# Mental Health Law Online

## Monthly Update, January 2013

## Contents



## Introduction

In addition to being available on the Mental Health Law Online website, each month's legal update is available in PDF format for printing, and in Kindle format for e-book reading. This update is based on the content at http://www.mentalhealthlaw.co.uk/January_2013_update It is a snapshot of the online page – the online page will be automatically updated when case and legislation pages are updated.

## Cases

- **Upper Tribunal case.** AC v Partnerships in Care Ltd (2012) UKUT 450 (AAC), (2012) MHLO 163 — *AC appealed against the tribunal's rejection of his application for a notification under s74 that, if subject to a s37/41 hospital order rather than a s47/49 prison transfer direction, he would be entitled to a conditional discharge. (1) The tribunal failed to explain why it rejected Dr Kahtan's independent evidence which supported discharge: (a) although it stated that the RC had more experience of the patient, this is not of itself a reason for preferring evidence but rather is the background to almost every case, and it does not always follow that greater knowledge means greater insight; (b) the tribunal's criticisms of Dr Kahtan's evidence on the link between the index offences and AC's mental state did not necessarily undermine his views on discharge. (2) The tribunal was right not to consider the conditions which might be imposed by the Parole Board (and any consequent diminution of risk on release) and only to consider conditions possible with a conditional discharge: (a) the tribunal's statutory function is limited to considering discharge from the scope of the Act; (b) it is true that the tribunal should take into account the practical reality, as in a case where release into the community is impossible and prison is the only alternative (Abu-Rideh), but this reasoning does not apply to a case such as AC's because it is unknown whether the Parole Board will release or what conditions it might impose.*

- **COP medical case.** Re P (hunger strike) (2013) MHLO 4 (COP) — *(1) The press has reported this case as follows: (a) P came to the UK on a six-month visa to learn English but refused to leave, asylum having been refused twice; (b) he stopped eating in May 2012 in protest at the UKBA's refusal to return his passport unless he returns to Iran; (c) an NHS Trust in the South-east of England is seeking to force-feed him on the basis that he lacks capacity because of a delusional disorder. (2) The case is ongoing and a reserved judgment is expected by mid-February 2013.*

- **COP medical case.** Re AW (Permanent Vegetative State); The NHS Trust v AW (2013) EWHC 78 (COP), (2013) MHLO 3 — *AW was in a permanent vegetative state, having suffered a spontaneous, severe intra-cerebral haemorrhage in 2008. The NHS Trust responsible for AW's care sought a declaration that it would be lawful and in her best interests to withdraw active medical treatment, including specifically artificial nutrition and hydration, even though this would lead to AW's death. The application was supported by AW's family, by all the medical staff who looked after her, by the evidence of the expert witnesses provided reports, and by the Official Solicitor on behalf of AW herself. (1) The judge's findings were as follows: (a) AW is in a permanent vegetative state; (b) there will be no change or improvement in her condition; (c) there is no treatment available which could confer any benefit and that accordingly her treatment regime is futile; and (d) he suffering caused by withdrawal of artificial nutrition and hydration will be managed by appropriate use of pain relief in accordance with the plan that has been created for AW. (2) The following declarations were made: (a) AW lacks capacity to litigate in these proceedings or to make decisions about the medical treatment she should receive, including as to the withdrawal of artificial nutrition and hydration and other life-sustaining treatment; (b) it is lawful and in AWs best interests for life-sustaining treatment in the form of artificial nutrition and hydration to be withdrawn; and (c) it is in AW's best interests to receive such treatment and nursing care as may be appropriate to ensure that she retains the greatest dignity until her life ends. (3) By agreement, the NHS Trust was ordered to pay half of the costs of the Official Solicitor, to be subject to detailed assessment if not agreed.*

- **COP medical case.** Re P (abortion) (2013) MHLO 1 (COP) — *The press has reported this case as follows: (1) The solicitor who was one of P's deputies queried whether P had capacity in relation to whether to continue with her pregnancy or have an abortion. (2) Hedley J held that she manifestly lacked litigation capacity but did have capacity in relation to continuing the pregnancy. (3) Generally courts and health officials should not try to decide whether P would be able to bring up a child but should instead concentrate solely on whether the pregnancy itself is in her best interests (the reasoning being that once a child is born, if the mother does not have the ability to care for a child, society has perfectly adequate processes to deal with that). (4) The judge also stated that '[t]he purpose of [mental capacity legislation] is not to dress an incapacitated person in cotton wool but to allow them to make the same mistakes that all other human beings are able to make and not infrequently do'.*

    - **Jerome Taylor, 'Woman with limited mental capacity can have her baby' (Independent, 10/1/12).** See Re P (abortion) (2013) MHLO 1 (COP)

- **Community care case.** R (Cornwall Council) v SSH (2012) EWHC 3739 (Admin), (2012) MHLO 162 — *PH was a young man born with significant learning and*

*physical disabilities. The Secretary of State decided that when he turned 18 he was ordinarily resident under the NAA 1948 in Cornwall, where his parents lived, despite his physical presence elsewhere. The court held that the Secretary of State had lawfully applied the test in Vale relevant to a person who is so severely handicapped as to be totally dependent upon a parent or guardian (termed 'test 1' in the guidance), which states that such a person is in the same position as a small child and his ordinary residence is that of his parents or guardian because that is his base.*

- **Sentence appeal case.** R v Fletcher (2012) EWCA Crim 2777, (2012) MHLO 161 — *IPP sentence quashed and a restricted hospital order substituted in its place: the judge had not properly been informed as to the appellant's mental state, because the original reports focussed on mental illness (which the appellant did not suffer from) rather than learning disability (which he did).*

- **Employment case.** West London MH NHS Trust v Dr Chhabra (2013) EWCA Civ 11, (2013) MHLO 2 — *(1) Various complaints had been made against Dr Chhabra, including in relation to breaches of patient confidentiality, and the case investigator's report stated that Dr Chhabra admitted to reading CPA notes and dictating reports on public transport. (2) Upon reading the case investigator's report the case manager decided to convene a disciplinary panel to consider the following allegations and to consider them as potential gross misconduct which could lead to dismissal: (a) that Dr Chhabra breached patient confidentiality whilst reading notes and discussing patients whilst on public transport (the complaint being made by another passenger who happened to be Head of Secure Services Policy at the Department of Health); (b) that she undertook dictation on at least two occasions whilst completing Mental Health Tribunal reports whilst on public transport (the complaint being made by a member of secretarial staff); (c) that whilst travelling to work on public transport she would often call her secretary to discuss patient related matters breaching confidentiality (the complaint being made by her PA). (3) The High Court had made a declaration and injunction the effect of which were to prevent a disciplinary panel from investigating these complaints as matters of gross misconduct and under the terms of its disciplinary policy. (4) The Court of Appeal overturned that decision, stating the case manager's decision was justified on the basis of the disciplinary procedures and the evidence: patients' right to confidentiality is fundamental in the Health Service and must be respected by doctors and other staff; the case manager was entitled to regard breach of it in a public place by a consultant at Broadmoor as a potentially serious offence.*

## CQC

- **CQC, 'Mental health services must improve the care they provide to patients' (news item, 30/1/13).** This web page contains a brief summary of the report plus links to: (a) the report, (b) a summary document, (c) an easy-read version, and (d) the CQC's press release. See CQC

- **CQC, 'Monitoring the Mental Health Act in 2011/12' (30/1/13).** The following are the report's key findings for each chapter, and its concluding recommendations: (1) **Use of the Act:** (a) The number of people subject to detention under the Act is rising. The number of detentions rose by 5% on the previous year; the number of community treatment orders rose by 10%. (b) Of the 4,576 patient records checked in 2011/12,

4% showed irregularities that called the legality of the detention into question. (c) Care planning was the most frequently raised category of concern; 85% of the care plans examined showed evidence of individualised planning, regular review and evaluation, 15% did not. This was no change on 2010/11 and amounted to just over 650 patients where basic expectations about care planning were not met. (d) The greater detail now available in the Mental Health Minimum Data Set has exposed a number of data quality issues that must be addressed before the data can realise its full potential. (2) **Participation and Respect:** (a) CQC's MHA Commissioners visited many mental health wards where a great deal of respect was given to patients. (b) Patients were able to influence the running of their ward in almost all cases – 94% of all wards in 2011/12, up from 90%. (c) Patients were more involved in planning their own care: their views were recorded in 63% of care plans, a rise from 58%. But this means an unacceptably high proportion – more than a third – did not have their views written down. (d) More than half of patients were still not given a copy of their care plan. (e) Most patients (90%) were given general information about their rights when they were first detained. (f) But one patient in five was not informed of their right to an Independent Mental Health Advocate (IMHA). (g) This may reflect continuing difficulties that some services have in accessing IMHAs. There was no evidence of an IMHA service in one in seven of the wards CQC visited. (3) **Coercion in practice:** (a) The human rights of patients are often affected by controlling practices that only seem to serve the hospital's needs. Hospitals have a difficult task in balancing the realities of detention and compulsory treatment with the requirement that they provide services according to a principle of least restriction on patients. But it has proved all too easy for cultures to develop in which blanket rules deny people their basic rights – especially the right to dignity. (b) In one in five visits – an unacceptably high number – MHA Commissioners thought that patients who were in hospital voluntarily might be detained in all but name. For example, in 88 out of 481 visits there were no signs on locked doors that explained to voluntary patients how they could leave the ward. (c) On 24 occasions, patients had been secluded but the ward staff had not realised this was classed as seclusion and they had not applied the proper safeguards. (d) In many hospitals restraint practices are generally safe and appropriate. Almost all staff will now have some degree of training not only in physical methods of restraint, but in ways to prevent confrontational situations. (e) However, CQC is still concerned at the lack of regulation of training programmes with regard to restraint. Safeguards could be improved. (f) CQC is talking with the Department of Health about how to promote best practice around support for positive behaviour. (4) **Care pathways** (a) CQC saw evidence that many Approved Mental Health Professionals are trying to find alternative care for people that avoids them having to be detained in hospital. (b) Pressures on beds continued to put services and patients under stress, making it harder to provide appropriate care for people in times of crisis. In 2011/12, 93 wards (6% of all wards) visited had more patients than beds; a further 10% were at full capacity. (c) Patients are being affected by reductions in staff numbers. For example, MHA Commissioners raised concerns in 77 visits that a lack of staff prevented patients taking escorted leave. (d) In some services MHA Commissioners saw excellent examples of patients benefitting from psychological therapies. But in others, services were too ready to rely on psychiatric medication as their response to patients' distress. (e) Patients are benefitting from good discharge planning in a number of units – with considerable investment in time and effort being spent in identifying step down accommodation and suitable support arrangements. But an unacceptably high proportion – more than a third of care plans – still showed no evidence of discharge

planning. (5) **Consent to treatment:** (a) Consent to treatment discussions (before the first administration of medication) improved in 2011/12 – 55% of records showed these, up from 46% in 2010/11. But this means that in almost half of cases there was no evidence that doctors had talked to patients about whether they consented to proposed treatment. (b) There was better evidence of consent discussions after the first use of medication (72% of records). But still this means consent was not discussed in more than a quarter of cases. (c) One patient in 10 (receiving medication for three months or more) was prescribed medication above the legally authorised care plan. (d) In CQC's view, the assumption of a patient's capacity to consent to or refuse treatment should be backed up by a written record. More than a third of records did not show any evidence of a capacity assessment (42% on admission; 36% at the end of three months or the last administration of medication). (e) Patients may be reluctant to say what they think about their treatment in public, particularly in a traditional ward round. CQC saw some good services that have developed private arrangements instead of ward rounds. (6) **Community Treatment Orders:** (a) CTOs are used widely by some providers, and used little by others. In an analysis of NHS organisations, the lowest reported 'discharge rate' onto a CTO was 4.0%; the highest was 45.5%. (b) There were also a number of NHS organisations – with considerable rates of detention under the Act – that provided nil returns for the use of CTOs. (c) A number of patients are worried that it isn't clear when a CTO will have served its purpose – and therefore they do not know what they have to do to come off a CTO. (7) **Recommendations:** (a) Policy makers must consider the reasons why there are rising numbers of people subject to the Act and develop an appropriate policy response. (b) The Boards of mental health trusts, independent providers of mental health care, and community trusts are responsible and accountable for the quality of care people receive. They must drive the changes needed in their organisations. In particular they need to recognise and promote good practice and ensure that robust mechanisms are in place to understand individuals' experience of their services. CQC reminds providers of their own duties to monitor how they use powers derived from the Act (see the Code of Practice) and their duties under the Health and Social Care Act 2008 to demonstrate how they have learned lessons from practice and have made consequent improvements. This is an area that CQC will focus on in the next 12 months in its regulatory activity. (c) The NHS Commissioning Board, local authorities, clinical commissioning groups and specialist commissioners must commission services that guarantee a person's dignity, recovery and participation. Clinical commissioning groups and local authorities must ensure that local needs assessments for community services and commissioned models of care are informed by an understanding of their statutory duties under the Act and by the experiences of people who use services. See CQC

## Newsletters

- **39 Essex Street, 'Court of Protection Newsletter' (issue 29, January 2013).** The cases ++mentioned in this issue are: Re L; The NHS Trust v L [2012] EWHC 2741 (COP), [2012] MHLO 159 — J Council v GU [2012] EWHC 3531 (COP), [2012] MHLO 137 — In the matter of A (a child) [2012] UKSC 60 — R (ET) v (1) Islington LBC (2) Essex CC [2012] EWHC 3228 (Admin) — R (Chatting) v (1) Viridian Housing (2) LB Wandsworth [2012] EWHC 3595 (Admin) — R (Cornwall Council) v SoS for Health & Ors [2012] EWHC 3739 (Admin) — Neon Roberts — An NHS Trust v DJ [2012] EWHC 3524 (COP), [2012] MHLO 138. The following decisions

are currently under appeal: ZH v Commissioner of Police for the Metropolis [2012] EWHC 604 (QB), [2012] MHLO 25 — CYC v PC and NC [2012] MHLO 103 (COP) — A, B and C v X, Y and Z [2012] EWHC 2400 (COP), [2012] MHLO 112 — Dunhill v Burgin [2012] EWCA Civ 397, [2012] MHLO 33 and Dunhill v Burgin [2012] EWHC 3163 (QB), [2012] MHLO 115. See 39 Essex Street COP Newsletter

- **39 Essex Street, 'Court of Protection Newsletter' (issue 28, December 2012).** The cases mentioned in this issue are: Re CP; WBC v CP (2012) EWHC 1944 (COP), (2012) MHLO 144 — Re Harcourt (2012) MHLO 74 (LPA), R v Ligaya Nursing (2012) EWCA Crim 2521, (2012) MHLO 134 — Dunhill v Burgin (2012) EWHC 3163 (QB), (2012) MHLO 115 — Re X & Y (Children) [2012] EWCA Civ 1500 — Sykora v Czech Republic 23419/07 [2012] ECHR 1960. Further information is given on the following subjects: (1) Debt relief orders; (2) Transfer of supervisory body responsibilities from PCTs to Local Authorities; (3) Regulatory review; (4) Home care and Human Rights; (5) CQC, 'The state of health care and adult social care in England: An overview of key themes in care in 2011/12' (November 2012); (6) ECtHR Guide to Article 5; (7) 'Tying ourselves into (Gordian) knots' article. See 39 Essex Street COP Newsletter

- **Alex Ruck Keene, 'Advance Decisions: getting it right?' (December 2012).** See 39 Essex Street COP Newsletter#January 2013

## Website

- **New MHLO books.** The Mental Health Law Online Annual Review 2012 has been published in paperback and Kindle format, and is now available on Amazon. The Annual Review 2012 contains all news items, arranged thematically, which were added to the website during 2012. The Annual Review 2011 is also now available in paperback and Kindle formats. See Books

- **Lucy Series, 'My top ten Mental Capacity Act resources' (The Small Places Blog, 27/12/12).** This article recommends the following resources: (1) Mental Health Law Online, (2) 39 Essex Street Court of Protection Newsletter, (3) Court of Protection Law Reports, (4) Mental Capacity Act Manual, (5) Social Care Institute for Excellence, (6) Google Alerts, (7) Essex Autonomy Project, (8) Mental Health Foundation MCA literature review, (9) Mental Disability Advocacy Center, (10) Twitter. See Miscellaneous external links

- **Cases.** On 31/1/13 Mental Health Law Online contained 1307 categorised cases

- **Chronology.** See January 2013 chronology for this month's changes to the website in date order