceeded to decide that, then and now, the statutory pre-conditions to the making of a hospital order were met. In so deciding, it accepted and relied on the submission of the Criminal Cases Review Commission that a bed might have been available within 28 days of O being sentenced in 1998.

The Court briefly considered whether there was any point in substituting a hospital order for O's life sentence, given that he was in hospital now and likely to remain so. It decided that there was a point. The Court of Appeal imposed a hospital order with restrictions (so that O shall be a restricted patient).

#### **The welfare benefits dimension to this case**

The Criminal Cases Review Commission argued that welfare benefits entitlement was one factor in support of the patient's case. Interestingly, this was adopted by the Court of Appeal as a factor in favour of allowing the patient's appeal and replacing his life sentence with a hospital order. It seems that this is the first reported decision in which the availability of welfare benefits was a factor taken into account by the Court of Appeal in allowing an appeal against a refusal to impose a hospital order.

What, then, is the welfare benefits context? This concerns the different welfare benefits treatment of different types of hospital patient, according to the initial legal basis for their detention. Following the enactment of the Social Security (Persons Serving a Sentence of Imprisonment Detained in Hospital) Regulations 2010 (introduced to reverse the effect of the Court of Appeal's decision in *R (D & M) v Secretary of State for Work and Pensions* [2010] EWCA Civ 18) the position is as follows:

- (i) 'Civil' patients (whose detention was not ordered following a criminal conviction) are eligible for income support (or state pension credit if of pensionable age) whilst detained in hospital under the MHA 1983.
- (ii) Certain criminal patients are also entitled to income support (or pension credit) while detained in hospital under the MHA 1983. These are patients subjected to a hospital order following conviction for a criminal offence and who, as a result, went straight to hospital rather than being transferred to hospital following the commencement of a prison sentence.
- (iii) Transferred patients who, prior to transfer, were serving a determinate (time-limited) sentence are entitled to Income Support once they reach the point at which, had they remained in prison, they would have had to have been released.

Under O's original sentence, therefore, he was not entitled to income support. By contrast, under the fresh sentence imposed by the Court of Appeal he was entitled to income support payments.

(a) The Crown Court may not make a hospital order unless it is satisfied that arrangements have been made for the defendant to be admitted to a particular hospital within 28 days of an order being made.

The Court of Appeal (Criminal Division) gave its decision in *R v O* on 9 February 2011: [2011] EWCA Crim 376. The Court was comprised of Gross LJ, Ramsey J and Sir Christopher Holland.





# WELFARE BENEFITS

## EMPLOYMENT & SUPPORT ALLOWANCE

### Revised official Workbook for Health Care Professionals carrying out Work Capability Assessment examinations

The Department for Work & Pensions have published a revised Handbook for Health Care Professionals (HCPs) carrying out Work Capability Assessment medical examinations. The Work Capability Assessment (WCA) is used to decide if someone is entitled to Employment & Support Allowance the replacement for incapacity benefit. One of the drivers behind the introduction of the new Allowance was the increasing numbers of persons with mental health conditions who were being found entitled to incapacity benefit. It is likely therefore that many persons with mental health problems will face the WCA over coming months and years.

At over 180 pages, the Workbook is a detailed publication. The parts of most interest to advisers will be (a) section 2.3 (pages 19 to 31) which give examples of what types of severe disability are likely to merit a person falling within the 'support group' (persons who are not expected to do work-related activity) and (b) sections 3.3 to 3.6 (pages 64 to 113) as this is where detailed advice is given to HCPs about the WCA descriptors and what sort of conditions should lead to a recommendation that a particular descriptor is met. Overall, these sections are useful if an adviser or client wants to know what a HCP is 'really' looking for.

The Workbook also gives detailed advice to HCPs on how they should conduct themselves during an examination. This could be useful reference material for those cases where a person wishes to make a complaint about an examination. The Workbook also confirms, if any confirmation were necessary, that an examination commences as soon as an individual enters the examination room. The Workbook in a number of places emphasises that HCPs should closely monitor an individual throughout the period of the examination and not simply take into account the individual's responses to instructions given and questions asked.

[www.dwp.gov.uk/docs/wca-handbook.pdf](http://www.dwp.gov.uk/docs/wca-handbook.pdf) - the Workbook is available here.

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