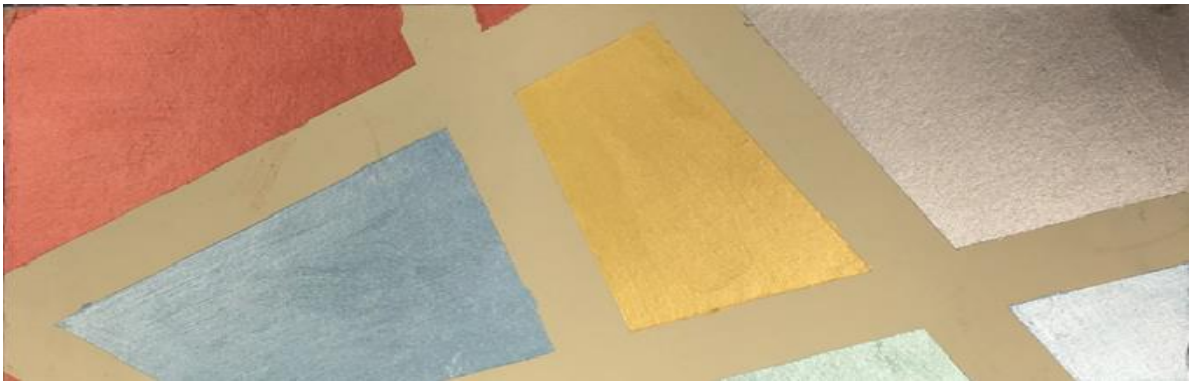
MENTAL CAPACITY REPORT: THE WIDER CONTEXT

March 2019 | Issue 92



Welcome to the March 2019 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: an update on the Mental Capacity (Amendment) Bill; capacity and social media; the limits of the inherent jurisdiction (again); and best interests at the end of life;

(2) In the Practice and Procedure Report: an important decision on when it is legitimate summarily to dispose of s.21A applications; litigation capacity in the Court of Protection, Brexit contingency planning; and the launch of the Court of Protection Bar Association;

(3) In the Wider Context Report: CQC guidance on sexuality, litigation friends in the immigration tribunal; Strasbourg on the obligations towards voluntary psychiatric patients; and the Special Rapporteur on the Rights of Persons with Disabilities on ending disability-based deprivation of liberty.

We do not have a Property and Affairs report this month as there are insufficient developments to warrant a standalone report (but see the Practice and Procedure report for an update on the OPG's mediation pilot). Nor do we have a Scotland report, in part because we are disappointingly unable so far to report further progress on reform of the Adults with Incapacity (Scotland) Act 2000.

You can find all our past issues, our case summaries, and more on our dedicated sub-site here. You can also find here an updated version of our capacity assessment guide, with the best interests guide also due a refresh in the near future.

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

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Capacity, minors and presumptions

R (on the application of JS, SJ, SS and NL) v Secretary of State for the Home [2019] UKUT 64 (IAC) Upper Tribunal (IAC) (Lane J, Upper Tribunal Judge Rintoul, Upper Tribunal Judge Rimington)

Litigation friend - other

Summary

The applicants in this case were all minors who had issued applications for judicial review in the Upper Tribunal. The absence of any provisions in the Tribunal Procedure (Upper Tribunal) Rules 2008 and practice directions regarding the use of litigation friends in judicial review proceedings before the Upper Tribunal meant that there was a degree of uncertainty when an application for immigration judicial review was made in respect of a child without a litigation friend. The Lord Chancellor was joined as an interested party so that the Tribunal could give general guidance on whether a litigation friend should be appointed.

The Tribunal recognised that "[i]*t is now firmly established that the Upper Tribunal has power to appoint a litigation friend and that, in certain circumstances, not to do so will amount to a breach of the common law principles of fairness and access to justice*" (para 70). Although the issue arose in the context of immigration judicial review proceedings, the Tribunal's general guidance is also relevant to statutory appeals in the Immigration and Asylum Chambers of both the First-tier Tribunal and the Upper Tribunal.

The Upper Tribunal gave general guidance as follows:

> *(1) Although all cases are fact-specific, the following general guidance represents the approach the Upper Tribunal is likely to adopt in deciding whether a child applicant in immigration judicial review proceedings requires a litigation friend to conduct proceedings on the child's behalf:*
>
> *(a) As a general matter, applicants aged 16 or 17 years, without any attendant vulnerability or special educational need or other characteristic denoting difficulty,*

will be presumed to have capacity and so be able to conduct proceedings in their own right. They will generally not require a litigation friend. This is the position even if they are not legally represented.

(b) The appointment of litigation friends for applicants between the ages of 12 years and 15 years inclusive (i.e. 12 and over but younger than 16) needs to be considered on a case-by-case basis and the circumstances which should be considered, but which are not exhaustive, are:

(i) whether the applicant is legally represented;

(ii) whether there is an assisting parent;

(iii) whether there is a local authority involved; and

(iv) whether the applicant has any type of vulnerability.

(c) If an applicant in this age group is legally represented, the Tribunal will expect the representative specifically to address in writing the issue of whether, in the representative's view, a litigation friend is necessary, having regard to capacity and the position of any parent.

(d) Applicants under the age of 12 will normally require a litigation friend.

(2) The above approach is one that, as a general matter, should also be followed in appeal proceedings, whether in the First-tier Tribunal or the Upper Tribunal.

(3) In deciding who is to be a litigation friend in a particular case, the guiding principles, derived from the Civil Procedure Rules, are:

(a) can he or she fairly and competently conduct proceedings on behalf of the child?

(b) does he or she have an interest adverse to that of the child?

(4) For practical purposes, only one person should normally be nominated as a litigation friend. A parent of a child will often be the obvious choice but not the only option.

The Upper Tribunal also confirmed that the duty of the litigation friend is to (i) to act competently and diligently and (ii) to act in the best interests of (and without conflict with) the party for whom he is conducting proceedings.

Comment

At a practical level, the Upper Tribunal's general guidance is welcome – filling an obvious gap in the Tribunal Rules which make no provision for the appointment of a litigation friend. Although the guidance was only given in respect of minors (as all applicants in the case were under the age of 18), the judgment usefully confirms that the Upper Tribunal (and First-tier Tribunal) has the power to appoint a litigation friend and, we would suggest, there is no reason in principle why this power could not extend to appoint a litigation friend on behalf of an adult who lacked capacity

to conduct proceedings. What remains to be seen are the practical consequences of the Tribunal's guidance. In relation to minors, the obvious candidate for litigation friend is the parent but this may not always be possible or appropriate. Drawing on the approach under the Civil Procedure Rules, the Tribunal noted that the Official Solicitor may act on behalf of a child if there is no one else to act. However, where it is sought to appoint the Official Solicitor as the litigation friend, "*provision must be made for payment of his charges*". Quite how the Official Solicitor's costs will be met in such circumstances is unclear, especially if there is a risk of adverse costs and, as ever, resources may well be a limiting factor.

More widely, it is interesting to note that the Upper Tribunal, untrammeled by procedural rules, took the view that they did not accept that a child had to have a litigation friend unless the court or tribunal ordered otherwise, and was "emboldened" (at para 79) by the presumption of mental capacity in the MCA 2005 in relation to children aged 16 and 17. Indeed, in light of these observations, one might think it was, in fact, anomalous that none of the Civil Procedure Rules, the Court of Protection Rules or the Family Procedure Rules proceed on the basis of a presumption that a child aged 16 or 17 has the mental (and hence legal) capacity to give instructions.

Sexuality and capacity – new CQC guidance

At the end of February the CQC published guidance for care providers on relationships and sexuality in social care which aims to support care providers and their clients with building and maintaining emotional and sexual relationships.

The guidance considers how those who are provided with personal care can lose privacy during the provision of personal care and can become vulnerable. It acknowledges sexual expression as a "positive, natural human need"; that ignoring it can have a negative impact on physical and mental wellbeing. While noting – of course - that best interests decisions regarding sexual relations cannot be made on P's behalf the guidance looks at how those living with disabilities may be provided with support for the practicalities of engaging in an active sex life.

It suggests CQC inspectors should ask organisations whether they have a relationship and sexuality policy and should train staff to support people with their personal relationship needs. The CQC also give guidance as to the approach to adopt to assessing capacity (endorsing the same approach as set down in our capacity guide) drawing, most recently, on *LB Tower Hamlets v TB & Ors* [2014] EWCOP 53 and *LB Southwark v KA (Capacity to Marry)* [2016] EWCOP 20, which includes the requirement that the person can understand, retain, and use and weight the fact that they have the choice whether to have sex and can refuse and that they can change their mind in relation to consent to sex at any time leading up to and during the sexual act.

The second appendix to the report may be of particular interest to some care providers: it lists a number of useful resources aimed at facilitating intimacy and sexuality for those in adult social care.

Consultation on autism and learning disability training for health and social care staff

The Department of Health and Social Care is consulting as to how to ensure that health and social care staff have the right training to understand the needs of people with a learning disability and autistic people, and make reasonable adjustments to support them.

The consultation, which closes on 12 April, considers issues around the training and development staff need to better support people with a learning disability or autistic people.

Chief Coroner's Report

The Chief Coroner's Report to the Lord Chancellor for 2017-18 contains some interesting insights into the effect of the changes introduced to the Coroners and Justice Act 2009 in 2017. It would appear that there were 3,866 DoLS deaths reported to the coroner in 2017. In other words, the fact that, since 3 April 2017, DoLS deaths are no longer automatically reportable has led to a 18% reduction in the number of inquests compared to 2016, as previously all such deaths required an inquest.

In this regard, some may be interested to note what the independent Review of the MHA 1983 had to say about 'deaths under DoLS':

> [f]*ollowing changes to the CJA introduced in 2017, someone who has died whilst subject to DoLS (or, in future, the Liberty Protection Safeguards) is not considered to have been in state detention for purposes of determining that there should be an investigation by a coroner, which means there is no automatic investigation of their death by the coroner. In many cases, this is entirely appropriate, it is simply wrong to consider the natural death of an elderly person in a care home a death in state detention for these purposes simply because they were subject to a DoLS authorisation. But in the case of those in a psychiatric hospital subject to DoLS (or, in future the LPS), it may be far more appropriate to think of them as being in state detention. We are not recommending further amendments to the CJA, but we do think that it is important that all relevant guidance (including from the Chief Coroner, but also the Mental Health Act Code of Practice) make it clear that in these circumstances it should be presumed that the individual is in state detention for purposes of triggering the duty for an investigation by a coroner.*

Voluntary psychiatric patients, suicide and the duty to protect – Strasbourg pronounces

Fernandes de Olivera v Portugal [2019] ECHR 106 European Court of Human Rights (Grand Chamber)

Article 2 ECHR – CRPD

Summary

The Grand Chamber of the European Court of Human Rights, in a majority decision, has identified the obligations arising under Article 2 ECHR in the context of voluntary patients at risk of suicide, accompanied by a fascinating part-dissent from two judges.

The applicant complained under Article 2 ECHR that her son had been able to take his own life as

a result of the negligence of the psychiatric hospital where he had been hospitalised on a voluntary basis. Under Article 6 ECHR she also complained about the length of the civil proceedings she had instigated against the hospital.

As the court observed, this meant that:

> *two distinct albeit related positive obligations under Article 2, already developed in the jurisprudence of the Court, may be engaged. First, there exists a positive obligation on the State to put in place a regulatory framework compelling hospitals to adopt appropriate measures for the protection of patients' lives* […]. *Second, there is a positive obligation to take preventive operational measures to protect an individual from another individual or, in particular circumstances, from himself.*

As the Grand Chamber noted, it had recently pronounced upon the first obligation (those observations being rapidly translated into English law in the *(Parkinson) v HM Senior Coroner for Kent* [2018] EWHC 1501 (Admin), discussed in the July 2018 Mental Capacity report). It found on the facts that the manner in which the regulatory framework was implemented did not give rise to a violation of Article 2 in the circumstances of the present case. It noted, in particular, that the lack of security fences and walls around the hospital was in line with the legislation in place at the time, which:

> *117.* […] *indicated that mental-health care should be provided in the least restrictive environment possible. These general principles mirrored the therapeutic desire to create an open regime where the patient retained the right to move about freely. This approach is in line with the international standards which have been developed in recent years on treating psychiatric patients (see the International Law section above and see also Hiller, cited above, § 54).*

As regards the second, and as it had previously hinted it might (*Reynolds v. the United Kingdom* (Application no. 2694/08, 13 March 2012), the Grand Chamber extended the scope of the 'operational' duty to voluntary psychiatric patients, albeit on a specific basis:

> *124. There is no doubt that as a person with severe mental health problems A.J. was in a vulnerable position. The Court considers that a psychiatric patient is particularly vulnerable even when treated on a voluntary basis. Due to the patient's mental disorder, his or her capacity to take a rational decision to end his or her life may to some degree be impaired. Further, any hospitalisation of a psychiatric patient, whether involuntary or voluntary, inevitably involves a certain level of restraint as a result of the patient's medical condition and the ensuing treatment by medical professionals. In the process of treatment, recourse to further kinds of restraint is often an option. Such restraint may take different forms, including limitation of personal liberty and privacy rights. Taking all of these factors into account, and given the nature and development of the case-law referred to in paragraphs 108-115 above, the Court considers that the authorities do have a general operational duty with respect to a voluntary psychiatric patient to take reasonable measures to protect him or her from a real and immediate risk of suicide. The specific measures required will depend on the particular*

> *circumstances of the case, and those specific circumstances will often differ depending on whether the patient is voluntarily or involuntarily hospitalised. Therefore, this duty, namely to take reasonable measures to prevent a person from self-harm, exists with respect to both categories of patient. However, the Court considers that in the case of patients who are hospitalised following a judicial order, and therefore involuntarily, the Court, in its own assessment, may apply a stricter standard of scrutiny.*

In deciding whether the operational duty had arisen and breached in the instant case, the court had regard to the following criteria drawn from previous case-law concerning the assessment of suicide risk:

> *i) a history of mental health problems*;
>
> *ii) the gravity of the mental condition;*
>
> *iii) previous attempts to commit suicide or self-harm;*
>
> *iv) suicidal thoughts or threats;*
>
> *v) signs of physical or mental distress* (citations omitted).

Taking account of the facts that "*according to the expert evidence, complete prevention of suicide in patients such as A.J. was an impossible task* […] *and that the Coimbra Administrative Court found that A.J.'s suicide was not foreseeable*" and that the *"question of risk* [must be approached] *with a view to assessing whether it is both real and immediate and notes that the positive obligation incumbent on the State must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities*," the court "*conclude*[d] *that it has not been established that the authorities knew or ought to have known that there was an immediate risk to A.J.'s life in the days preceding 27 April 2000.*" The Grand Chamber did not therefore need to go on to decide whether the duty had been breached.

However, and not least as the Portuguese government conceded that the proceedings brought by A.J.'s mother had taken excessively long to conclude, the Grand Chamber found that there had been a violation of the procedural limb of Article 2 ECHR.

In a separate, part-dissenting, and part-concurring judgment, Judge Pinto de Albuquerque (the Portuguese judge), joined by Judge Harutyunyan, attacked what he perceived to be the majority's pursuit of an "*ideologically charged minimalist approach to the State's positive obligations in the sphere of health care to its limits, this time regarding the particularly vulnerable category of psychiatric inpatients under State control. The effect is that of downgrading the level of Convention protection to an inadmissible level of State inertia*." He was particularly scathing of the Grand Chamber's decision to apply a less strict standard of scrutiny to voluntary patients, noting that there had been no justification, in face of the unanimous Chamber view to the contrary:

> *21. The argument that there is an emerging trend to treat persons with mental disorders under an "open door" regime is not decisive* […]. *First, it only shows one side of the coin, because there is also a counter-trend to increase State obligations with regard to suicide prevention, which is totally neglected by the majority* […] *The core of the problem today lies precisely in the inter-*

relationship between these two different trends of international health law and practice, which the majority do not even seek to consider. Moreover, as put by Judge Iulia Antoanella Motoc, dissenting in Hiller, "the duty to protect the right to life should not be sacrificed in an attempt to comply with the above-mentioned recent trend in healthcare" […]. *The right to life prevails over the right to liberty, especially when the psychopathological condition of the individual limits his or her capacity for self-determination. It is nothing but pure hypocrisy to argue that the State should leave vulnerable suicidal inpatients in State-run psychiatric hospitals free to put an end to their lives merely in order to respect their right to freedom. At the end of the day, what really drives the majority is not the concern for more or less freedom of psychiatric inpatients interned in public hospitals, but the strict financial interest in safeguarding the hospital authorities from legal challenges to "excessively restrictive measures"* […], *while "bearing in mind the operational choices which must be made in terms of priorities and resources in providing public healthcare and certain other public services".* […] *Ultimately, this reflects a hidden social-welfare disengagement policy, which aims at the maximum commodification of health-care services and above all at the protection of health professionals in an untouchable legal bubble, shirking State responsibility for health-system and hospital-related death or serious injury under the Convention and consequently limiting the Court's jurisdiction in this area.*

Judge Pinto de Albuquerque also conducted a tour d'horizon of the relevant international law norms in play, noting that it is "*confusing, to say the least, signaling tough ongoing discussions on the matter*."

Comment

For English domestic purposes, voluntary and involuntary psychiatric patients at risk of suicide have been assumed to be essentially interchangeable from the perspective of Article 2 ECHR since the decision of the Supreme Court in *Rabone*. The Grand Chamber's decision shows that Lord Dyson and Lady Hale were largely right to infer in 2012 that the obligations under Article 2 ECHR as applied to detained patients would be applied by Strasbourg to informal patients if the question came before it. However, it is interesting to note the nuanced fashion in which the Strasbourg court approached the question when it actually came for determination before it.

First, the Grand Chamber expressly held that it could apply a higher standard of scrutiny where the detention was involuntary (which would apply equally whether the detention was authorised judicially, as in Portugal, or administratively, as in England and Wales). The potential for such a differential approach attracted the scorn of the dissenters in Strasbourg, but will no doubt need to be translated into domestic jurisprudence in due course here.

Second, and making express reference to the CRPD, the Strasbourg court also took into account "*the therapeutic desire to create an open regime where the patient retained the right to move about freely. This approach is in line with the international standards which have been developed in recent years on treating psychiatric patients*" (paragraph 117). Perhaps because of the facts

of the *Rabone* case,[1] and the way in which evidence had been put before it, the Supreme Court's decision in retrospect is conspicuous for the starkness of the binary contrast it set up between keeping Melanie Rabone in hospital (and therefore, by definition, alive[2]) and allowing her to go home and take her own life. One of the (no doubt) inadvertent consequences of this contrast and one that greatly exercised the independent review of the Mental Health Act 1983, has been the potential for increased risk aversion on the part of professionals. The Grand Chamber's decision, as in the earlier (2016) decision in *Hiller v Austria*, arguably points the way towards a better calibration of the positive obligations imposed under Article 2 ECHR in this context.

There are, of course, elephant traps in that calibration exercise. Some might doubt the dissenters' suggestion that there is a "*hidden social-welfare disengagement policy*" at play in the thinking of the majority of the Grand Chamber. Not least in light of *Rabone*, it is also not immediately obvious, at least in England & Wales, that healthcare professionals either sit or perceive themselves to sit "*in an untouchable legal bubble*."

However, there is undoubtedly a very real potential danger of social-welfare disengagement, albeit from a slightly different direction to that identified by the dissenters. A key consideration in the 'confidence tests' developed by the MHA review for purposes of determining recommendations for the future direction of travel,[3] was the fear expressed by at least some service users that moving to a capacity-based model would lead to refusal of services on the basis that "*you have capacity, and it's your choice what you do*." This refusal of services could sometimes (as the Review noted) represent "*a reaction from overstretched staff (these examples often came from crisis services or A&E) with a very limited or non-existent choice of alternative services.*" In other words, pushing capacity-based mental health legislation unsupported by state-level obligations to provide alternative services meeting the needs of the individuals in question could very well lead to catastrophic "social-welfare disengagement."

Finally, it is perhaps of note that the Grand Chamber, in full knowledge of the CRPD Committee's views upon mental capacity, had no hesitation in relying upon the concept (at paragraph 127) in founding a conclusion that Article 2 was engaged. The day may well be coming when the Strasbourg court concludes that detention and/or treatment in the face of capacitous refusal cannot stand with the ECHR, but there is no sign from this judgment that it is likely to abandon the validity of the concept of mental capacity as a factor in deciding where the balance lies between protection and autonomy.

Ending disability-based deprivation of liberty?

The report has been published by the UN Special Rapporteur for Persons with Disabilities, Catalina Devandas, on 'Ending the deprivation of

[1] Including an admission of negligence by the Trust.
[2] Lord Dyson's observations are particularly striking here, holding at para 28 that "[t]*he statutory powers of detention are the means by which the hospital is able to protect the psychiatric patient from the specific risk of suicide*."
[3] See pp.213-218.

liberty on the basis of disability."[4] In it, the Special Rapporteur seeks to outline the scope of the problem of deprivation of liberty on the basis of disability world-wide, its causes, as well as a set of recommendations to end it. The examples she gives of what – on any view – are human rights abuses are compelling, and the call to action loud and clear. For an analysis of the difficult issues that arise because of the (over)reach of the Special Rapporteur's challenge to the justifications advanced for deprivation of liberty, see Alex's website.

'Benevolent coercion'

The German Ethics Council has published a report on "Benevolent Coercion – Tensions between Welfare and Autonomy in Professional Caring Relationships." The full, very detailed, report is available as yet only in German, but an executive summary is available in English here. It makes a particularly interesting counterpart to the two items discussed immediately above.

[4] A version of a report presented at the 40th session of the Human Rights Council, that version being available here.

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Conferences

Conferences at which editors/contributors are speaking

Essex Autonomy Project summer school

Alex will be a speaker at the annual EAP Summer School on 11-13 July, this year's theme being: "All Change Please: New Developments, New Directions, New Standards in Human Rights and the Vocation of Care: Historical, legal, clinical perspectives." For more details, and to book, see here.

Advertising conferences and training events

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

Our next edition will be out in April. Please email us with any judgments or other news items which you think should be included. If you do not wish to receive this Report in the future please contact: marketing@39essex.com.

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