



## SEPTEMBER 2011 NEWSLETTER

### NEWS FROM PETER EDWARDS LAW

Peter Edwards Law is one of the very few dedicated **specialist law practices** operating solely in the fields of the Mental Capacity Act, Mental Health Act, Court of Protection (financial / health and welfare) DOLS, safeguarding and community care

We advise families and service users who feel aggrieved at actions of health and social services. We have a team of specialists dedicated to Court of Protection advice including finance, health and personal welfare and DOLS appeals.

We also provide advice to:

- Local authorities and their legal departments
- Independent sector providers of hospital, residential and domiciliary care
- Old age services and learning disability organisations
- Voluntary and Charitable organisations

We can also provide specialist advice under Welsh legislation and regulations.

We represent families and service users (including those who are sectioned) in the North West, North Wales, West and East Midlands, the London area as well as in Ashworth and Rampton.

We have **experienced lawyers based in the North West, London and Nottingham.**

For **specialist Court of Protection** work we cover the court centres in Liverpool, Manchester, Chester, Preston, Caernarvon, Leeds, Birmingham and London.

For **specialist advice to service providers** we cover the whole of England and Wales

As evidence of our commitment to **quality**, not only has Peter Edwards Law achieved a Category 1 (Excellent) from the Legal Services Commission but also, on 31st May 2011, we were proud to be awarded the **Lexcel Quality Mark** by the Law Society, who congratulated the Practice on its achievement.

The objective of Lexcel is to enhance the service that we give to our clients, improve the management of the practice, and enhance the morale and motivation of our staff. Being awarded the Lexcel quality mark is evidence of us meeting these objectives.

We have continued to build our **Court of Protection department**; including representing incapacitated clients on behalf of the Official Solicitor. Increasingly we are advising the vulnerable and their families who are frustrated, either at the lack of a service, or the imposition of a service that they do not want. So often we find that when families are unhappy with the service given to their loved ones in residential accommodation or supported living, that this is often not recognised as contributing to a **deprivation of liberty**. If, as a result of our intervention, a DOLS is granted, then this might trigger an appeal to the Court of Protection against the Deprivation of Liberty Authorisation and legal aid for this appeal is not means tested.

Our team in the **Mental Health Tribunal department** spend the majority of their time on the road representing those who are detained under the Mental Health Act.

# TRAINING EVENTS FROM IMHL 2011

For full details and bookings go to [www.imhl.co.uk](http://www.imhl.co.uk) Phone: 0151 633 2184 Fax: 0151 632 0090  
E-mail: [bookings@imhl.co.uk](mailto:bookings@imhl.co.uk)

13 <sup>th</sup> September	<i>Intensive Introduction to the MHA</i>	London
14 <sup>th</sup> September	<i>Administering the MHA</i>	London
19 <sup>th</sup> October	<i>Using the Court of Protection: DOLS</i>	Merseyside
20 <sup>th</sup> October	<i>Top 20 Court of Protection (Personal Welfare) Cases Avoiding Pitfalls - Learning from what the Judges say</i>	Merseyside.
25 <sup>th</sup> October	<i>Intensive Introduction to the MCA (inc. DOLS)</i>	London
26 <sup>th</sup> October	<i>A day for Hospital Managers: Rights, risks and reasons</i>	London
27 <sup>th</sup> October	<i>Human Rights Act and the MHA</i>	London
28 <sup>th</sup> October	<i>The Mental Health Contract – Surviving the LSC (For Mental Health Solicitors)</i>	London
17th / 18th November	<i>Two day admission to Tribunal Panel Course (For Mental Health Solicitors)</i>	Hoylake
24 <sup>th</sup> November	<i>Intensive Introduction: Forensic Patients</i>	Merseyside
29 <sup>th</sup> November	<i>DOLS: Getting it right (inc. Human Rights Act obligations)</i>	London
30 <sup>th</sup> November	<i>Using the Court of Protection: DOLS, Best Interests and Safeguarding</i>	London
1 <sup>st</sup> December	<i>Intensive Introduction: Forensic Patients</i>	London
8 <sup>th</sup> December	<i>Intensive Introduction to the MHA</i>	Merseyside
13 <sup>th</sup> December	<i>Intensive Introduction to the MCA (inc. DOLS)</i>	Merseyside

## PETER EDWARDS LAW TRAINING

In these difficult economic times I have been heartened by the number of organisations who have collaborated together in order to share the costs of training. I am very happy to help you identify training needs, strategies and then deliver a training programme to target the needs of your organisation.

One course that is going down very well at present is when I take a number of scenarios, e.g. a patient refusing to get into an ambulance or wanting to leave A & E, and look at how they could be managed safely and lawfully using the MHA and/or MCA.

**For in-house training please contact me on 0151 632 6699**

- Introduction to Mental Health Law including the MHA Code of Practice
- Back to Basics - Law and Practice Refresher Training
- Legal Update for AMHPs / multi-disciplinary groups
- Guardianship and Supervised Discharge
- Nearest Relatives
- Victims under the DVCA (especially the enhanced role of hospital managers and RCs)
- Capacity and Consent to Treatment
- Challenges to detention
- Mental Health Law for Hospital Managers
- Writing & presenting reports/evidence at Tribunals/ Managers hearings
- The new Tribunal - First and Upper Tier
- Mentally disordered offenders and the law (forensic patients)
- Supervision of conditionally discharged patients
- People with learning disabilities under the Mental Health Act
- Complete package for independent hospitals
- European Convention of Human Rights / Human Rights Act 1998
- Mental Capacity Act 2005 (Basic and Advanced)
- Using and understanding the Court of Protection especially for personal welfare and POVA
- Deprivation of Liberty including advanced BIA training
- Treating mentally disordered children and young people
- S.12 (re)approval training
- RC Training
- [Wales](#) reflecting separate MHA Code, MHRT rules and regulations.

### **PRIMARILY FOR MENTAL HEALTH LAWYERS**

***Two day admission to Tribunal Panel Course approved by Law Society –  
17<sup>th</sup> and 18<sup>th</sup> November 2011***

## LEGAL UPDATE

### Introduction by Peter Edwards

What I like about preparing this newsletter is that I can search through all that has been happening in the last few months, pull together the elements that I think are very useful for our clients, families and professionals and then express my views.

For me, the key words when taking decisions that may impact on human rights of others are 'lawful' and 'evidence based'.

I have to say that through my work at Peter Edwards Law, I am sometimes surprised at the authoritarian and unlawful approach taken by health and social services particularly when assuming control of the lives of others through what is seen to be part of 'safeguarding'. I am clearly not alone, as the case of Neary below indicates.

I would like to thank **Dave Sheppard**, **Laura Davidson** and **Kris Gledhill** for their assistance in preparing this newsletter. Laura is a barrister with a Ph.D in mental health law and human rights and practises in the public law team at No.5 Chambers [lda@no5.com](mailto:lda@no5.com). Kris edits the Mental Health Law Reports, contributes regularly to the Journal of Mental Health Law, has written Mental Health Law - Essential Cases, and is involved in mental health law training on his regular return visits to the UK. <http://www.southsidepublishing.co.uk>



Through DSA there is a subscription service that enables access for all subscribers staff to the Mental Health Act and Mental Capacity Act website ([www.davesheppard.co.uk](http://www.davesheppard.co.uk)). The site contains over 800 cases – many with full transcripts. There is a *monthly* mental health practice e-bulletin containing:

Latest case law - summarised - with full transcripts; latest news re Mental Health Act and Mental Capacity Act; latest inquiries following homicide and other publications

**Free sample e-bulletin:** <http://www.davesheppard.co.uk/DSAsample.pdf>

*"Informative, apposite and, as one has come to expect from Dave Sheppard, remarkably comprehensive in its coverage."* Richard Jones, Solicitor

There is also access to a Mental Health Act 1983 & Mental Capacity Act discussion forum for staff of subscriber organisations ONLY

Subscribers are also entitled to a **£100 reduction on in-house training** provided by DSA and a **£50 reduction per booking** on all DSA & IMHL courses. For more information please contact [dave@davesheppard.co.uk](mailto:dave@davesheppard.co.uk)

## THE MENTAL CAPACITY ACT

### COURSE

#### **Top 20 Court of Protection (Personal Welfare) Cases Avoiding Pitfalls - Learning from what the Judges say**

Thursday 20th October 2011

PELT, Hoylake, Merseyside CH47 2AE

**What is a DOL** - *Cheshire v P; Hillingdon v Neary; P and Q*

**Article 8** - *YA(F) v A LA; Re MM; Sunderland v MM; LBB v JM; D v R and S; G v E; A LA v A*

**Interrelationship between the MCA and MHA**

*BB v AN; GJ v The Foundation Trust*

**Inherent jurisdiction for vulnerable adults who have capacity** - *A LA v DL*

**Capacity** - *RT v LT*

**Local Authority and personal welfare deputy** - *Havering v LD*

**Consultation** - *Re Allen*

**Authority to convey and return** - *Re P*

**Sexuality** - *D Borough Council v AB*

**Weight to be attached to wishes and feelings** - *In Re M, ITW V Z*

**Evidence** - *Enfield v SA,*

### The Court of Protection

On the 27th July 2011 The Court of Protection issued '**The second annual report of the Court of Protection 2010.**' As evidence of the substantial amount of court time being taken up, there are now over one hundred judges authorised to exercise the court's jurisdiction under the Mental Capacity Act 2005. In addition, with effect from 28.7.11, all Queen's Bench Division Judges have been nominated for purposes of s.46 MCA 2005 to exercise the jurisdiction of the Court of Protection. It is likely that they will only be required to hear Court of Protection applications on an emergency basis in the unlikely event that it has not been possible to identify a High Court Judge of the Family Division to hear the matter.

The Association of Directors of Adult Social Services (ADASS) and the Social Care Institute for Excellence (SCIE) have produced **Good practice guidance on accessing the Court of Protection**, Social Care Institute for Excellence, May 2011. This is a very useful guide to the Court of Protection. In the introduction it says that it may be useful for:

- health and social care staff
- local authorities and NHS trusts
- Independent Mental Capacity Advocates (IMCAs)
- relatives and friends of people who may lack capacity to make key decisions.

This guide contains information about:

- when people may or must be supported to access the safeguard of the Court of Protection
- how cases can be taken to the Court of Protection
- what happens at each stage of the process
- other legal options (for example, judicial review).

### **DOLS, The Court of Protection and Safeguarding**

Much of the spotlight on *London Borough of Hillingdon v Neary & Anor* [2011] EWCH 1377, Ct of P, 9th June 2011 related to the reporting Court of Protection cases in the press. However, yet again, another local authority has been 'named and shamed' by the court.

The case concerned Steven Neary, a 20 year old man with autistic spectrum disorder and severe learning disability. In December 2009, Steven had been placed in the care of the local authority for a few days' respite, with his father's agreement. At the end of the respite period, the local authority came to the view that it would not be in Steven's best interests to return to the care of his father. Steven remained in the care of the local authority until December 2010. The father and the Official Solicitor argued that the local authority's refusal to allow Steven to return home was unlawful.

In this case Jackson J approved the what has become know as the 'two-stage test' set out by Hedley J in *Independent News and Media v A* [2010] EWCA Civ 343. Firstly, the Court should ask whether there is a 'good reason' to make an order to allow the media to attend. Secondly, if there is a 'good reason', the Court should then decide whether the requisite balancing of Article 8 and Article 10 justifies the making of the order.

Mr Justice Peter Jackson said very publically that Hillingdon had

*'acted as if it had the right to make decisions about Steven, and by a combination of turning a deaf ear and force majeure, it tried to wear down Mr Neary's resistance, stretching its relationship with him almost to breaking point. It relied on him coming to see things its way, even though, as events have proved, he was right and it was wrong. In the meantime it failed to activate the statutory safeguards that exist to prevent situations like this arising.'*

What this case shows that a supervisory body, or indeed anyone responsible for caring for an individual who may be deprived of their liberty,, ignores that person's family at its peril. I would go further, as in my experience not only do organisations tend to listen best to those who agree them but also forget that the views of caring friends and neighbours can be equally important in either helping to establish capacity or reflecting a person's 'wishes and feelings'.

#### **The Role of the supervisory body**

The judge said that:

*'The suggestion that the supervisory body is bound to act on any assessment that is not grossly and obviously defective sets the standard too low. It supposes an essentially passive supervisory body. This would not meet the objectives of the Act and would not provide effective protection against breaches of Article 5'.*

The obligation of a supervisory body if it receives an assessment which it knows, or should know, is inadequate is not to follow the recommendation and it should then take all necessary steps to rectify the situation. If necessary this should include bringing the DOL to an end by conducting a Part 8 Review or applying to Court.

Interestingly, this brings the role of the supervisory body closer to that of Mental Health Act Managers.

Solicitors, advocates, family and friends may have information that wrong or inadequate information was given to the supervisory body or that things have changed. How many of them realise that if they bring this information to the attention of the supervisory body, it will be under duty to commission a review. As chapter 8 of the DOLS Code states:

*8.2 There are certain statutory grounds for carrying out a review. If the statutory grounds for a review are met, the supervisory body must carry out a review*

*8.3 The statutory grounds for a review are:*

*There has been a change in the relevant person's situation and, because of the change, it would be appropriate to amend an existing condition to which the authorisation is subject, delete an existing condition or add a new condition.*

One of the criticisms of the DOLS procedure in the Neary case is that it focuses too much on procedure and not enough on safeguards. This judgement has gone some way to addressing that criticism, but the procedure is still a long way from the detailed provisions set out in the Mental Health Act. Supervisory bodies will need to review their practices in dealing with applications for authorisations, including separating functions within their organisations and ensuring that where papers are received they are proactively considered.

There are a number of practice issues for those working in the field. In his judgment in para 33, the judge identified 3 points:

*"The purpose of DOL authorisations and of the Court of Protection: Significant welfare issues that cannot be resolved by discussion should be placed before the Court of Protection, where decisions can be taken as a matter of urgency where necessary."*

*"Decision-making.: Where a local authority wears a number of hats, it should be clear about who is responsible for its direction."*

*"The responsibilities of the supervisory body: The responsibilities of a supervisory body, require it to scrutinise the assessment it receives with independence and a degree of care that is appropriate to the seriousness of the decision and to the circumstances of the individual case that are or should be known to it."*

In addition he found that there was a breach of Steven's rights under Article 5(4) because:

1. An IMCA should have been appointed in April 2010. LB Hillingdon should have persisted in obtaining one for Steven Neary;
2. There was no effective review;
3. The local authority had an obligation:

*"to ensure that a person deprived of liberty is not only entitled but enabled to have the lawfulness of his detention reviewed speedily by a court."*

### **Some Court of Protection cases. DoLS Appeal s.21A MCA.**

***Cheshire West and Chester Council v P (by his litigation friend, the OS) and M***, [2011] EWHC 1330 (Fam), Ct of P, 14th June 2011

The importance of this case is that it is the first reported decision to apply *P and Q v Surrey County Council* [2011] EWCA Civ 190 in the context of supported living. I wonder just how many incapacitated people with significant levels of physical and learning disabilities are unlawfully deprived of their liberty.

On the issues was whether P's circumstances objectively amounted to a deprivation of liberty. The Court held that there were a number of features that, by themselves, might suggest it was not a case of deprivation of liberty. The fact that P's life was made as normal as possible was a factor that made it less likely for restrictions to amount to a deprivation of liberty, as the Court of Appeal endorsed in *P & Q v Surrey County Council* (2011) EWCA Civ 190). However, P's life was completely under the control of staff at Z House, and he could not go anywhere or do anything without their support or assistance. His occasionally aggressive behaviour and habit of touching and eating his continence pads required a range of measures to protect him, including occasional physical restraint and the intrusive procedure of inserting fingers into his mouth to

remove bits of the pads whilst he was being restrained. Thus, P was being deprived of his liberty.

In addition to naming the council, Mr Justice Baker also ordered the authority to pay some of the costs incurred by the other parties.

In the case of **PH v A Local Authority, Z Ltd. and R [2011] EWHC 1704 (Fam)** Court of Protection, (Baker J) 30th June 2011 the issue was whether the independent expert was correct to find that PH had the capacity to make decisions about his residence, treatment and care, contrary to all other professional opinion. The moral of the tale is that the independent is not always right and the additional experience of a practitioner who has known PH for a while will weigh heavily in the balance.

PH (through the OS) appealed under s.21A MCA 2005 against the standard authorisation permitting his residence at a placement specialising in Huntington's Disease - a degenerative condition from which he suffered. The challenge was to the capacity and best interest assessments.

PH had been cared for by his partner R for many years until he felt he could no longer cope. He was admitted to the placement against his wishes when he went there for an outpatient's appointment and R refused to take him home again. PH was then assessed as eligible for continuing healthcare. The judge heard competing views as to PH's capacity, the independent expert said he did (supported by the OS and R) and the GP said he didn't.

Baker J said:

*"16. .... In other words, courts must guard against imposing too high a test of capacity to decide issues such as residence because to do so would run the risk of discriminating against persons suffering from a mental disability. In my judgement, the carefully-drafted detailed provisions of the 2005 Act and the Code of Practice are consistent with this approach.*

*xii) The 2005 Act generally, and the DOLS in particular, are compliant with Article 5 of the European Convention for the Protection of Human Rights and Fundamental Freedoms – see my earlier decision in G v E [2010] EWHC 621 upheld by the Court of Appeal at [2010] EWCA Civ 822 and in particular paragraphs 24-25 and 57 of the judgment of Sir Nicholas Wall P in the Court of Appeal. Just as there is no justification for imposing any threshold conditions before a best interests assessment under the DOLS can be carried out (the point taken up unsuccessfully by the appellants in G v E) so in my judgment there is no reason for adopting the approach advocated by Miss Morris on behalf of the Official Solicitor in this case, namely that a finding of a lack of capacity should only be made where the quality of the evidence in support of such a finding is "compelling". Equally, it is unnecessary for the court to adopt an approach, also advanced by Miss Morris on behalf of the Official Solicitor, that the statutory test should be construed "narrowly". The statutory scheme is, as I have already observed, carefully crafted. I agree with the submission made on behalf of Z Limited (in written submissions by Mr Vikram Sachdeva who did not appear at the hearing) that the question of incapacity must be construed in accordance with the statutory test – "no more and no less".*

*xiii) In assessing the question of capacity, the court must consider all the relevant evidence. Clearly, the opinion of an independently-instructed expert will be likely to be of very considerable importance, but in many cases the evidence of other clinicians and professionals who have experience of treating and working with P will be just as important and in some cases more important. In assessing that evidence, the court must be aware of the difficulties which may arise as a result of the close professional relationship between the clinicians treating, and the key professionals working with, P. In Oldham MBC v GW and PW [2007] EWHC136 (Fam) [2007] 2 FLR 597, a case brought under Part IV of the Children Act 1989, Ryder J referred to a "child protection imperative", meaning "the need to protect a vulnerable child" that for perfectly understandable reasons may lead to a lack of objectivity on the part of a treating clinician or other professional involved in caring for the child. Equally, in cases of vulnerable adults, there is a risk that all professionals involved with treating and helping that person – including, of course, a judge in the Court of Protection – may feel drawn towards an outcome that is more protective of the adult and thus, in certain circumstances, fail to carry out an assessment of capacity that is detached and objective. Having identified that hypothetical risk, however, I add that I have seen no evidence of any lack of objectivity on the part of the treating clinicians and social worker who gave evidence in this case.*

As a result of the Supreme Court case of **McDonald v RB Kensington and Chelsea** [2011] UKSC 33 the scope for **challenges to funding decisions** based upon Article 8 ECHR is likely to be very limited.

Lord Brown JSC made a particular point of noting that a local authority can choose between appropriate care packages upon the basis of cost – see paragraph 22:

*“I add only that, even if such an interference [with the Claimant’s Article 8(1) ECHR rights] were established, it would be clearly justified under article 8(2)... on the grounds that it is necessary for the economic well-being of the respondents and the interests of their other service-users and is a proportionate response to the appellant’s needs because it affords her the maximum protection from injury, greater privacy and independence, and results in a substantial costs saving.”*

If the decision of Local Authority is only challengeable by way of judicial review, then as long as they can demonstrate that the options before the Court of Protection can meet the needs of P, then it is likely that the Admin Court will be slow to find its decision is flawed on the basis that a more expensive package would be better.

## **DOLS Statistics**

**Statistics** are rarely sexy but for those like me, who worry about the number of people unlawfully deprived of their liberty by local authorities, trusts, care homes and organisations providing supported living, there is some evidence in the recently produced **Mental Capacity Act 2005, DOLS Assessments (England) - Second report on annual data, 2010/11, The Information Centre for Health and Social Care, 20th July 2011**

The key findings **for the whole year** are:

- The total number of applications made was still **much lower** than expected for the second year of DOLS (8,982 in England compared with the number predicted for in England and Wales which was around 18,600). This compares to the 7,157 applications made in 2009/10; just over 34 per cent of the predicted number for that year.
- However, the number of **successful applications** resulting in an authorisation was about the expected number (4,951 in England compared to the 5,000 predicted for in England and Wales), though a much higher percentage of applications than expected were successful (55% compared with the predicted 25%). In the previous year 3,297 applications were approved - a 46% approval rate compared to the 25% expected. This suggests to me that where the applications are being made assessors are taking their job seriously.
- About **2% of applications that were not authorised** involved situations where the person was nevertheless judged as being in a situation that amounted to a DOL. In these cases the hospitals and care homes could be acting illegally, if that person was not swiftly cared for or treated in less restrictive circumstances. This is half the percentage in 2009/10 (4%). The numbers may be small but urgent action is always required to rectify an unlawful deprivation of liberty. This also would cause me to ask the question ‘*how long has this unlawful situation been continuing and is there a case for claiming compensation*’.
- Perhaps predictably of more than half (55%) were for a person who lacked capacity because of dementia.
- 57% of those applications made to a Local Authority were granted when applying for a deprivation of liberty compared to 50% in Primary Care Trusts.
- In relation to **duration**, authorisations granted for people in care homes were generally for longer periods than for people in hospitals (62% of authorisations granted by Local Authorities were for more than 90 days compared with 23% of PCT authorisations).
- **Rather worryingly, there is a big difference in the number and rate of applications in different parts of England**, with the highest number and rate of applications being made in the East Midlands (1,644 applications and 46 applications per 100,000 population) compared to the England rate (22 applications per 100,000 population) and the lowest number of applications made in the North East (579) with the lowest rate being in the East of England with just 13 applications per 100,000 population.

### **Between 1st January and 31 March 2011**

- There were 2,308 authorisation requests completed in the quarter. 1,696 (73.5%) were received by Local Authorities and 612 (26.5%) were received by PCT’s
- 1,326 (57.5%) of the completed assessments resulted in an authorisation. 1,010 (59.6%) of the assessments received by a LA resulted in an authorisation. 316 (51.6%) of the assessments received by PCT’s resulted in an authorisation.

- Of the total assessments completed a higher proportion was for females, 1,238 (53.6%) than males 1,070 (46.4%).
- At the end of the quarter 4 period, as at 30 March 2011, 1,512 people were subject to a current standard authorisation. 1,336 (88.4%) following a granted LA authorisation and 176 (11.6%) following a granted PCT authorisation

### **The mapping of DOL authorisation – literally!**

<http://carlplant.me/mental-capacity-act-2005-deprivation-of-liber>

This is a map putting into graphical form the information on DOLS applications. Fascinating.

## **Medication and DOLS**

A recently issued ‘**Dementia Commissioning Pack**’ published by the Department of Health states:

*‘Thousands of people across England who are living with dementia are taking **antipsychotic medication that they do not need** and that could possibly harm them. Evidence tells us that although there are clinical situations where a time-limited prescription of antipsychotic drugs may be appropriate, antipsychotic drugs are often overprescribed and continued when alternative therapies are more beneficial. There is an unambiguous case for a substantial reduction in their use alongside the wider adoption of alternative interventions which we know can help to maximise the quality of life for people with dementia and their carers.’*

I wonder how many of these people are being deprived of their liberty as a result of the unnecessary administration of these drugs.

I am sure that you will recall earlier this year in the Court of Appeal decision of P and Q (otherwise known as MIG and MEG) v Surrey County Council, that the court said that

*‘Medication would always be a pointer towards the likely satisfaction of the objective element [of a DOL] (particularly if supplied by force), as it could suppress a person’s liberty to express themselves as they would otherwise wish.’*

## **Unlawful actions taken by financial deputies**

How many deputies, including local authority and professional deputies are putting themselves at **risk of a negligence** claim because they have left significant amounts of money in Court Funds?

The Special Account used to pay 6% as recently up until two years ago, but it dropped to 0.5% in July 2009. It would appear that many deputies kept the money where it is despite the impact this is having. Where Peter Edwards Law act as financial deputy, we ensure that funds are held in a current account that currently pays just over 2%.

I also wonder how many financial deputies **take full control** of financial affairs even where the individual **has capacity**. You might remember the story of Mrs Arnold at page 21 of the MCA Code of Practice.

*‘Her son concludes that she has capacity to deal with everyday financial matters but not more difficult affairs at this time. Therefore, he is able to use the LPA for the difficult financial decisions his mother can’t make. But Mrs Arnold can continue to deal with her other affairs for as long as she has capacity to do so.’*

## **Prevention in adult safeguarding, Social Care Institute for Excellence, May 2011**

This report outlines the literature on a range of methods for preventing the abuse of vulnerable adults, from public awareness campaigns through to approaches that empower the individual to be able to recognise, address and report abuse. In addition, it examines policy and practice guidance and examples of emerging practice. The report has been informed by SCIE’s Adult Safeguarding Service User Advisory Group.

*Prevention in adult safeguarding*

<http://www.scie.org.uk/publications/reports/report41/files/report41.pdf>

## **Planning for the future**

This summer I had the pleasure of working with the staff of a general hospital, looking at practice issues relating to the law of end **of life decisions**.

Peter Edwards Law is very keen to encourage people to consider whether or not it would be right for them to plan for future incapacity. Much of the work that we do flows from people's failure to do this. Our website [www.losingyourmarbles.com](http://www.losingyourmarbles.com) provides more information.

One of the most commonly held myths is that when you lose capacity your next of kin will automatically assume the role of your decision maker. Not true.

In June, the Lancet carried an article called: **Advance decisions, chronic mental illness, and everyday care**. It describes 'advance decisions' as '*an important and highly valued way in which a person can ensure that his wishes will be respected when, due to lack of capacity, he is no longer capable of expressing them himself.*' The article addresses some of the concerns in relation to attempted suicide. It also states:

*'They can be of great significance, and no less problematic, in day-to-day care, and particularly in the setting of chronic mental illness that affects capacity.'*

Also in June there was a lengthy article in the Independent headed, '**How to protect your finances with a power of attorney**'. It quoted Andrew Proctor, Head of Knowledge for the Alzheimer's Society.

*"People need to be talking about contingencies before it comes to the crunch,"*

*"The earlier you can put plans in place the less scary it is and the more robust you and your loved ones can be. We come across frequent instances where people haven't taken out a Lasting Power of Attorney, families become fractured and the courts have to get involved."*

In reality though, many of us put it off until it's too late.

## LEGAL AID IN CRISIS

I am quoting below the entire text of this important document. Perhaps the government is banking on public support for any measure that reduces the income of lawyers. However, as can be seen below, the impact will be potentially catastrophic on vulnerable people and those detained under the Mental Health Act.

**Response of the Mental Health Lawyers Association to Legal Aid, Sentencing and Punishing of Offenders Bill "Destroying Representation for the Mental Unwell for £3 million?"**

### 1. Introduction

*The MHLA represents the majority of solicitors and solicitors firms who represent those detained in hospital. Our members have been involved in significant cases that have helped establish the rights of vulnerable people. The Association was founded in 2000 and has contributed to many consultations on issues that concern our members and those we represent. The Association is recognised as the organisation representing specialist lawyers in the field by bodies including the Law Society, the Judiciary, the charity MIND and the Ministry of Justice itself. We have met with a range of Government and parliamentary figures, including Ministers. In addition a representative of the Conservative Party, Edward Garnier, addressed a recent MHLA conference, in November 2009.*

### 2. 10% Reduction in Fees

#### 2.1. Introduction

*The MHLA welcomes that the work of our members will generally remain in scope of the legal aid scheme. However we are greatly concerned with regards to the 10% reduction in fees which are still proposed, notwithstanding our particular earlier representations as to this jurisdiction, which were not addressed in your response. This will be disastrous for many of our members and therefore for the highly vulnerable clients that we represent. We see ourselves as a frontline service to our clients, but now consider that much of this service will collapse. This risk of collapse runs directly counter to the acceptance that this representation should remain within scope as a central plank of the legal aid scheme.*

*Our work with detained patients is seen by all, including the Ministry of Justice, as "core legal aid work". Indeed when we were addressed by Edward Garnier, and in other dealings with the Conservative Party prior to the last election, we were impressed by the acceptance that our work was central to the operation of justice in a civilised society given our highly vulnerable clients.. However these proposals, and in particular the 10% cutback, do appear to directly contradict this assurance.*

*The ability of those detained due to an alleged mental disorder to receive representation to challenge such detention is critical to the United Kingdom's compliance to the ECHR. This is why such work it is one of the few non-means tested areas of legal aid. However, the effectiveness of such representation, as we pointed out to shadow conservative Ministers prior to the election, has been in decline for many years.*

## **2.2. Decline in Specialists in the field**

*The need for specialist representation for the most vulnerable in our community was the reason why the Law Society set up the first specialist Panel of lawyers in this area of practice. However, membership of this Panel has declined by around 25% since 2000, whilst the number of patients requiring representation has increased by around 30%; according to figures provided by the Tribunal Service. Furthermore a previous Law Society survey has shown that the average age of Panel members is middle age or above. Far fewer "young" entrants have been joining the Panel. Our members directly report to us that the reason for leaving this area of practice is the existing fee levels. The arbitrary proposals to reduce fees in this area of representation by a further 10% will certainly rapidly accelerate this process.*

*The implications of the 10% reduction have been clearly depicted by a very longstanding and experienced practitioner in East Anglia who, when indicating he would have to leave this area of work, said: "This work is like being a minicab driver. You work Monday to Friday to cover your overheads: you make money that you can live off on Saturday. They now want to take away our Saturday"*

*Our Association has been received numerous responses from members who will now no longer be able to carry out this work. It should also be born in mind that this cut is on the back of a lack of any recent increase and ongoing inflation, results in real cuts of around 15% in the last three years already.*

*A 10% reduction is therefore very much more than a simply shaving a few pounds off the budget. It is frequently the profit margin on which our members survive. And, as has been pointed out to the Conservative party previously, many of our members operate in small specialist practices. They have nothing to buffer their work and will simply go to the wall; notwithstanding their longstanding expertise.*

## **2.3. Judicial View of Mental Health Representation**

*The need for retaining such experience in the work we do has long been recognised by the judiciary. At the time of the introduction contracting Mr. Justice Brooke in the year 2000 (now Lord Justice Brooke) in the case of R v Legal Aid Board ex parte Mackintosh and Duncan (2000) gave the view of the Court on that occasion: "We are worried, however, that the Board (then the Legal Aid Board) has not yet appreciated how difficult Mental Health Law is, and how generally solicitors cannot pick up the expertise needed to serve the clients effectively, unless they have strong and practical grounding in this field of Law. We hope that the Board will now take urgent steps to identify the really skilled solicitors who are willing to serve their clients in this field at Legal Aid rates of pay .....". He also commented: "Reading the Report of a psychiatrist, identifying its areas of weakness, commissioning evidence and the appropriate expert challenge to it and representing a client at a Tribunal requires expert professional skills borne, as we have said, of education and practical experience. It is not like going down to the Magistrates Court as a Duty Solicitor, arduous though those duties are."*

*Mr Stanley Burnton J. in KB & Others v MHRT [2003] made it clear that the MHRT is the most fundamentally important Tribunal in this country in that it deals with the liberty of the individual in circumstances where that liberty has been removed without having been sanctioned by a court. "The issues before MHRTs are probably the most important issues decided by any tribunals. The Tribunals make decisions as to the compulsory detention and treatment, and thus the liberty, of the individual. A wrong decision may lead on the one hand to the unnecessary detention of a patient, and, at the other extreme, to the release of a patient who is a danger to himself and may present a risk to the public. A patient will be the victim of a wrongful decision to detain him. Conversely, however, he may also suffer from a mistaken decision to direct his discharge. The decisions of the MHRTs are as intrinsically important as many of those of the Crown Court....."*

*We are aware of the grave continuing concerns held by the Tribunal Judiciary relating to the decline in the quality of representation of patients in recent years and understand that they are looking to see how such decline can be addressed. Their particular concern is the continuing decline in availability of Panel members in relation to the rising amount of Legal Representation required. This has been great acerbated by the effects of the MHA 2007 and the new Code of Practice attached to the MHA; coupled, of course, with the substantial decline in Panel Membership since 2000.*

## **2.4. Concerns of Care Quality Commission**

We certainly consider that there is a link between the decline in the quality of representation; the decline in panel membership and the previous imposition of the fixed fee scheme in Mental Health Tribunal work. Indeed the link between the fixed fee scheme and declining standards has been raised in the last three Mental Health Act Commission/Care Quality Commission reports (those for 2005-7, 2007-9 and 2009-10). The CQC has reiterated the MHAC's call for an independent review of the effects of the revised fee system, with a particular focus on Tribunal representation. It is of great regret that no steps appear to have been taken to set up such an enquiry. A further reduction of fees will only greatly worsen the concerns already raised by the Commission.

### **2.5. Ministry of Justice Research**

Recent research by the Ministry of Justice itself in July 2010: *Court Experience of adults with Mental Health Conditions, Learning Disability and Limited Mental Capacity* confirmed the vulnerability of our client group. In particular it concluded the following findings:

*Whilst across the board there was a range of awareness among legal representatives of the particular needs of this client group, legal representation was seen as a key support, particularly when the representative was experienced in working with this client group, providing "a unique authority, perspective and understanding";*

*Fixed fees were seen to be a barrier to good quality advice for this client group who required more time spent on their case, for which the legal representatives would not get paid; and*

*This client group had mixed success in accessing solicitors by telephone.*

*Again, a 10% cut, with its implications to specialists' employment, appears to run directly counter to these findings.*

### **2.6. Concerns of MIND**

The Association has been contacted by the charity MIND. As you know this charity is frequently seen as the strongest voice for those suffering from a mental disorder. They are already aware of the research indicating a decline in the quality of representation and are greatly concerned as to the impact of the 10% reduction. We understand they are responding directly to your consultation.

### **2.7. Possible breach of the Disability Discrimination Act 1995**

In the recent case of *PIL & RMNJ Solicitors v Legal Services Commission (2010)* the Court recognised there would be issues regarding detained patients with longstanding relationships with legal representatives. The Court was impressed particularly by medical evidence that the sudden breach of such relationships might well cause relapses in vulnerable patients' mental health. The Court also noted that extensive psychiatric histories, including perhaps details of extreme abuse, would have to be re-counted at great length to new representatives. In the scenario resulting from a 10% cutback this situation is likely to be replicated as a number of long established practitioners suddenly leave the field. Although, of course, it would not be clear what representatives, particularly Panel members, who would be available to take over this role.

### **2.8. Specialist Panel Membership Recognition**

We have consistently argued for the need for good quality advice in the Mental Health category of law. We have in particular argued for recognition of membership of the Law Society's specialist panel in this area, notwithstanding the decline in such membership since ten years ago. We feel that the failure of Government, to date, to link panel membership to fees has led to the decline in take up of the panel, with a knock-on effect on quality. We expressed concern about the imposition of the fixed fee scheme in 2008 given the effect we thought it would have. Again the 10% reduction in fees is a further leap in the wrong direction.

### **2.9. Financial Implications**

Our estimate is that would the financial implications of retaining the 10% would be very small. Our estimate is that the cost of provision of our work is around 1.6% of the total legal aid budget. Immediate savings made might be in the region of £3 million pounds however, the ultimate cost would be very much higher. Once specialists are lost to this area it is very unlikely they will return. Nevertheless the UK's obligation to provide this representation will remain. Ultimately, therefore, the Government might be faced with a much higher bill to re-establish this "core" service.

### **2.10. Proposals for savings**

We consider that this process has already started because of more case management decisions following the 2008 Tribunal Rules. Adjournments have reduced over the last year.

There should be a review of Schedule A1 MCA 2005. This provides a legal framework for the detention of those lacking capacity but who are not receiving treatment in hospital for mental

disorder under the MHA 1983. The DOL Safeguards are cumbersome and unpopular with nearly all those who have to deal with them. The only appeal avenue is to the Court of Protection at considerable expense. Often, the case has to be heard in London, a long way from where the person subject to the DOLS (and their family and the professionals concerned) is based. DOLS cases are mainly still heard before the senior judiciary, with the effect that counsel is often relied upon. The costs are often many times in excess of the costs of even the most complex tribunal. The Safeguards could be replaced by amendments to the Guardianship scheme under the MHA 1983, with the Tribunal service dealing with appeals rather than the Court.

Setting a limit on the hourly rate that NHS Trusts and other public bodies can spend on legal advice which is equivalent to that which is spent on advising detained citizens.

### **2.11. 10% Reduction – Conclusion**

The Association is greatly disappointed that this blanket reduction has been proposed for our work with detained patients, notwithstanding earlier assurances given. Ongoing departure of specialists from the field, in direct contrast to a rise in demand for their services, will turn into a torrent should this reduction be implemented. Such a decision will run directly counter to senior judicial concern, coupled with those of the leading mental health charity MIND and the Care Quality Commission; not to mention research work carried out by the Ministry of Justice itself. Its implications may also be unlawful in terms of the Disability Discrimination Act. Our members see ourselves as a front line service for our clients and very much hope that the Department and Central Government will re-think this 10% reduction for our members. We would welcome the opportunity to expand on, or clarify, our concerns  
Mental Health Lawyers Association 9th August 2011

## **THE MENTAL HEALTH ACT**

On the 20th June 2011 The Guardian reported, '**Mental health services in crisis over staff shortages**'. It reports a survey by Royal College of Psychiatrists which found that 544 consultants' posts in the UK – 14% of the total – are either unfilled or filled by a locum. In addition, 209 consultants intend to retire or resign soon, a situation exacerbated by the government's cap on immigration from outside the EU. The report says that average bed occupancy rates in English inpatient units are much higher than the 85% standard, with some wards running at 120% occupancy.

The report reveals that more than half of all adult general wards run at more than 100% occupancy, with 16% meeting the required target. Just 21% of acute wards meet the 85% target

Professor Dinesh Bhugra, the outgoing president of the Royal College of Psychiatrists stated  
"The Care Quality Commission has found that unnecessary and excessive restrictions, and security measures are sometimes imposed on detained patients,"

**"Undue restrictions on a patient's autonomy compromise their personal dignity and rights as an individual.** Such excessive restrictions are upsetting for the patient and can delay recovery. Safety and risk policies are in place to aid patient recovery. Unnecessary bureaucracy and rules can not only hamper a patient's recovery but possibly exacerbate their mental illness. Whether a person is detained or voluntarily admitted to hospital, general ethical standards that are adhered to in the community should, wherever possible, apply on the ward."

I wonder if these restrictions will cause more informal patients to be deprived of their liberty and following the case of *GJ v The FT and The PCT and the Secretary of State for Health (2009)* EWHC 2972 (Fam), 20th November 2009 may then increase the numbers of those who are entitled to free non means tested after care under s.117 Mental Health Act. It's a strange world!

### **Representation before mental health tribunals, The Law Society, 19th May 2011**

New guidance was issued in May prepared by the Law Society's Mental Health and Disability Committee. This committee is made up of senior and specialist lawyers. Assistance was also given by Paul Bowen, of Doughty Street Chambers, the Mental Health Lawyers Association and Anthony Harbour who took over from me as Chief assessor of the MHT Panel. This guidance is very useful for anyone who has any involvement in MH(R)Ts.

<http://www.lawsociety.org.uk/productsandservices/practicenotes/mentalhealthtribunal/3386.article>

I would just like to update you on a Peter Edwards Law case. In ***R (Modaresi) v SSH (2011) EWHC 417 (Admin)***, 3rd March 2011 the issues were:

- (1) Whether an administrative error by hospital administrators which led to a late application outside of the statutory timeframe for a tribunal hearing by a s.2 patient invalidated the application;
- (2) Whether the Secretary of State for Health's refusal to make a statutory reference pursuant to s.66 MHA 1983 had been unreasonable and
- (3) Whether there had been a violation of Article 5(1) or Article 5(4) ECHR.

This will be heard by the Court of Appeal in November.

This was the case where EM was detained under s.2 MHA. She signed a tribunal application and gave it to a nurse, who faxed it to the MHA Administration office at around 4.40pm. Either it was not noticed or the staff member on duty had left early for the day, it being New Year's Eve. The office was then closed until 4th January 2011, when EM's application was noticed and faxed to the Tribunal Office. **It was pronounced out of time and thus invalid.** EM therefore lost the right to a hearing within 7 days, as provided for by r.37(1) of the Tribunal Procedure Rules 2008, and the important right - in view of the fact that mental conditions may fluctuate or respond to treatment - to make a further application to a tribunal. Subsequently, EM was detained under s.3 MHA. On 7th January 2011 the Secretary of State refused to refer EM to a tribunal under s.67 MHA because they said that she was able to make a fresh application herself under s.3.

The Secretary of State contended that the proceedings were academic and served no purpose because the patient had been discharged. It was also argued that the Claimant had an effective alternative remedy, given her right to make a further application herself. EM contended that by refusing to make a referral under s.67, the Secretary of State had deprived her of the opportunity of retaining the right to make a further application for the review of her detention under s.3 during the six months from when she was detained for treatment, and so there had been a diminution of her rights under Article 5(4). The Secretary of State pointed to the fact that it had offered to reconsider a referral if an application made by her under s.3 failed. The Trust supported the Secretary of State's position and submitted that the conduct about which there was complaint was properly characterised as one of clerical error or oversight, in respect of which there was no public law remedy. The tribunal was not represented but provided an Acknowledgement of Service.

The issues that will be raised in the Court of Appeal include:

- (1) The Trust wrongly believed that the tribunal's practice was to calculate the 14 day period during which an application to a tribunal might be made by a s.2 patient by reference to the date of the patient's signature, rather than the date of receipt by the tribunal. The Court held that in the light of this mistaken belief, it was not unreasonable for the Trust to have in place a system which did not provide for applications to be transmitted without delay outside working hours. However, it is difficult to understand why an erroneous belief might be sufficient to validate the system based upon that erroneous belief. Whether or not a system is reasonable ought to be objective – in other words, based upon the real state of play, not the imagined one.
- (2) The Court might have interpreted the Rules in EM's favour. Rule 12 states that an act is valid if done on the next working day as long as the time is 'specified' by the Rules. Rule 32(1)(c) states that an application must be 'received' within the time specified in the MHA. As r.12 mentions time limits for applications specified in the MHA, arguably all MHA time limits for the submission of applications including those made under s.66(1) have been 'specified' by the Rules (notwithstanding the fact that the time limit is mentioned in the statute).
- (3) DoH Guidance referred to by the Secretary of State highlighted the fact that the most common reason for a s.67 reference was the s.2 patient missing the 14 day deadline through no fault of their own, where there was still time for the hearing to be arranged prior to expiry of s.2.
- (4) EM essentially complained of the loss of a chance of discharge. Given that she was indeed discharged from detention before the end of the six month period, it is certainly arguable that EM might have been discharged sooner than she was, had she appeared before a tribunal.

Just to remind you about some **Upper Tribunal cases earlier this year**

***MP v Mersey Care NHS Trust, Upper Tribunal (AAC)***, [2011] UKUT 107 (AAC), HHJ Pearl, 15th March 2011

**Issue:** Whether a decision to set aside a discharge on the basis of a comment by the Tribunal that consideration should be given to a community treatment order was lawful.

***CM v Derbyshire Healthcare NHS Foundation Trust and Secretary of State for Justice***, Upper Tribunal (AAC), [2011] UKUT 129 (AAC), UTJ Levenson, 23rd March 2011

**Issue:** Whether the upholding of detention on the basis of the nature of the patient's disorder was rational.

**PS v Camden and Islington NHS Foundation Trust**, Upper Tribunal (AAC), [2011] UKUT 143 (AAC), UTJ Jacobs, 30th March 2011

**Issue:** Whether a reference made on the revocation of a Community Treatment Order lapsed when the patient was placed on a fresh CTO; whether a letter complaining about a Tribunal decision should be treated as an application to the Tribunal.

**TR v Ludlow Street Healthcare Ltd** Upper Tribunal (AAC), [2011] UKUT 152 (AAC), 7 April 2011, UTJ Jacobs

**Issue:** The correct route to challenge a case management decision by a Tribunal; whether permission to appeal should be granted in relation to decisions not to order disclosure and adjourn a hearing.

**RN v CC (2011)**, 11th April 2011, UTJ Edward Jacobs

**Issue:** Whether a refusal at the start of a hearing by a Tribunal to consider making a recommendation for a Community Treatment Order was biased or gave the appearance of bias and was lawful.

**CX v A Local Authority (Defendant) & A NHS Foundation Trust (Interested Party) [2011] EWHC 1918 (Admin) QBD (Spencer J) 20th April 2011**

The issue in this case was whether a patient's detention under the MHA 1983 was **unlawful because the nearest relative was misled about her rights** which vitiated her decision not to object.

CX was 21 years and had a diagnosis of schizophrenia. He was admitted to hospital informally because he felt safer there. He was subsequently detained under s.2. His mother and nearest relative MX was extremely unhappy about the section because she felt that her son's care had been badly managed on the ward and that there had been inconsistencies with his medication. She wanted formal detention to end, and wished to be more involved in her son's care. CX's responsible clinician requested an assessment for admission for s.3 and AY, an AMHP became involved.

It was clear that any application to displace would not be dealt with by the county court until it reopened on 4th January 2011.

MX bitterly objected on the telephone when informed by AY of the intention to detain her son under s.3. At a meeting between AY and MX, MX said that if she continued to object, she would have to be represented at court by a solicitor and could have all her rights in respect of CX's welfare and treatment taken away from her if she was unsuccessful.

MX wished to consult her son before making a final decision. She knew that she was not eligible for legal aid. Her son knew she could not afford legal representation and urged her not to object for that reason. MX believed that she had no real choice but to agree, and reluctantly withdrew her objection by telephone the next day. The s.3 application was made. When MX later discovered that she had a right to discharge her son under s.23 MHA she exercised it within a few days. Her son's discharge was then barred by his RC.

Several months later, CX had a tribunal hearing for which the admission papers were disclosed, and Counsel's opinion was taken in relation to the lawfulness of the admission.

**An application for habeas corpus** was issued within proceedings for judicial review. At an oral hearing with evidence, it was argued that the withdrawal of objection was vitiated by the fact that MX had been misled into believing that she had to pay for legal representation if it was maintained. It was further contended that AY had not sufficiently 'consulted' MX within the meaning of s.11 (4) because she had not been informed fully and accurately as to her role and rights under the Act.

The local authority solicitor gave evidence, as did MX. For health reasons AY was unable to attend the oral hearing. In her witness statement she denied that she had made reference to MX having any parental rights removed by the court. She thought that she may have given MX a leaflet setting out her rights as nearest relative under the MHA.

**The judge decided that consultation required a genuine invitation to give advice and a genuine consideration of that advice** (*Re Briscoe [1998] COD 402 citing R v Secretary of State for Social Services, ex parte Association of Metropolitan Authorities [1986] 1 All ER 164 approved*). An AMHP had a duty to consider the guidance in paragraph 4.64 Code of Practice MHA. The court found as a fact that:

- MX had not been given a leaflet about her rights under the MHA as a nearest relative. Had she been given that, she would have had the opportunity to reflect overnight on what she had been told at the meeting with AY.

- The AMHP's witness statement did not assert that AY had informed MX of the practical effect in the short-term of an application to displace her as nearest relative, despite having had her attention drawn to the relevant provisions by the solicitor earlier.
- Further, she had failed to make a contemporaneous record of the meeting at MX's house as advised.
- There was no evidence from AY denying that she had said that she could not maintain her objection without the services of a solicitor or that she told MX that she would be entitled to represent herself.
- Crucially, AY did not explain that if MX did object, the s.3 application could go no further, or that a displacement application would be unlikely to be heard until mid-January and that the s.2 would continue in the interim and MX had expressed her willingness to agree to the continuation of s.2 if it were legally possible as a second best option. AY had ticked the box in the assessment report to confirm that MX had been informed of her rights, but there was no evidence before the court as to what the rights would have been and in particular that she had the right to discharge her son under s.23 of the MHA. There was no mention in any of the narrative records made by AY of even the possibility of a displacement application, let alone the practical implications of and procedure for such an application, and MX had been given inaccurate and incomplete advice as to her position and her rights.

Whilst there was **no suggestion of bad faith**, and paragraph 4.65 Code of Practice recognised the proper place of persuasion in relation to nearest relative objections, **the AMHP had acted contrary to both the letter and spirit of that Code and the requirements of s.11(4).**

The LA had the burden of proof to satisfy the Court that CX's detention was lawful, but there had been an insufficiently informed consultation with his nearest relative. The withdrawal of MX's objection was not full and effective, and was vitiated by incorrect and misleading advice. MX had been presented with a false picture of her options, and she was not told that she could object, that she could represent herself, that no application for displacement would be heard until around mid-January in any event (which would have given her time to obtain independent legal advice), or that the s.2 would remain in place if an application for displacement was made. All these matters were crucial for there to have been proper and effective consultation for the purposes of s.11(4) of the MHA.

MX was intelligent and articulate and would have understood the difference between it being desirable for her to seek legal advice and that she would have to be represented if she objected to her son's admission for treatment under s.3. There was no other explanation for MX's change of position overnight other than that she believed that she could not maintain her objection without representation at court by a solicitor. Her defence to a displacement application would have been by no means hopeless as outside the band of reasonable stances which a NR in her position could adopt. Over Christmas MX would have had valuable breathing space and would have had access to her son's medical reports. Had she then abandoned her objection, adverse costs implications would have been unlikely.

It is evidentially valuable for there to be two AMHPs present when an objection is being discussed. In any event, each case must be decided on its own facts and what is required by way of consultation will depend upon the individual facts and circumstances and upon the personalities involved. A writ of habeas corpus was granted. CX was currently on home leave so the issue of the writ was symbolic and technical, rather than practical and physical.

This case emphasises the importance of making **contemporaneous notes** of nearest relative consultations when s.3 admissions are being considered. AMHPs who are consulting NRs would do well to provide a leaflet of their rights under the MHA as a matter of course. Whilst it is legitimate to try to persuade a nearest relative that s.3 admission is appropriate, misleading a NR as regards the result of objection, the procedure of displacement, or the person's legal rights will lead to a vitiation of any subsequent withdrawal of objection. The author suggests that the same failures would also lead to vitiation of a decision not to object if a nearest relative is, initially, open-minded and unsure whether to object.

***JP v Birmingham and Solihull Mental Health NHS Trust and Others, Upper Tribunal (AAC), 30th July 2011, UTJ Ward***

The issue in this case was whether a Tribunal's **reasons were adequate**. I can almost hear you saying 'not another case on inadequate decisions!'

JP was a restricted patient, with a diagnosis of paranoid schizophrenia; the index offence was an attempted murder. At a Tribunal, the only issue was whether detention in hospital for treatment was necessary for the protection of others, failing which a conditional discharge was sought. This was supported by evidence from a psychiatrist, a psychologist and a social

worker; they agreed that it was necessary to secure JP's compliance with medication and also his abstinence from cannabis (which he had used as a Rastafarian). The Tribunal declined to discharge, finding that the evidence of the Responsible Clinician in support of detention compelling and concluding that the risk of non-compliance with medication, of cannabis abuse and failure to engage with treatment in the community, and consequent relapse, was too great. This was based on JP's own evidence that he was likely to return to cannabis and that he was reluctant to take anti-psychotic medication. The Upper Tribunal held that the **reasons given for preferring the expert views of the RC were adequate**: it engaged with the substance of the evidence and why it provided answers to the evidence of the other experts. The Tribunal decision allowed the parties and the Upper Tribunal to analyse the essential reasoning behind the decision.

A procedural point arising in the case was what should happen if a patient had been transferred between hospitals between the Tribunal and the appeal, the detaining authority at the time of the Tribunal would be the respondent to the appeal, though the fresh detaining authority could be added as a party.

This decision makes the point that on an appeal, there is no rehearing or reconsideration of the evidence: the question is whether the Tribunal decision is adequate, including in relation to its duty to provide adequate reasons. The adequacy is a matter of allowing the parties to understand why evidence in favour of discharge had been rejected, and that was met on the facts.

### **PETER EDWARDS**

Peter Edwards has been specialising in all aspects of mental health and incapacity law since 1975.

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