FEBRUARY 2011 NEWSLETTER

NEWS FROM PETER EDWARDS LAW

SUSAN MACHIN JOINS PETER EDWARDS LAW

We are proud to announce another consultant is becoming part of Peter Edwards Law. Roger Hargreaves and Dave Sheppard are joined by **Susan Machin,** whom many of you will know as a highly experienced mental health and incapacity law barrister. Much of her time was spent advising local authorities especially in relation to the Court of Protection. She has now ceased to practice as a barrister but her knowledge and experience will continue to be put to good use for clients of Peter Edwards Law.

TRAINING EVENTS FROM IMHL

All these take place in our conference centre at the HQ of Peter Edwards Law in Hoylake (near Liverpool). The venue is next to Hoylake railway station. Click on any of the events to get the full brochure including the views of previous delegates.

15th March 2011	**S.117 Aftercare** (Including funding)
5th April 2011	Using the **Court of Protection**: DOLS, Best Interest And other applications
4th April 2011	How to become a better **Mental Health Tribunal Advocate**
10th May 2011	An Intensive Introduction: **Forensic patients**
7th June 2011	**An Intensive Introduction to the Mental Capacity Act & Deprivation of Liberty Safeguards**
12th July 2011	**An Intensive Introduction to the Mental Health Act**

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 staff.

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

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

- Introduction to Mental Health Law
- Mental Health Act 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 Domestic Violence Crime and Victims Act (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 – 19th and 20th May 2011

This course would also be a wonderful intensive introduction to mental health / tribunal law and practice.

Day 2 alone ideal for those seeking Panel reaccreditation.

Phone 0151 632 6699 for details

LEGAL UPDATE

These newsletters are not designed as a regular updating service. They are a subjective analysis by myself and each has a particular theme. For previous newsletters go to http://www.peteredwardslaw.com/index.html and then 'Legal Update'. **Highlights from previous newsletters include**:

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Christmas 09 - Whatever happened to the new Mental Health Act?

April 10 - An analysis of the important **117 case** *of R (on the application of M) v (1) Hammersmith & Fulham LBC (2) Sutton LBC: R (on the application of Hertfordshire CC) v Hammersmith & Fulham LBC (2010).*

An analysis of ***G v E*** by Roger Hargreaves**,** consultant to Peter Edwards Law.

June - a look at various cases including two from the Upper Tribunal.

September - a critical look at **safeguarding** particularly in the light of the comments by Lord Justice Munby in the case of *Re A (child) and Re C (adult) [2010] EWHC 978 (Fam)*

November - I examined some common myths like '*Your next of kin can make decisions for you if you lose capacity'* and how these affect the legality of decision making.

This month I have drawn together key information that has come to light recently. **My comments are written in blue**. If you wish to contact me for more information then please do so at peter@peteredwardslaw.com

For me one of the most interesting cases is that of the unfortunate Mr Davies.
I have long been predicting that the vulnerability of professionals comes not from the courts but from **disciplinary bodies**. I assume nobody would try to get someone to sign something where there was evidence that they lacked capacity to do so. Really?

I would like to thank Jonathan Wilson who maintains **Mental Health Law Online,** Some of the links referred to below with parentheses don't always hyperlink properly in mail readers so it may help if you cut and paste into the URL bar if necessary.

The GSCC conduct committee decision: Philip Julian Davies 10/12/10.

The social worker was suspended for misconduct for 12 months. Two of the proven allegations were that, without authority, on or around 18th July 2008, he requested service user Mrs Z to sign financial papers after she had been diagnosed by a consultant psychiatrist as having a lack of mental capacity. In addition, between 20th May 2008 and 30th October 2009, he failed to ensure that an application for a Court of Protection order in respect of a service user Mr Z, was made expeditiously, or at all. For more details go to: *http://www.mentalhealthlaw.co.uk/GSCC_conduct_committee_decision:_Philip_Julian_Davies_10/12/10*

THE MENTAL CAPACITY ACT

PROSECUTIONS UNDER THE MCA

It is good to see that there have been two successful prosecutions under the MCA. The comments of the police officer in charge look on the face of it very reasonable. But he said that those who put relatives into homes should also be vigilant in checking that they are being properly cared for.
However, in my opinion it is very difficult for families to raise these issues without fear of retribution from the care home or the local authority.

BBC - Two care home workers have been given suspended jail sentences for using a Green Goblin Glove puppet to bully elderly women. Cardiff Crown Court heard how Helen Males and Eleni Saunders frightened two residents with a Green Goblin puppet at The Old Rectory care home for Alzheimer or dementia patients, near Cardiff. Males, 34, received a 52-week jail term and 22-year-old Saunders was given 38 weeks. They must also observe a curfew for the next 24 weeks between 2000 and 0800. Branding the offences "disgraceful", Judge Philip Richards banned them from working in the care profession indefinitely. He said the defendants ridiculed and frightened those in their care and asked the pair how they would feel if someone close to them was treated in the same manner. "*They were employed to care for them but they ridiculed them, frightened them and caused distress to them on repeated occasions*," he said

The puppets were based on the Green Goblin character in Spiderman
Det Insp Huw Thomas of South Wales Police applauded the judge's decision to ban the women from the profession for life. "*I think this is the worst sort of offence because people put their relatives in these homes to be looked after and cared for and then something like this happens*," he said. "*I think abuse of the elderly is one of the worst crimes because they are vulnerable and can't retaliate or stand up for themselves.*" He praised the care worker who raised the alarm for her bravery in reporting the incidents. But he said those who put relatives in homes should also be vigilant in checking that they are being properly cared for.

CAPACITY TEST

In the second case, the criminal court of appeal also had to consider what the capacity test actually was. The appeal was unsuccessful.

R v Dunn (2010) EWCA Crim 2935
Before: Lord Judge CJ, Calvert-Smith and Griffith Williams JJ Hearing: 23 November 2010

Dunn had been convicted of four counts of ill-treating a person without capacity contrary to MCA 2005 s44 against three victims at the residential care home of which she was manageress. The judge had directed that **'a person without capacity' meant** a person unable to make decisions for himself because of a disturbance or impairment of function of the mind or brain, that a diagnosis of dementia was not enough, that 'impairment' could be permanent or temporary, that capacity was presumed unless disproved on the balance of probabilities, and that this direction applied to all three victims. The defendant appealed on the basis that the direction on 'a person without capacity' was inadequate, failed to focus on the capacity of each victim to make a decision at the relevant time, and failed to identify the questions required by s3 **Appeal dismissed**.

(1) The legislation, including s2 was convoluted and did not appropriately define the elements of the offence (including 'matter' and 'disturbance or impairment').
(2) Lack of capacity had to be decided on the balance of probabilities.
(3) There was a disconnect between s44 (referring to 'persons without capacity') and the elaborate definition sections (ss2 and 3), but it was open for the jury to conclude that the decisions regarding care (the 'matter') were taken had been made because the victims lacked capacity.
(4) It was unnecessary for the judge to complicate matters by referring to s3, and the conviction was safe.
For more details go to:
http://www.mentalhealthlaw.co.uk/R_v_Dunn_(2010)_EWCA_Crim_2935

DOLS

It is very interesting to look on the one hand at the very low number of DOLS and then look at the case of *G v E* (see below) which reputedly has cost Manchester City Council somewhere in the region of £1million in costs and damages.

NHS Information Centre, **'Quarterly analysis of Mental Capacity Act 2005, Deprivation of Liberty Safeguards** Assessments (England) Quarter 2 2010/11', 22/12/10. The summary states that these statistics provide the first official information about authorisations using the legislation. Key facts listed are:
(1) the number of authorisations completed was 2,333 in quarter 2;
(2) of the total assessments completed in this quarter, a higher proportion were for females than for males;
(3) in quarter 2, 76 per cent of assessments were made by local authorities while the rest were made by primary care trusts;
(4) the percentage of authorisations granted which led to someone being deprived of their liberty was 54 per cent in quarter 2;
(5) at 30 September 2010 1,436 people were subject to such authorisations.

For more information see:
http://www.mentalhealthlaw.co.uk/Statistics

CHALLENGE TO A DOLS STANDARD AUTHORISATION

(DOLS APPEAL TO THE COURT OF PROTECTION)

For those who read my Newsletter on Safeguarding (September 2010) you will be aware of the concern of the courts that some urgent removals of people from their own homes may be made without lawful authority. The case of P (below) is particularly interesting because a local authority were refused permission to remove (in fact they had to return) pending a full hearing.

Re P (2010) COP 23/12/10 (Mostyn J) There was effectively a **presumption against deprivation of liberty** (pursuant to MCA 2005 s1(6)) and, on the facts, the balance tilted in favour of P returning home pending a final hearing at which full evidence could be considered. [Summary based on counsel's case report. Victoria Butler-Cole 39 Essex Street, 'Court of Protection Newsletter' (issue 5, January 2011)
Victoria Butler-Cole appeared for P's daughter in a challenge to a standard authorisation under s.21A MCA 2005. The case concerned P, an elderly gentleman with moderate dementia, who had been kept against his wishes in a care home since early November 2010. The local authority had prevented him returning home after a stay in hospital due to concerns raised by P's general practitioner.
At an interim hearing before Mostyn J on 23 December 2010, it was held that P should return home notwithstanding that it was accepted that better care would be provided in the care home, that there were risks to P of returning home, and in the face of opposition from the local authority and the Official Solicitor. The Official Solicitor did not express a view as to the merits of the original grounds of challenge to the SA but argued that P ought to remain in the care home until, at the very least, better evidence was available to satisfy him and the Court that it was in P 's best interests to return home. The judge accepted evidence from P's family that P was 'desperately unhappy' and wanted to leave the care home. He held that there was effectively a presumption against deprivation of liberty (pursuant to s.1(6) MCA 2005), and on the facts, the balance tilted in favour of P returning home pending a final hearing at which full evidence could be considered.
For more details see:
http://www.mentalhealthlaw.co.uk/Re_P_(2010)_COP_23/12/10_(Mostyn_J)

DAMAGES AND COSTS FOR UNLAWFUL DOL

This is a case in which I provided legal advice to the domiciliary care organisation. It has given rise to a number of issues including;
1. The probability that deprivations of liberty, within domiciliary care settings, are easy to miss. A key factor in identifying a deprivation is where a family member or carer objects to the placement, especially if they believe the person should be at home with them.
2. The patent illegality of getting those who lack capacity to understand documents, to nevertheless sign them! This would include tenancy agreements and also financial assessments which include threats of prosecution. (See the case of the GSCC conduct committee: Philip Julian Davies, above)
3. The need for placing authorities to recognise that the responsibility lies on their shoulders in identifying and obtain authorisation for the DOL in supported living.
4. The potentially catastrophic cost of getting it wrong.

G v E (2010) EWHC 3385 (Fam) **Costs judgment**.
"In all the circumstances, I conclude that this is a case for departing from the general rule set out in rule 157 of the Court of Protection rules, and I make an order in the following terms:
(1) That the local authority should pay the costs of G, F and E, including pre-litigation costs, up to and including the first day of the hearing before me on 14th January 2010 on an indemnity basis.
(2) The local authority shall pay one third of the costs of G, F and E from that date up to and including the hearing on 6 May 2010 on a standard basis.
(3) All costs will be subject to a detailed assessment, if not agreed."
For more details see:
http://www.mentalhealthlaw.co.uk/G_v_E_(2010)_EWHC_3385_(Fam)

POWER OF RETURN UNDER DOLS

There is clearly a distinction between the ability to **return someone** who is already under a DOL and the degree of force required to **get them to** the place where they are to be deprived of their liberty. It has long been a mystery to me that under the MHA no one would dream of using force to take a person to hospital where they were to be sectioned before the sectioning application is complete. However people remain relaxed about forcing someone into a care home and then working out whether they are deprived of their liberty! If it is anticipated that someone will be deprived on arrival then the managers should only accept them if the were subject to a DOL authorisation. Is not one of the roles of the BIA to consider whether that place is in the person's best interests? Once they are already there it becomes very difficult to change the status quo.

Re P (Scope of Schedule A1) (2010) COP 30/6/10
39 Essex Street, 'Court of Protection Newsletter', issue 4, December 2010

Given that a standard authorisation extends to restraining P from leaving the accommodation, it must also extend to compelling him to return.

Robert Eckford of the Official Solicitor's office has recently kindly brought to our attention an important decision of Mostyn J of June 2010 regarding the scope of the powers that are granted by a standard authorisation under Schedule A1 to the MCA 2005. The authors understand that there is no transcript of the judgment, but that no problems will be caused by the dissemination of the gist of the judgment in an entirely anonymised form.

Mostyn J was considering the extent of the powers granted to a local authority and a care home under existing (and any renewed) standard authorisations. He noted that it was common cause that these powers extended to a power to restrain P if he tried to leave the care home. The question for him was **whether within those powers there was a power to coerce P to return if he refused to return to the care home from a period of leave**. Mostyn J noted that it was understandably in P's interests that he should have access to society in the community and 'escape' the confines of the care home, and that the relevant PCT had agreed to fund 'befrienders' to encourage access to the community.

Mostyn J therefore asked himself whether the powers under the existing standard authorisation extend to coercing P back to the nursing home if P refused to return. He noted that it would be little short of absurd if the local authority and care home had powers to restrain P from leaving but not to compel him to return, and that the greater power must include the lesser. Mostyn J therefore declared that the power was implicit in the current and any future standard authorisation.

This decision is of some importance as a companion piece to and/or re-affirmation of the decision of DCC v KH (2009) COP 11729380, in which DJ O'Regan held that a DOLS standard authorisation was sufficient to return P on the long journey from contact sessions to his residential placement. Notwithstanding the conclusions expressed in these two cases, however, the authors' clear view (and one accepted in at least one case in which they have appeared in Archway) remains that **standard authorisations are not cover any deprivation of liberty arising whilst P is being taken to the placement covered by the standard authorisation.**

REPORTING DEATHS UNDER DOLS

Another job for the DOLS coordinator! Whilst there is a requirement to report deaths of detained patients there has been an inconsistency when those under DOLS die. As can be seen from this new guidance, it is necessary to liaise with your local coroner to see what is expected of you in your local area.

Reporting the death of a person subject to an authorisation under the Mental Capacity Act Deprivation of Liberty Safeguards, Department of Health, 19th January 2011 The Department, in conjunction with the Ministry of Justice, has clarified the requirements on managing authorities, care homes and hospitals, to report to the relevant coroner the death of a person subject to an authorisation

under the MCA DOLS. There is currently no statutory requirement for anyone other than the Registrar of Births and Deaths (or a Prison Governor who has a separate statutory duty) to refer certain deaths to a coroner. These are deaths where there is reasonable cause to suggest that the person died a violent, unnatural or sudden death of which the cause is unknown or where the person died in prison or police custody. There is therefore no statutory requirement for the Registrar to refer deaths of those who are subject to DOLS.

However, there is a common law duty (which applies to everyone) to refer deaths to a coroner in the circumstances set out above. The subsequent action taken by the coroner will vary but could include no further action, the commissioning of a post-mortem examination or the opening of an inquest with or without a jury. Should you wish to notify a death to a coroner, you should speak immediately to the Coroner's office covering the district where the body lies and subsequently confirm your conversation in writing. If a death is referred to a coroner, a doctor should not issue a Medical Certificate of Cause of Death until the coroner has made a decision about whether or not to undertake further investigation. This is not a legal requirement but it avoids the family thinking they can register the death before the coroner has made his or her decision. Care homes and hospitals who are managing authorities under the MCA DOLS, need to know how to contact the relevant coroner's office should a person in their care who is deprived of their liberty die whilst subject to that authorisation. Some coroners have indicated that they expect managing authorities to refer to them all deaths of those who are deprived of their liberty under the MCA DOLS. **Supervisory bodies, local authorities and PCTs, should ascertain what their local coroners' expectations** are in this regard and communicate that in turn to all the managing authorities that they liaise with. If in doubt, it is always preferable to report the death as no harm can come from this cause of action, whereas not reporting the death can be problematic.

THE COURT OF PROTECTION

GUIDANCE ON THE ROLE OF OFFICIAL SOLICITOR UNDER THE MCA

The Official Solicitor and the President of the Family Division have met in order to discuss the difficulties which the OS had been having in accepting requests to act as guardian ad litem / litigation friend for 'protected parties' in proceedings relating to children. The OS's role in proceedings under the MCA 2005 was also discussed. At the end of the meeting the President invited Pauffley J to draft guidance for courts dealing with such cases. The first part related to children but para 3 and 6 – 9 address the significant rise in Court of Protection welfare cases.

Peter Edwards Law has a dedicated department dealing with such matters on behalf of families, local authorities and the OS.

December 2010 - Guidance in cases involving protected parties in which the Official Solicitor is being invited to act as guardian ad litem or litigation friend

1. Many practitioners and judges will know of the OS's recent difficulties in accepting requests to act as guardian ad litem / litigation friend for protected parties in proceedings relating to children. Although, currently, there are unallocated cases, the backlog has reduced significantly in recent months.

2. The OS is subject to severe budgetary constraints – a situation which is unlikely to ameliorate in the medium term.

*3. In all cases, the OS will need to be satisfied of the **following criteria** before accepting a case, and parties may need reminding of the need to provide confirmation of these matters immediately on approaching the OS's office:*

- *satisfactory evidence or a finding by the court that the party **lacks capacity** to conduct the proceedings and is therefore a protected party;*
- *confirmation that there is security for the **costs of legal representation**;*
- *there is **no other person who is suitable** and willing to act as guardian ad litem/litigation friend.*

*4. In order to assist the OS in the decisions he makes about allocating case workers, in certain cases, judges should consider whether it may be appropriate to indicate with as much particularity as possible the relative **urgency** of the proceedings and the likely effect upon the child (and family) of delay. The OS will very carefully consider giving priority to such cases.*

5. It is and remains the judge's duty in children's cases, so far as he is able, to eradicate delay.

Court of Protection welfare cases (including medical cases)

6. The number of welfare cases brought under the provisions of the MCA 2005 is rising exponentially with concomitant resource implications for the OS.

7. Judges should be alert to the problems the OS may have in attending at each and every preliminary hearing. Consideration should be given, in appropriate cases, to dispensing with the requirement that he should be present at a time when he is unable to contribute meaningfully to the process. In circumstances where his position has been / will be communicated in writing it may be particularly appropriate for the judge to indicate that the ***OS's attendance*** *at the next directions' hearing is unnecessary.*

8. The Court of Protection Rules make clear that the judge is under a duty to ***restrict expert evidence*** *to that which is reasonably required to resolve the proceedings. The explanatory note to r.121 states that the court will consider what 'added value' expert evidence will give to the case.* ***Unnecessary expert assessments must be avoided****. It will be rare indeed for the court to sanction the instruction of more than one expert to advise in relation to the same issue.*

9. The Practice Direction – Experts (PD15A) specifies that the expert should assist by "providing objective, unbiased opinion on matters within his expertise, and should not assume the role of advocate". The form and content of the expert's report are prescribed, in detail, by paragraph 9 of the Practice Direction. ***It is no part of the expert's function to analyse or summarise the evidence****. Focussed brevity in report writing is to be preferred over discussion.*

Mrs Justice Pauffley - December 2010.

PREPARING EVIDENCE FOR THE COURT OF PROTECTION, LOCAL GOVERNMENT LAWYER, 1ST DECEMBER 2010

Victoria Butler-Cole and **Alex Ruck Keene** (barristers) provide guidance on how local authorities and other statutory bodies should approach the preparation of care plans, transition plans and best interests assessments for Court of Protection proceedings. This short paper is designed to assist local authorities and other statutory bodies applying to the Court with preparing evidence to support applications relating to health and welfare. A common complaint from the Court, other parties or the OS is that there is **insufficient written information** about **what is proposed** for P, **why** the proposed option is considered to be in P's best interests, and **the details of the care plan and transitional arrangements.**

Often, the relevant issues have in fact been considered by professionals working with P, but the written documentation such as care plans and witness statements does not reflect this adequately. The checklists below list the sort of information and detail that is likely to be required to support an application to the Court and within proceedings. We hope they will serve as a useful guide to non-lawyers preparing evidence and documentation in best interests cases (whether or not there are court proceedings contemplated).

They should not, however, simply be applied to every case since not every element will necessarily be relevant. Furthermore, because the checklists are the product of the experience of the 39 Essex St Court of Protection team we do not claim that they are exhaustive (and certainly do not serve as a substitute for following the reams of guidance issued by the government).

Checklist for Best Interests evidence

1. Clinical and social work information about P

including diagnosis, prognosis, presentation, and history. Although this information will be contained in the various records, it is helpful to have a summary of relevant details so that anyone unfamiliar with the case can have a picture painted of P and P's care needs.

2. P's wishes (including IMCA reports if available).

P's wishes must be taken into account in making a best interests decision and it is therefore important to make sure that a clear record of P's wishes is kept, whether obtained directly from P, or through reports from third parties such as family members, paid carers, or advocates. This applies whether P expresses consistent or inconsistent wishes - in either case, the information about what P has said will need to be considered, although clearly in the former case it will likely be accorded more weight. Information should also be included about steps that have been taken to improve P's understanding of the issues in dispute, and to assist P in expressing his or her wishes.

3. Views of family members.

Careful recording of the views of family members is helpful, including family members who are not parties to proceedings. A record should also be kept of decisions taken as to why particular family members have not been consulted (if relevant).

4. Details of every option considered for P.

It is critical to 'show your working'. If the team working with P have decided that a particular option is in P's best interests, it can be tempting only to explain in detail that preferred option. The other parties and the court need to know what all the possible options are, even if they include options that can immediately be discounted (for example, the option of doing nothing where P faces a serious risk to his or her wellbeing). Make sure that options proposed by family members are included in the list of possibilities, even though they may not be recommended by the professionals working with P.

5. Factors for and against each of the options under consideration.

For every option, details of the benefits and risks or disadvantages to P must be set out (See footnote). It is often easiest to do this in table form, or using bullet points, so that the reader can easily see the issues and can compare the various options under consideration. Don't forget to include practical implications for P as well as less tangible factors such as relationships with family members and care home staff.

6. The likelihood of the pros and cons of each option eventuating.

Give some indication of whether the risks and benefits you have identified are likely to occur or not, and why you take this view.

7. The relative seriousness and/or importance of the pros and cons of each option.

It may not always be obvious which benefits and disadvantages you place particular importance on and why. A common tension is between avoiding risk and promoting independence: explain why you have given more weight to one approach in the particular case.

8. Reasons for identifying a particular option as being in P's best interests

and for rejecting the other options. Although it may seem clear in light of the analysis of benefits and disadvantages, it is helpful to set out separately a conclusion about which option you consider to be in P's best interests and why. This is particularly important where there is a dispute and where the option you prefer does entail significant disadvantages to P, such as a loss of independence, intrusion into a longstanding relationship, or inevitable distress caused by a change of environment.

9. If proposed option entails risks or disadvantages to P,

the reasons why these are thought to be outweighed and steps to be taken to minimise them. Having decided that certain risks are worth taking in P's best interests, or that certain disadvantages are outweighed by benefits, it is important to show that you have considered what could be done to reduce these risks or disadvantages and set out detailed plans for dealing with them. This might include additional care or staff support for particular periods of time, or the provision of financial assistance to ensure that relationships can continue.

10. Detailed contingency plans if the proposed option is implemented.

Where there is the prospect that a proposed option may fail in the short or medium term, there must be thought given to what will happen in those circumstances, to reassure the other parties and the court that hasty and off-the-cuff decisions will not suddenly be required, to the possible detriment of P.

Checklist for Care Plans

1. Take into account the guidance given by Munby J (as then was) in *R(J) v Caerphilly County Borough Council [2005] 2 FLR 860*:

> *"46. A care plan is more than a statement of strategic objectives - though all too often even these are expressed in the most vacuous terms. A care plan is - or ought to be - a detailed operational plan. Just how detailed will depend upon the circumstances of the particular case. Sometimes a very high level of detail will be essential. But whatever the level of detail which the individual case may call for, any care plan worth its name ought to set out the operational objectives with sufficient detail - including detail of the 'how, who, what and when' - to enable*

the care plan itself to be used as a means of checking whether or not those objectives are being met."

2. The assignation of specific responsibilities to individuals is particularly important in the CoP context.
3. Take into account the factors set out in checklist A above wherever the care plan involves the making of decisions for or on behalf of P.
4. Ensure, where appropriate, that consideration is given to the person-centred planning approach in the previous government's Valuing People guidance.
5. Where the care plan involves any degree of restraint, identify the precise nature of the restraint, the rationale for it, plans to minimise the need for restraint (and contingency plans in case the need for restraint is escalated). If, in the consideration of the need for restraint, it emerges that the requirement goes beyond restraint into a deprivation of the person's liberty then authorisation will be required for that deprivation (how this will be achieved will depend on the setting, and whether the DOLS procedures apply).
6. Be realistic. There is nothing that the OS/Court of Protection likes less than to see a care plan founded upon optimism alone: if this means that it is necessary to set a series of apparently limited objectives on the way to a more distant goal, then so be it.

Checklist for Transition Plans

1. Details of P's current and proposed care, including full care plans for each setting.
2. Step-by-step account of how P will be moved from A to B including: Timing; Personnel involved; Who will take responsibility for the transition on the day and subsequently; What will happen from P's perspective (eg. moving possessions, arrangements for meals on the day etc); Whether police will be present and if so, details of their involvement (note that unless physical force and/or restraint and/or sedation are essential, it is best to plan on the basis that they will not need to be authorised by the court, and then to return to court in the event the transition does not work and further steps are required); and Monitoring in days/weeks immediately following move.
3. Where police will be involved in the removal, ensure that the transition plan includes information sufficient to satisfy the guidance given by Coleridge J in *Re MP; LBH v GP [2009] FD08P01058:*

> *"In the event that it is expected that the assistance of the Police may be required to effect or assist with the removal of a vulnerable/ incapacitated adult ("P") which the Court is being asked to authorise, the following steps should generally be taken:*
>
> *(1) the Local Authority/NHS body/other organisation/person (the Applicant) applying to the Court for an authorisation to remove P should, in advance of the hearing of the Application, discuss and, where possible, agree with the Police the way in which it is intended that the removal will be effected, to include, where applicable, the extent to which it is expected that restraint and/or force may be used and the nature of any restraint (for example, handcuffs) that may be used;*
> *(2) the Applicant should ensure that information about the way in which it is intended that removal will be effected is provided to the Court and to the litigation friend (in cases where a person has been invited and/or appointed to act as P's litigation friend) before the Court authorises removal. In particular, the Court and the litigation friend should be informed whether there is agreement between the Applicant and the Police and, if there is not, about the nature and extent of any disagreement;*
> *(3) where the Applicant and the Police do not agree about how removal should be effected, the Court should give consideration to inviting/directing the Police to attend the hearing of the Application so that the Court can, where appropriate, determine how it considers removal should be effected and/or ensure that any authorisation for removal is given on a fully informed basis."*

Footnote

Following the well-established '**balance sheet'** approach identified by Thorpe LJ in Re A [2000] 1 FLR 549 at 560:

> *"There can be no doubt in my mind that the evaluation of best interests is akin to a welfare*

appraisal. .Pending the enactment of a checklist or other statutory direction it seems to me that the first instance judge with the responsibility to make an evaluation of the best interests of a claimant lacking capacity should draw up a balance sheet. The first entry should be of any factor or factors of actual benefit. In the present case the instance would be the acquisition of foolproof contraception. Then on the other sheet the judge should write any counterbalancing dis-benefits to the applicant. An obvious instance in this case would be the apprehension, the risk and the discomfort inherent in the operation. Then the judge should enter on each sheet the potential gains and losses in each instance making some estimate of the extent of the possibility that the gain or loss might accrue. At the end of that exercise the judge should be better placed to strike a balance between the sum of the certain and possible gains against the sum of the certain and possible losses. Obviously, only if the account is in relatively significant credit will the judge conclude that the application is likely to advance the best interests of the claimant."

Whilst this pre-dates the coming into force of the MCA, the Courts have continued to adopt the approach.

Victoria Butler-Cole and Alex Ruck Keene are barristers at 39 Essex Street.

THE MENTAL HEALTH ACT

R (SP) v SSJ (2010) All ER (D) 308 (Nov)

The Secretary of State for Justice was entitled to rely on a medical recommendation under s47 MHA which did not explicitly address the new **'appropriate treatment' test**:

(1) his case workers are not concerned to pursue medical reasoning, but only to see whether the expert had given some reasons which they considered adequate and did not conflict with the facts known or the statutory requirements;

(2) he was entitled to give the reports a sensible meaning, and to satisfy himself that the 'appropriate treatment' test was met by reference to matters which had been in the report by necessary implication.
For more details see:
http://www.mentalhealthlaw.co.uk/R_(SP)_v_SSJ_(2010)_All_ER_(D)_308_(Nov)

MENTAL HEALTH TRIBUNAL

Is the case of CB below a sign that the tribunal is getting tougher? Whilst this was about the failure to answer a witness summons on a wider point it is about the failure to comply the direction of a tribunal.

SS CB v Sussex County Council (2010) UKUT 413 (AAC)
(1) Under s25 TCEA 2007 the Upper Tribunal issued a fine of £500, payable within 28 days, for failure to comply with a witness summons issued by the HESC chamber (education jurisdiction). (2) Under s16(3) Contempt of Court Act 1981 the Upper Tribunal specified a term of imprisonment of 7 days if payment was not made within the specified period. The court ordered that:
(A) Mr Allard failed to comply with the witness summons dated 30 April 2010.
(B) In the exercise of the powers conferred upon it by s 25 TC & E Act 2007, the UT orders Mr Allard to pay a fine of £500.
(C) Payment within 28 days (subject to successful application under (D)).
(D) He has liberty to apply, before expiry of the period referred to in (C), for that period to be varied and/or for provision to be made by the UT for the fine to be payable by instalments.
(E) Acting under s 16(3) Contempt of Court Act 1981 the UT specifies a term of imprisonment which will apply if payment is not made within the period specified at (C) (subject as above).
In that eventuality, Mr Allard is sentenced to a term of imprisonment of 7 days
For more details see:
http://www.mentalhealthlaw.co.uk/CB_v_Sussex_County_Council_(2010)_UKUT_413_(AAC)

WP v SS (DLA) (2010) UKUT 384 (AAC)
The decision under challenge was stated to have been made **unanimously when in fact it was made by majority.**

There is no obligation on the First-tier Tribunal (Social Entitlement Chamber) to state whether a decision is made by a majority or is unanimous; however, any statement given must be accurate. If the decision notice accurately records that the decision was by a majority then any statement of reasons must contain at least a brief statement of the reasons for the dissent of the minority member. An inaccurate statement that a decision is unanimous amounts to an error of law. The decision was therefore set aside and remitted to a freshly constituted Tribunal for reconsideration. For more details see:

http://www.mentalhealthlaw.co.uk/SSWP_v_SS_(DLA)_(2010)_UKUT_384_(AAC)

SSJ v RB (2010) UKUT 454 (AAC) —

The Tribunal **may conditionally discharge with conditions which amount to a regime of detention (deprivation of liberty) to any establishment which is not defined as a 'hospital'.**

The Upper Tribunal will follow High Court decisions unless it is convinced they are wrong, but where highly specialised issues arise the UT may feel less inhibited than the High Court in revisiting the issues.

This is a particularly significant decision because the cases listed below under 'related judgements' essentially prevented a tribunal ordering discharge to any place that the patient would continue to be deprived of their liberty. This case usefully distinguishes a DOL in a hospital from that in a place which is not designated as a hospital. The other judgements are not affected by this case in so far as the discharge is to a place that is registered as a hospital.

RB was granted a deferred conditional discharge with a condition that he 'does not leave the grounds of except when supervised'. The Secretary of State appealed, relying on a Court of Appeal case (PH) and three High Court cases (G, MP, IT) which had been decided on the basis that the Tribunal could not conditionally discharge with a condition which itself inevitably amounted to an Article 5 deprivation of liberty.
(1) The Upper Tribunal is bound by Court of Appeal decisions. But the UT was not bound by the CA decision in PH because the relevant point had not been decided but merely accepted as correct by the CA.
(2) The High Court is not bound by previous High Court decisions but follows them unless convinced they are wrong; the UT takes the same approach as the High Court except (a) the UT is bound where the High Court has judicially reviewed it, and (b) where highly specialised issues arise the UT may feel less inhibited in revisiting the issues. On the current issues, the High Court had been wrong.
(3) Discharge does not connote release from detention to a state of liberty. It means release from 'detention in a hospital for treatment'.
(4) If the patient no longer meets the criteria for detention in hospital for treatment, and some other form of accommodation (not being a hospital) is appropriate subject to the possibility of recall, the Tribunal must order a conditional discharge subject to suitable conditions without concerning itself with Article 5.
(5) Even if the conditions amount to detention there will be no breach of Article 5 because of the procedural safeguards in the MHA.
(6) A 'qualified PH principle' still applies: a Tribunal cannot conditionally discharge with conditions that amount to detention in a hospital for treatment, as this would be inconsistent with the discharge criteria.
(7) (Obiter) The condition amounted to a deprivation of liberty: (a) objectively, because of comparisons with ECHR cases (and the reasoning in PH about purpose did not apply, as here the condition was to protect the public); and (b) subjectively, because RB's consent was not free and unfettered since he only had the choice of two detention regimes.
(8) (Per Judge Rowland) Although the Tribunal can conditionally discharge from one regime of detention to another, only the Secretary of State can transfer from one regime of detention *for treatment* to another. The definition of 'hospital' is wide so the Tribunal cannot conditionally discharge to a regime of detention in any establishment where the patient will receive 'assessment or medical treatment' (England) or 'treatment or nursing' (Wales).
For more details see:
http://www.mentalhealthlaw.co.uk/SSJ_v_RB_(2010)_UKUT_454_(AAC)

Related judgments

- R (RB) v First-tier Tribunal (Review) (2010) UKUT 160 (AAC)
- R (SSHD) v MHRT, re PH (2002) EWCA Civ 1868
- R (SSHD) v MHRT, re PH (2002) EWHC 1128 (Admin)
- R (G) v Mental Health Review Tribunal (2004) EWHC 2193 (Admin)
- R (SSHD) v MHRT, re MP (2004) EWHC 2194
- R (IT) v SSJ (2008) EWHC 1707

DL v South London and Maudsley NHS Foundation Trust (2010) UKUT 455 (AAC)
The Tribunal ***failed to explain why it rejected medical and social reports which recommended absolute discharge****. Their decision was set aside and the case remitted to the First-tier Tribunal for a rehearing.*
For more details see:

http://www.mentalhealthlaw.co.uk/DL_v_South_London_and_Maudsley_NHS_Foundation_Trust_(2010)_UKUT_455_(AAC)

DAMAGES FOR UNLAWFUL DETENTION

AMHPs beware. The local authority has been found to be liable in damages where a detention is unlawful. The amount has not yet been fixed. It will be interesting where the AMHP is a nurse and employed by the new GP arrangements. Who will pay the compensation then?

TTM v LB Hackney (2011) EWCA Civ 4 —

(1) Where a local authority makes an unlawful application to a hospital for the detention of a patient under the MHA, it can be held liable in ***damages for false imprisonment*** *when its unlawful act directly causes the detention;*
(2) although the hospital may act lawfully in detaining such a patient under the s6(3) defence (if the application appeared to be duly made) that does not prevent the detention being held to be unlawful from the outset as against the local authority;
(3) an application for detention that is made contrary to s11(4) (in the face of the NR's objection) is in breach of Article 5(1);
(4) Article 5(5) entitles a person detained in breach of Article 5(1) to compensation, and s139(1) (no liability unless bad faith or lack of reasonable care) can be read down so as to allow such a claim to proceed;
(5) the word 'practicable' in s12(2) (requiring a recommendation from a doctor with previous acquaintance if practicable) should be broadly construed;
(6) (obiter) a breach of s12(2) does not go to jurisdiction, but is one made in the exercise of that jurisdiction, and as such is less likely to make detention unlawful;
(7) on the facts, the local authority was liable in false imprisonment and breach of Article 5 because of the s11(4) breach, and permission was granted under s139(2) for a compensation claim to be pursued, but there was no s12(2) breach because it had been reasonable to obtain two external opinions given the divergence of views between the treating doctors.

Council faces payout over unlawful detention under MHA, Local Government Lawyer, 17th January 2011 The Court of Appeal has ordered a local authority to pay compensation following a man's unlawful detention in hospital under the MHA 1983. In TTM v London Borough of Hackney & Ors [2011] EWCA Civ 4, the appellant M had been detained at Homerton Hospital between 30 January and 11 February 2009. His detention followed an acceptance by East London NHS Foundation Trust, which manages the hospital, of an application for his admission under s.3 of the 1983 Act. The application had been completed by an approved mental health professional (AMHP), for whose conduct Hackney had accepted responsibility. M challenged the lawfulness of his detention through a writ of habeas corpus against the NHS trust. The London Borough of Hackney was joined as an interested party. On 11 February 2009 Burton J gave judgement for M and ordered his release. The judge concluded that **although the AMHP honestly believed the brother (M's nearest relative) had agreed to his sectioning, it was not reasonable for her to have believed that this was the case**.
On the first day of the hearing M also issued a claim for judicial review against the local authority and the hospital trust, seeking damages for his detention or - if his claim was barred by the 1983 Act - a declaration of incompatibility with Article 5 ECHR. Burton J said the judicial review proceedings - rather

than the habeas corpus proceedings - were a more suitable route for addressing the issue of damages. Mr Justice Collins dismissed the claim for judicial review at a hearing on 11 June. The judge said M's detention during the period up to Burton J's order was not unlawful as a matter of domestic law and that there was no incompatibility as suggested. However, he gave leave to appeal on limited grounds M argued before the Court of Appeal that his admission for treatment under s. 3 and detention was unlawful on two grounds. The first was that his brother had objected to the application. The second was that neither of the doctors who provided the medical assessment on which the application was founded had previous acquaintance with M. His counsel therefore argued that the application failed to conform with the requirements of s. 12(2) of the 1983 Act. In the case M asserted a number of grounds for judicial review. These were claims for unlawful detention and/or trespass to the person, negligence, breach of statutory duty under the MHA and breach of duty under s. 6 of the Human Rights Act 1998 coupled with Article 5.

The Court of Appeal allowed the appeal. Giving the lead judgement, Lord Justice Toulson suggested that Collins J should have held that M was unlawfully detained both as a matter of domestic law and within Article 5 (the right to liberty). The appeal court judge rejected Hackney and the Health Secretary's argument that M was not unlawfully deprived of his liberty by the conduct of the AMHP since the conduct of the hospital trust was lawful. Following Sir Thomas Bingham in Re S-C (Mental Patient habeas Corpus) [1996] QB 599, the fact that the hospital trust's actions were lawful did not cure the underlying unlawfulness, he said.

Lord Justice Toulson ruled that M had been deprived of his liberty as a direct consequence of the AMHP's unlawful act in applying for his admission in breach of the Act. "The only matter which protects the local authority from liability for false imprisonment is the statutory defence provided by s. 139(1)," he added. "That subsection does not stop the AMHP's conduct from being unlawful. The application was an undoubted breach of the Act."

Lord Justice Toulson explained what s. 139(1) does is limit the civil liability of the AMHP (and the local authority) for the AMHP's unlawful act to cases where the act was done in bad faith or without reasonable care. "That restriction, however, is subject to the provisions of the Human Rights Act," he added. The judge ruled that M's rights under Article 5 had been infringed and that he was entitled to compensation. "The correct starting point is to examine the nature of the conduct and whether it conformed with the safeguards for the patient's liberty prescribed by Parliament, which it did not," he said. "The next question is whether that conduct was the direct cause of the claimant's loss of liberty, which it was." He said: "This is a case of detention by the state under a statutory scheme involving two agents of the state, between whom the scheme provides for an internal division of responsibility. The first agent has responsibility for ensuring that any application which it makes for a patient's detention is lawfully made.

The second agent has responsibility for carrying out the detention on the application of the first agent, provided that the application appears to be in order. Things went wrong in the present case when the first agent made an application for M's detention which was prohibited by law. It cannot be right, because of the division of responsibility, to regard the resulting state detention as consistent with Article 5, when the fundamental cause of the detention was an application made in contravention of the Act."

Lord Justice Toulson said he was not persuaded by Hackney's submission that in cases of wrongful detention where everyone acted in good faith, it would be more appropriate for compensation to be paid by the party which detained M (i.e. the hospital). The judge said: "Although the AMHP acted in good faith, the unfortunate fact remains that she acted in contravention of s.11(4), whereas the hospital trust acted lawfully."

He added: "S. 6(3) serves a positive purpose. it is in the public interest that a hospital trust should act promptly on receipt of an application for admission which appears to be in proper form, and that it should not think it necessary for its own legal protection to incur time and expense in checking the accuracy of the various matters which s. 6(3) entitles it to accept as correct."

In conclusion, Lord Justice Toulson said he had "considerable" sympathy with the local authority's position. "The AMHP was clearly conscientious, and it may be that if she had not been mistaken in supposing that M's brother no longer objected to the application, the ultimate result would have been the same, but by a different route," he said. "However, while that may affect the amount of any compensation, it cannot affect the legality of what occurred. Our system of law is rightly scrupulous to ensure that in matters affecting individual liberty the law is strictly applied. It is a hallmark of a constitutional democracy." The judge said he echoed the President of the Queen's Bench Division's "strong hope" that the parties could agree compensation without the need for further proceedings. For more details see:

http://www.mentalhealthlaw.co.uk/TTM_v_LB_Hackney_(2011)_EWCA_Civ_4

CHANGES TO MENTAL HEALTH LEGISLATION

‘Liberating the NHS: Legislative Framework and Next Steps’, Department of Health, 15th December 2010

“Responsibility for commissioning independent mental health advocacy under the Mental Health Act will also move from PCTs to local authorities, together with the role of the supervisory body in respect of hospitals under the Mental Capacity Act deprivation of liberty safeguards. However, owing to its highly specialised nature, mental health advocacy will not be a part of the NHS complaints advocacy services that local authorities will be able to commission from HealthWatch.”

Letter 19 January 2011

Health and Social Care Bill - Amendments to the Mental Health Act 1983

The Government has today published a Health and Social Care Bill. The Bill includes a number of small amendments to the Mental Health Act 1983 (MHA). I thought members of the Mental Health Alliance might find it helpful if I summarised those amendments.

The Bill is largely concerned with the Government’s plans for reform of the NHS set out in the Command Paper Liberating the NHS: Legislative Framework and next steps1. Most of the amendments to the Mental Health Act are consequential on those reforms, especially the proposed abolition of PCTs and SHAs, and the creation of the NHS Commissioning Board (the Board) and GP commissioning consortia.

*Because PCTs are to be abolished, clause 32 transfers to commissioning consortia (and, where relevant, the Board) PCTs’ duty to provide after-care under **section 117 MHA**. In doing so, it also makes a number of largely technical changes to ensure that the duty on consortia and the Board is aligned as closely as possible with their functions under the mainstream of NHS legislation in the NHS Act 2006 (as amended by the Bill). **It does not change the fundamental duty to provide after-care to patients who qualify under section 117.***

*Clause 37 transfers from PCTs to commissioning consortia the duty under **section 140 MHA** to notify local social services authorities about the hospitals to which their patients can be admitted in cases of urgency, or which are especially suitable for children and young people under the age of 18.*

*Paragraph 7 of Schedule 5 similarly transfers from PCTs to consortia (and, where relevant, the Board) the duty in **section 39 MHA** to give information to the criminal courts about the availability of hospital places for defendants the court is considering detaining under the MHA.*

Paragraph 117 of Schedule 4 transfers to commissioning consortia the duty under section 236 of the NHS Act 2006 to pay fees to doctors who examine patients in connection with applications for detention under the MHA. (It also makes a small further change to tighten the rules which are meant to ensure that such fees do not have to be paid where the examination is carried out as part of a service for which the NHS is already paying.)

*As announced in Liberating the NHS: Legislative Framework and next steps, clause 35 transfers the responsibility for **arranging IMHA services** to LSSA. At present, the responsibility formally lies with the Secretary of State, but has been delegated to PCTs. The Bill does not change the “qualifying patients” for whom IMHA services must be made available.*

*Decisions have yet to be taken about how the Secretary of State’s powers to **approve section 12 doctors** and approved clinicians under the MHA should be exercised in future. At the moment these important approval functions are delegated to SHAs. But to provide flexibility for the future, clause 30 sets out new ways in which arrangements could be made for these functions to be exercised. **The Secretary of State would be able to arrange with any willing party for them to exercise the approval functions**. Instead (or in addition) the Secretary of State could require the NHS Commissioning Board or a Special Health Authority to do so.*

*The Government is also taking the opportunity to **abolish a few powers in the MHA** which no longer fit well with the way the NHS operates today.*

Clause 31 removes the Secretary of State’s anachronistic power to discharge people from detention (and supervised community treatment) in independent hospitals. The Secretary of State has no such power to discharge people from NHS hospitals. The clause also removes the little known power of NHS bodies to discharge patients from detention (and supervised community treatment) in independent hospitals.

*Clause 33 repeals the old power in **section 122 MHA** for the Secretary of State to make “pocket money” payments to in-patients in mental health hospitals. This will not affect payments to those patients who have been transferred from prison to hospital and are not eligible for social security benefits. Like PCTs now, commissioning consortia (and, where relevant, the Board) will still be able to arrange for providers to make these payments as part of the in-patient services they commission.*

Clause 34 removes Secretary of State's ***power to direct that patients in the high secure psychiatric*** *hospitals be transferred to another hospital. That power appears to be left over from when the Department of Health directly managed the high secure hospitals. For similar reasons, clause 36 removes the option* ***in section 134 MHA*** *for people who do not want to receive correspondence from detained patients to notify the Secretary of State of that wish. They will still be able to notify the hospital managers or the approved clinician in the charge of the patient's case.*
The Bill also includes ***two other changes to the MHA which are not directly related to the wider reforms of the NHS.***
Part 7 of the Bill transfers the regulation of social workers in England from the GSCC's to the Health Professions Council (which is to be renamed the Health and Care Professions Council). Alongside this, it also ***transfers the GSCC's role in approving training courses for approved mental health professionals under the MHA.***
Finally, clause 273 changes the rules on when the treatment of patients on SCT needs to be approved by a SOAD.
In summary, it means that a SOAD's certificate of approval will no longer be required where the patient is consenting to the treatment in question (and has the capacity to do so). Instead, it would be sufficient for the AC in charge of the treatment to certify the patient's consent.
This would bring the system for SCT patients much more in line with that for patients detained in hospital. The Government and the CQC believe this would help target the work of SOADs more effectively, without lessening safeguards for patients. We also conscious that some SCT patients resent having their decision to consent to medication second-guessed (as they see it) by a SOAD.
Unlike most of the changes described above, the change to the rules on SOADs for SCT patients applies to Wales as well, with the support of the Welsh Assembly Government. The other changes which apply to Wales as well are clause 31 (powers of discharge), clause 34 (transfer from high secure hospitals) and clause 36 (patient's correspondence).
There is more detailed information on these clauses, and the Bill in general, in the Explanatory Notes which will published shortly, and available (with the Bill) on Parliament's website at http://services.parliament.uk/bills/2010-11/healthandsocialcare.html
If you would like more information on these clauses in particular, please feel free to contact Richard Rook (020 7972 4648) or Clive Marritt (020 7972 4492) or by e-mail MentalHealthAct2007@dh.gsi.gov.uk I will be arranging for this letter to be available on the Department's website.
Yours sincerely
Bruce Calderwood
Director of Mental Health and Disability

LEGAL AID

This is a very difficult time for both suppliers of legally aided legal advice and for clients. The Legal Services Commission has come up with a deeply unsatisfactory way of seeking to control solicitors who give legally aided advice. Law firms are franchised to provide different types of advice. Here at **Peter Edwards Law** we are franchised to provide both **mental health/incapacity** and **community care** advice. So far so good.
However the crazy part is that firms are now allocated a certain number of **'new starts'**. These are the number of cases that they can open in a year. If say, by the 9th month of the contract they have used up the new starts there is no guarantee that the LSC will allocate them any more. This means that any client (new or existing) then wanting to instruct them would have to find a different firm who had some matter starts left. This is likely to make **more work for mental health act administrators**. It may be that the firms with unused starts might be the ones that patients chose not to instruct.

The case below was about the allocation of new starts for high security hospitals

Public Interest Lawyers v LSC (2010) EWHC 3277 (Admin)

The verification process following the LSC's public law and mental **health tendering process fell short** of what was required by the Public Contract Regulations 2006. No objection was taken, nor could it be, to self-certification. But the self-certification supervisor forms did not require supervisors to confirm

specifically the nature of the employment arrangements between them and the organisation or whether they had complied with the supervision standards set out in the contract, in particular the supervision experience or training course requirement (clause 2.28) and the 1:6 supervisor ratio requirement (clause 2.35). There may therefore be a number of firms with contracts who did not meet the supervision criteria, for example who have an external non-employed supervisor, or a part-time supervisor who is not employed for sufficient hours. The LSC must ensure, within a limited period, that all firms currently comply with the supervision standards; those who do not must have their contracts removed and the matter starts redistributed pro rata.

The disability equality duty challenge to the HSH contract under s49A Disability Discrimination Act 1995, as originally raised, was essentially a challenge to the consultation and the formulation of the tender proposals; as it was brought eight months after the proposals were available, it was out of time. However, the outcome of the of the tender exercise was only recently known: in particular, senior psychiatrists had given evidence of the distress changing solicitors would cause to a considerable number of patients in the light of the reduction in number of solicitors with contracts (of 98 existing providers, 43 did not bid; of those who bid, six firms were successful at Ashworth, and five at each of Broadmoor and Rampton). The outcome engaged the s49A duty so the LSC must gather information, consult with interested stakeholders, and have due regard to whether they need to take steps to ameliorate the result of the contracting exercise. (3) The public law tender, and the reduction in matter starts, met the LSC's legal obligations under s4 Access to Justice Act 1999.

A further hearing was held on 21/12/10. As a consequence of the case, the LSC sent out more detailed self-certification forms to firms, and are considering how to approach the HSH equality duty issue. One answer would be to relax the rules on those without HSH contracts continuing to represent HSH patients: at the moment they can only carry out remainder work and, in certain circumstances, follow patients who *in future* are transferred into high security.
The **final order** provided that:
1. Permission to apply for judicial review in claims CO/11265/2010 and CO/11267/2010 is granted.
2. In relation to the contracts for the provision of publicly funded services for mental health and public law, the Defendant shall, subject to the outcome of any formal review requested by a provider dissatisfied with a decision on verification, complete the verification process within 6 weeks of the date hereof, and in particular shall
(a) request all persons awarded a contract for mental health and public law confirm that they comply with clause 2.28 and 2.35 of the Standard Civil Contract;
(b) remove the contract of any firm found not to comply with the requirements in clause 2.28 or 2.35 of the Standard Civil Contract;
(c) redistribute any NMS to those firms who do meet the verification requirements pro rata to their original bids.
3. It is declared that the outcome of the tender process for the high secure mental health contract engages the duty under section 49A of the Disability Discrimination Act 1995.
4.The Defendant do pay 70% of the Claimant's costs in claims CO/11265/2010 and CO/11267/2010 and HX10X04109 & HX10X04110 to be subject to a detailed assessment if not agreed.
For more details see:
http://www.mentalhealthlaw.co.uk/Public_Interest_Lawyers_v_LSC_(2010)_EWHC_3277_(Admin)

CHILDREN

Re RK; YB v BCC (2010) EWHC 3355 (COP)

Given the terms of s20(8) Children Act 1989 (that any **person with parental responsibility** may at any time remove the child) the provision of accommodation to a child under s20(1), (3), (4) or (5) will **not ever give rise to a deprivation of liberty** within the terms of Article 5.
If the child is being accommodated under the auspices of a care order, interim or full, or if the child has been placed in secure accommodation under s25, then the position might be different.
In any event:
(a) the objective element of deprivation of liberty was not remotely close to being met on the facts;
(b) the subjective element was not met, as the parents had consented on RK's behalf;
(c) RK's placement was at the behest of her parents and could not be imputed to the state.

For more details see:
http://www.mentalhealthlaw.co.uk/Re_RK;_YB_v_BCC_(2010)_EWHC_3355_(COP)

WALES

The Mental Health (Wales) Measure 2010 received Royal Assent on 15/1/10. Mental Health (Wales) Measure 2010

'A Measure of the National Assembly for Wales to make provision about primary mental health support services; the coordination of and planning for secondary mental health services; assessments of the needs of former users of secondary mental health services; independent advocacy for persons detained under the Mental Health Act 1983 and other persons who are receiving in-patient hospital treatment for mental health; and for connected purposes. This Measure, passed by the National Assembly for Wales on 2 November 2010 and approved by Her Majesty in Council on 15 December 2010, enacts the following provisions...'

THE GOVERNMENT RESPONSE TO THE LAW COMMISSION CONSULTATION DOCUMENT ON ADULT SOCIAL CARE LAW

64. The provision of social care to adults in prison is a complex area. The law is currently unclear where responsibility lies. We know we need more clarity, especially given the ageing prison population. Therefore, we welcome the Law Commission's consultation question on this issue and expect that the consultation exercise will inform our work in this area.

Provisional Proposal 11-6: We provisionally propose that the choice of accommodation directions should cover residential accommodation provided under section 117 of the Mental Health Act 1983.

Provisional Proposal 11-7: We provisionally propose that the additional payments regulations should cover residential accommodation provided under section 117 of the Mental Health Act 1983.

65. There will be certain people in receipt of section 117 after-care who are not free to choose their own accommodation, for example, where residence in a particular place is a condition of a community treatment order or conditional discharge under the 1983 Act. In other cases, we agree that it is anomalous that people accommodated by social services authorities under section 21 of the NAA 1948 should have a legal right to choose their accommodation, while those receiving equivalent accommodation under section 117 do not. It is similarly anomalous that the position on additional payments by service users and third parties should not be the same in both cases.
66. In principle, therefore, we welcome these two provisional proposals.

Provisional Proposal 11-8: We provisionally propose that the concept of ordinary residence should be extended to apply to after-care services provided under section 117 of the Mental Health Act 1983.

67. We agree that it is unhelpful that the rules for which social services authority is responsible for section 117 after-care are entirely separate from those in the NAA 1948. We agree in principle with the provisional proposal that the NAA concept of ordinary residence should be extended to apply to section 117 after-care as well. How easily this can be done in practice may depend in part on answers to the questions raised by provisional proposal 11-9 and questions 11-3 and 11-4 below.
68. We will be interested to see other commentators' views on the question of separate rules for section 117 after-care within the umbrella of ordinary residence. We suspect that it may not be possible to resolve this question of separate rules without taking some policy decisions (which the Commission rightly notes are outside its remit). That is because, on closer inspection, the fit between section 117 and the ordinary residence rules as they operate under the NAA 1948 is more complicated than suggested in paragraphs 11.68

and 11.69. There are at least two other scenarios in which the application of the ordinary residence rules would produce a different result to section 117 as it stands.

69. The first is where someone has been placed in a care home by local authority A in the area of local authority B, and is then detained under section 3 of the 1983 Act. Under the NAA ordinary residence rules, local authority A would retain responsibility for residential accommodation required on

the patient's discharge, because the patient would be "deemed" still to be ordinarily resident in local authority A. However, under section 117, the deeming rules do not apply, so local authority B would be responsible if the patient had, as a matter of fact, become resident in its area by virtue of living in the care home. The second is where someone who is in receipt of section 117 after-care voluntarily moves from one local authority area to another. Under ordinary residence rules, that move would normally change the local authority responsible – under section 117 it does not.

70. We could accommodate these differences within an expansion of the special rules of the type the Commission suggest. But in practice it might be better to take the opportunity of a new statutory framework to review, as a matter of policy, whether (and to what extent) the distribution of local authority responsibilities under section 117 should be brought into line with those under the main ordinary residence rules.

Provisional Proposal 11-9: We provisionally propose that section 117 should be amended to clarify that the duty falls on health authorities to provide health care after-care, and on social services authorities to provide social care after-care. We also propose that section 117 should be amended to clarify that health and social services authorities can commission after-care services.

71. We agree that it would be helpful to clarify these two points.

Question 11-3: If the section 117 duty should be split between health and social services authorities, should the termination of the duty also be split so that, for example, social care after-care ceases when the social services authority is satisfied that the person no longer needs social care after-care; or should both authorities be involved in the decision?

72. We will be interested to see other commentators' responses to this question. Provisionally, however, we think that the duty should be split, as it is in other cases where people are in receipt of both health and social care.

Question 11-4: Should section 117 be recast from a free-standing duty to a gateway provision?

73. Again, we will be interested to see other commentators' responses to this question. Nevertheless, provisionally we can see advantages in recasting section 117 as a "gateway" duty, for the reasons set out by the Commission. In particular, we think it could help simplify the statutory framework, without affecting the substance. However, it would be necessary also to address the interface with the statutory framework for children's social services, as section 117 applies to people of all ages.

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