

# Mental Health

## July 2010

This newsletter is a bumper edition, and its focus is firmly on recent case law.

There's **Savage**, in which the Supreme Court has now had its say: Emma Galland looks at the continuing relevance of the right to life and at why detained patients have greater protections than informal patients.

There have also been important cases recently on compulsion and incapable patients, a subject about which Bethan Bagshaw writes, and on the capacity to consent to contraceptive treatment. They are both covered here, alongside a brace of articles about the new mental health tribunal: one looking at the reasons it produces for its decisions, and the other, at a recent case about disclosure. The result of that case might suggest that as far as the Mental Health Act is concerned, the notion of best interests is now dead and buried.

Our clutch of mental health-specific articles also includes Simon Charlton's discussion of prison-to-hospital transfers, Sallie Harrington's note of a new case on the interface with the Immigration Act, and a piece by me on the subject of the nearest relative, objections to detention and the necessary state of mind of the AMHP. Another of my pieces looks again at the DoLS, and why they are less popular than was expected, and Emma Galland's second contribution looks at a recent case on section 117 and the 'responsible commissioner'.

In the last edition of this newsletter, I mentioned a new film in which I make an appearance. That film, called *Cutting the risk: self-harm minimisation in perspective*, is now out. Produced by the National Self Harm Minimisation Group and aimed at both professionals and service users, it attempts to explore new ways to engage positively and productively with people who self harm. It includes testimonies from such people, and from those who encounter self-harm in health care settings, interviews with what are described as key figures in the field, and a comprehensive information pack. More details of the film can be found, and orders can be placed, here:

[http://www.mind.org.uk/shop/dvds/diagnoses\\_treatment/628\\_cutting\\_the\\_risk\\_self\\_harm\\_minimisation\\_in\\_perspective\\_dvd](http://www.mind.org.uk/shop/dvds/diagnoses_treatment/628_cutting_the_risk_self_harm_minimisation_in_perspective_dvd)

Finally on the subject of shameless plugs, I really should mention that Weightmans will be sponsoring this year's Taking Stock conference in Manchester. Hosted by Cardiff Law School, the Approved Mental Health Professionals Association for the North West and Wales, and Manchester University, the conference will take place on October 15 at the Royal Northern College of Music. Among the speakers lined up for the event are Lord Justice Munby, Richard Jones and Professor Nav Kapur. More details can be found here: <http://www.wyed.co.uk/lukeclements/whatsnew/>

**David Hewitt**  
Partner, Weightmans LLP

## Featured articles

### Home thoughts abroad

It seems that opinion is divided on the subject of the DoLS.

### Beyond reasonable belief

Must an AMHP be both unreasonable *and* wrong if detention is to be unlawful?

### To know at all costs

The law has struck a blow for patients' rights, but maybe at the expense of their best interests.

### More reasons

And more money spent on lawyers? That's what the new appeal court seems to want.

### Limited conception

When assessing a patient's capacity to make decisions about contraception, there are some issues that must be borne in mind. But not as many as you might expect...

### Transfer responsibility

Where a mental health patient is transferred from prison to hospital, there can be problems if out of date forms are used.

### Best interests and conveyance to hospital

The High Court has authorised the use of force to take a patient from her home.

### Deportation and mental disorder

The Court of Appeal has clarified the position of restricted patients who are to be dealt with under the Immigration Act.

### Establishing the responsible commissioner

A service user's 'settled presence' will be a significant factor.

### At what cost 'just satisfaction'?

The obligation that the 'right to life' imposes on mental health services has now been clarified.

## Home thoughts abroad

### It seems that opinion is divided on the subject of the DoLS

In the last edition of this newsletter, I wrote about the Deprivation of Liberty Safeguards (DoLS), by which incapable people can be deprived of liberty but given some basic protection at the same time. I made similar comments elsewhere, and they received a number of heartfelt, though by no means unanimous, responses. I thought it might be helpful to report something of what my correspondents said.

No one disagreed that the number of DoLS applications is well below what was expected, but not everyone accepted that in some places, applications are actually being discouraged. One DoLS lead was “disappointed” by my suggestion. He said, “My team and I are working very hard at promoting the importance of the safeguards and very much take an if-in-doubt-apply approach”, and he described the DoLS as “a very powerful tool for positive change and holding services to account.”

Some correspondents felt the statistics might not reflect bad practice. One, a doctor in an area with little DoLS activity, referred to his local training strategy, which “emphasised that deprivation of liberty amounts to relatively draconian control over someone's life.” He favoured an approach based on the Mental Health Act: “For the last 20 years I have been a proponent of the use of guardianship as a means of making important accommodation decisions for people who lack capacity, and we appear to have roughly trebled the number of guardianships used in the last ten months.” Of course, while guardianship may be appropriate for those who are not within the DoLS, the conventional view is that it has little to offer where someone is deprived of liberty.

Most correspondents considered the safeguards unduly complex, and some reported general opposition to their use. One, a Mental Capacity Act (MCA) co-ordinator, said, “Many senior people consider deprivation of liberty a ‘bad’ thing and therefore are reluctant to invite external scrutiny on whether they are responsible for it.” Some felt the process might fail even without overt opposition. A DoLS lead wrote, “Care managers are not always recognising behaviours that warrant the need for a referral”, while someone else said the MCA “is not clearly and properly understood by many practitioners on the ground and certainly not by managers of homes and hospitals.” This might, he felt, have profound implications: “I am not sure that decision-makers are even getting through the starting gate of the MCA, never mind reaching the logical finishing line that is DoLS.”

Several correspondents identified poor planning as a problem. The doctor who favoured guardianship said that before resorting to the DoLS, everyone “should consider first whether they could change the care plan so that an individual was not being deprived of their liberty – emphasis on choice, few restrictions and keeping relatives on side.” One DoLS lead, however, saw this differently: “care managers drag their heels trying endless means of pacifying anxious service-users, only resorting to a DoLS referral after about three months of perseverance.” Far from it being necessary to keep relatives onside, she said most are “fearful of the possibility of loved ones being discharged to their care, and therefore their views about whether there is deprivation of liberty are somewhat distorted.”

This correspondent said that recently, “a wife told an assessor that her husband was absolutely fine, rarely spoke of wishing to leave the care home and could easily be persuaded to behave. This was in stark contrast to what had actually been occurring.”

Inadequate recording was also identified as a problem, not least by this same DoLS lead: “one of our referrals ... failed due to insufficient evidential logging of the service-user’s behaviour. This raises the question: given that few care homes are meeting the guidelines for accurate and consistent recordings, will we ever be able to evidence a deprivation of liberty?”

Finally, several correspondents agreed that uncertainty about deprivation of liberty itself is a significant problem, and that different assessors might take different views, especially in more complex cases. A DoLS lead said, “I conclude that unless a person is shouting ‘let me out’ from the rooftops, wrestling staff to the floor and needing to be sat on, constantly making an opportune exit through any open door or needing heavy sedation to control their behaviour, it is just not obvious enough to amount to deprivation of liberty.”

The Deprivation of Liberty Safeguards continue to excite great debate, even if – or maybe because – they are so rarely encountered. From my own postbag, however, it seems that views are polarised, and that some people are profoundly dissatisfied, both with the purpose of the DoLS and with the way they are used.

**David Hewitt, Partner**  
**Weightmans LLP**

The original article may be found **here**:

[http://www.weightmans.com/library/newsletters/mental\\_health\\_-\\_april\\_2010/home,\\_sweet\\_home.aspx](http://www.weightmans.com/library/newsletters/mental_health_-_april_2010/home,_sweet_home.aspx)

---

## Beyond reasonable belief

### **Must an AMHP be both unreasonable *and* wrong if detention is to be unlawful?**

Where someone is to be detained under the Mental Health Act, his nearest relative has a significant part to play. If detention is to be for anything other than the short-term, the nearest relative may object and any objection might carry the day. The objection must be given to the Approved Mental Health Professional (AMHP) who will apply for detention, but what if she doesn’t believe it has been made?

Recently, a nearest relative who objected to admission went on to make comments that were more ambiguous. The AMHP said she believed that he had eventually agreed to detention, but although genuine, this understanding was held unreasonable and Burton J ordered the patient’s release (**M v East London NHS Foundation Trust**, 11 February 2009). The patient subsequently came back to court, and the result of that second hearing, before Collins J, could prove uncomfortable (**TTM v Hackney LBC and East London NHS Foundation Trust**, 11 June 2010).

One issue was the AMHP’s belief: must it be unreasonable if the patient is to succeed, or need it just be wrong? And what if it is both?

These questions arose when Collins J considered whether to permit a damages claim against the local authority whose AMHP had the patient detained. He decided not to do so, ruling that although detention was unlawful “there is no reasonable prospect of success in any negligence claim.” That is a surprising, if barely explained, decision, not least because at the first hearing, Burton J appeared to have taken a contrary view. He said, “I believe [the AMHP] did act properly ... [but] it was not reasonable of her to have formed the view that she did.” Collins J said this did not imply that the AMHP was negligent; it merely followed from Burton J’s finding of fact that having once objected to admission, the nearest relative hadn’t subsequently changed his mind.

There is logic in this position, for the Act itself makes no mention of ‘reasonable belief’. Section 11(4)(a) simply prohibits an AMHP from making an application for longer-term detention if the nearest relative has notified her that he objects to it, and that seems to impose an objective test. Burton J saw no tension between that and his ‘reasonable belief’ test, but Collins J said, “Lawfulness of detention ... does not depend on

whether the AMHP reasonably believes that there is no objection but on whether in fact there was no objection.”

The problem isn't so much what Burton J and Collins J say as the, perhaps diplomatic, attempt by the latter to suggest that it is the same thing. Burton J can be read to have dismissed the objective test. He offered the key question 'what was the reasonable belief of the AMHP?' and suggested three ways to reach an answer. He chose the third way: to ask "on analysis of the facts, did the AMHP act reasonably in concluding that there was an objection?" But he did so only after dismissing two other courses: to look at the subjective opinion of the nearest relative or to decide "whether there was objection by reference to analysis of the evidence." The latter is surely the objective analysis favoured by Collins J, but Burton J thought it "would be likely to ... create an unnecessary risk for the hospital and for the AMHP in relation to each particular case, without achieving any necessary protection for the patient." Surely, then, 'reasonable belief' is one thing and the objective test another, and Burton J does not say what Collins J says he says.

A more charitable view might be that Burton J did not seek to establish 'reasonable belief' as a discrete test; he simply used it to determine what, objectively, had been communicated to the AMHP by the nearest relative. Such an approach has an objective bias that would make it easier to reconcile with the one proposed by Collins J. Perhaps this will all be resolved on appeal.

It is hard not to feel sorry for the patient in this case, who was detained when, the High Court has twice accepted, he should not have been, and for his nearest relative, whose clear objection was not allowed to have effect. Yet, the patient finds he has no remedy, despite the AMHP's unlawful act, and she is not negligent, even though the belief she acted upon was not reasonably held. This case runs the real risk of perpetuating, and even compounding, the misfortune it has laid bare.

**David Hewitt, Partner**  
**Weightmans LLP**

The first hearing in this case, before Burton J, was the subject of an article in the September 2009 edition of this newsletter. That article may be found **here**:

[http://www.weightmans.com/library/newsletters/mental\\_health\\_-\\_september\\_2009/nearest\\_relative\\_objection.aspx](http://www.weightmans.com/library/newsletters/mental_health_-_september_2009/nearest_relative_objection.aspx)

The judgment following the second hearing may be found **here**:

<http://www.bailii.org/ew/cases/EWHC/Admin/2010/1349.html>

This is a revised version of an article published in the Solicitors Journal.

---

## To know at all costs?

### **The law has struck a blow for patients' rights, but maybe at the expense of their best interests**

The Upper Tribunal (UT) is the new court of appeal from mental health tribunal decisions. The tribunal that makes those decisions is the First-tier Tribunal of the Health, Education and Social Care Chamber (FtT), the successor to the MHRT. In a recent case, the UT had to consider the way the FtT had dealt with a man who is being medicated covertly (**RM v St Andrew's Healthcare**, 23 April 2010).

The FtT ordered that information including the fact of covert medication be withheld from the man, but the UT set that order aside. While disclosure might cause the man serious harm, the UT said that prohibiting it would

not be proportionate. This would be the case, even though the UT was told that when the information had been disclosed to the man previously, he had defaulted from his treatment, his condition had deteriorated, and he had had to be both restrained and secluded. Furthermore, his condition had improved of late, largely because covert medication had been re-introduced.

The UT summarised the relevant case law:

- It is “beyond argument and not in dispute” that openness is generally required, and that a hearing can be fair, even though every document is not disclosed.
- While a party’s solicitors might not be able to disclose information to their client, they can still take his instructions on its themes.
- In ‘control order’ cases, it would be unlawful to deny disclosure of evidence to detainees and their lawyers, even though it would be granted to the ‘special advocates’ appointed for them by the state.

Here, the UT found for the patient’s right to know. Without disclosure of the fact that he was being covertly medicated, any FtT hearing would be “a mere mummery”. Either the patient would have to be excluded or the lawyers and clinicians, and even the tribunal members, would be prevented from discussing everything they knew. Refusing disclosure would have involved not just “a compromise between justice and openness”, but “the sacrifice of the patient’s right to challenge his detention effectively”.

There is a certain logic to this decision, founded, clearly, in the ECHR and the Human Rights Act. But there is also reason for concern. The UT summarised one line of argument for the patient as follows: “If detainees under control orders are entitled to disclosure of the case to be answered even at the risk of a terrorist attack, so the more must the patient be entitled to disclosure *even at the risk of a deterioration in his own condition or potentially his death*” [emphasis added]. These were not the UT judge’s own words, admittedly, but he acknowledged that they represented the logical conclusion of the process his decision sanctioned. If, in the cause of a ‘fair trial’, a patient must be able to put his case, even if the result might be his own death, we have surely travelled a long way not just from the dusty paternalism of the past, but also from any, perhaps more contemporary, notion of ‘best interests’.

**David Hewitt, Partner**  
**Weightmans LLP**

The decision discussed in this article may be found **here**:  
<http://www.bailii.org/uk/cases/UKUT/AAC/2010/119.html>

---

## More reasons

### And more money spent on lawyers? That's what the new appeal court seems to want

It is now possible to challenge decisions of the mental health tribunal without going all the way to the High Court. The new tribunal, which has taken over from the much-loved Mental Health Review Tribunal (MHRT), is the First-tier Tribunal of the Health, Education and Social Care Chamber (Mental Health) (FtT). If that name recalls Jimmy Saville's Old Record Club – "That's: open bracket, I Can't Get No, close bracket, Satisfaction" – so does the title of the new appellate court: the Upper Tribunal (Administrative Appeals Chamber).

The Upper Tribunal (UT) is finally getting into gear, and some of its early judgments are about the reasons the FtT gives for its decisions.

#### Satisfactory reasons

In the case of **RH**, the UT said those reasons were perfectly adequate (**RH v South London and Maudsley NHS Foundation Trust (Restriction Order)**, 8 February 2010). The FtT had refused to discharge RH from conditional discharge, even though all the professionals, including his responsible clinician and social worker, and an independent psychiatrist, supported his case. The tribunal had formed a different, more pessimistic view of the risk he continued to pose.

When considering RH's appeal, the UT said there is a difference between a case where the tribunal disagrees with the clinical judgements of witnesses (where the explanation will have to be more detailed) and one where the only disagreement is as to the inferences to be drawn from those judgements. This was an example of the latter case, where the tribunal need only give sufficient reasons to show that it has directed itself properly as to the law and had regard to the appropriate matters.

#### Is this the job of the NHS?

Although this was sufficient to dispose of the appeal, the UT was also concerned that neither the hospital nor the Secretary of State had taken part in the proceedings. It said this approach was understandable in the past, when MHRT decisions were challenged by judicial review and the tribunal itself took the lead. Now, however, the UT said it is "extremely unsatisfactory" for hospitals (for example) to make no submission at all, for there is "a public interest in appeals at this level being properly argued". Hospitals and the Secretary of State, the UT said, "have an interest in the standards of adjudication in mental health cases, [so] one might also expect them to take an interest in the way mental health law is developed".

This comment was not central to the case, but it does raise a question that demands a response. And that response might be another question: why? Why should the NHS shoulder the burden – and the cost – of refining mental health law or, more to the point, of correcting the manifold errors of the First-tier Tribunal?

The second appeal came in the case of a restricted patient who suffers from anti-social personality disorder (**DL-H v Devon Partnership NHS Trust and Secretary of State for Justice**, 12 April 2010).

#### A difficult case

The UT acknowledged that this had been a difficult case: the statutory definition of 'mental disorder' had changed between the evidence being prepared and it being heard. The decision of the FtT was nevertheless set aside, because it had not been properly explained.

The FtT had decided not to discharge the patient, either absolutely or conditionally, but the UT said its reasons for doing so were inadequate. On the question of risk, for example, the FtT had excluded the evidence of the patient's expert witness for a reason that was equally applicable to that of his responsible clinician.



In general, the UT said that FtT reasons must “at least” say what points the tribunal regarded as decisive, and that they will have to be more detailed and more compelling if the overall decision is a surprising one.

### **Appropriate treatment**

Then, the UT turned once more to peripheral matters. It said that because of the way ‘medical treatment’ is defined in the Mental Health Act, it is not hard to satisfy the requirement that ‘appropriate’ medical treatment be ‘available’ for the patient. But this means that a patient “may be contained for public safety rather than detained for treatment”. To guard against this danger, the UT said that the FtT “must investigate behind assertions, generalisations and standard phrases”. Among the questions it said should be asked, and that services and clinicians can now expect to be asked, are: “what precisely is the treatment that can be provided?” “What discernible benefit may it have on this patient?” “Is that benefit related to the patient’s mental disorder or to some unrelated problem?” “Is the patient truly resistant to engagement?”

This tribunal didn’t even do that.

**David Hewitt, Partner**  
**Weightmans LLP**

The RH case may be found **here**: <http://www.bailii.org/uk/cases/UKUT/AAC/2010/32.html> and the DL–H case **here**: <http://www.bailii.org/uk/cases/UKUT/AAC/2010/102.html>

---

## **Limited conception**

**When assessing a patient’s capacity to make decisions about contraception, there are some issues that must be borne in mind. But not as many as you might expect...**

Mrs A hasn’t taken her contraceptive medication for some months now, and she gives conflicting accounts of her attitude to pregnancy and motherhood, and of what their implications might be. A complicating factor is her capacity.

Mrs A’s case came before the High Court recently (**A Local Authority v Mrs A and Mr A**, 4 May 2010). At one time, the local authority had thought it might be necessary to force her to take her medication, possibly with the assistance of the police.

The first task for the court was to decide how to assess Mrs A’s capacity. She has a very low IQ, and for the purposes of this case it was accepted that she has an impairment of the mind that might bring her within the Mental Capacity Act. The next question, therefore, was whether she can understand, retain, use and weigh relevant information, and also, what that information might be.

According to the Act, it includes “the reasonably foreseeable consequences of deciding one way or another” – here, whether to use contraception. Two conflicting views were before the court: it was said for Mrs A that she would be capable if she had a sufficient grasp merely of the medical features of the decision; while the local authority argued that she would be incapable – and so might be treated in her best interests, and without her consent – unless she understood the social consequences as well. (These might include possible conception and birth, and the parenting of a child.)

Ultimately, the judge adopted the more limited test. He said that as far as contraception is concerned, it is only necessary for someone to understand the ‘proximate medical issues’ in order to be capable. Requiring

her also to pass the ‘social consequences’ test would “set the bar too high [and] risk a move away from personal autonomy in the direction of social engineering”. It would impose too great a requirement of a test that “has to be applied daily in surgeries and family planning clinics during appointments lasting perhaps less than half an hour”.

The judge listed the medical issues he had in mind:

- The reason for contraception and what it does (including the likelihood of pregnancy if it is not in use during sexual intercourse)
- The types of contraception available and how each is used
- The advantages and disadvantages of each type
- The possible side-effects of each and how they can be dealt with
- How easily each type of contraception can be changed
- The generally accepted effectiveness of each

When this test was applied to Mrs A, it produced a stark result. There was a wealth of evidence that she had been overpowered, and even abused, by her husband, and the judge found that this was sufficient to render her unable to use or weigh information about contraception. She would therefore be incapable and, by virtue of the Mental Capacity Act, professionals and the court would be able to make decisions in her best interests.

That, however, was the high water-mark of the court’s involvement, for the judge seemed to shy away from the logical implications of his findings. He ruled that compulsion was out of the question, not least because both Mr and Mrs A had stated vehemently that they would resist it. Because of this ‘drawbridge-mentality’, the judge said, “it is difficult if not impossible to envisage any acceptable way forward on these particular facts, other than by an attempt to achieve *a capacitated decision* from Mrs A, through ‘ability-appropriate’ help and discussion without undue contrary pressure from Mr A” (emphasis added). With regard to Mr A, the judge accepted that there was the power to issue an injunction to prevent him pressurising his wife. The judge declined to use that power, however, because Mr A now said he would allow Mrs A to have free contact with professionals.

It is interesting that the judge accepted that his injunction-making power derived from the ‘inherent jurisdiction’ of the High Court, and that that jurisdiction continues to exist, at least in respect of ‘vulnerable’ people, despite the coming of the Mental Capacity Act. (The judge also accepted that incapable people can be vulnerable too.) More surprising, however, was his attitude to Mrs A’s state-of-mind.

The judge seemed to will the end – that Mrs A should take contraceptive medication – but not the means. It is easy to see why, for using the apparatus of the state to prevent a woman becoming pregnant is, to say the least, a significant step. Yet it seems odd that, having concluded that Mrs A lacked capacity with regard to contraception, the judge approved a solution that relies entirely upon her ‘capacitated decision’. If she does indeed become capacitated, surely no ‘best interests’ decision may be made or, if it has been made, may be enforced. And presumably, in that happy state, Mrs A will be able to decide not just to accept medication, but also to decline it. And if, as the judge clearly believes, there is indeed a chance that Mrs A will acquire capacity, to rule now that she lacks it is surely to act prematurely, and even, possibly, to contradict the Mental Capacity Act.

**David Hewitt, Partner**  
**Weightmans LLP**

## Transfer responsibility

**Where a mental health patient is transferred from prison to hospital, there can be problems if out-of-date forms are used**

A recent High Court case concerned the transfer of a patient from HMP Frankland to Rampton Hospital (**R (SP) v Secretary of State for Justice**, 12 February 2010). The transfer was made under section 47 of the Mental Health Act 1983 (MHA), and it had the same effect as a hospital order made under that Act.

The patient in question had been sentenced to seven years' imprisonment, and he was considered both dangerous and to be suffering from mental disorder within the meaning of the MHA. Any hospital transfer would be at the direction of the Secretary of State, and he would have to be provided with reports from at least two registered medical practitioners, stating that the prisoner suffered from a mental disorder, that the disorder was of a nature or degree that made it appropriate for him to be detained in hospital for medical treatment, and that appropriate medical treatment was available for him. This last requirement proved to be troublesome.

When the Secretary of State made the 'transfer direction', he relied upon reports provided by Dr A, who used a new form that reflected amendments to section 47 made in 2008, and by Dr B, who used an old form that reflected the un-amended provision. The significant difference lies in Section 47(1)(c). The old form deals with the question of 'treatability' and asks whether medical treatment "is likely to alleviate or prevent a deterioration of" the patient's condition. The new form, however, asks whether "appropriate medical treatment is available for him".

It was accepted that when filling in the new form, Dr A had applied the appropriate test. The patient argued, however, that Dr B had failed to do that, because, when using the old form, she had neither considered the availability of appropriate treatment nor provided any reasons why the proposed treatment was appropriate.

Giving judgment, Burnett J said that when a transfer direction is challenged, two questions must be considered: did the decision-maker actually apply her mind to the statutory criteria and was there sufficient material before her to sustain the conclusion?

The judge was clear that Dr B had not applied her mind to the new statutory criteria. But he nevertheless found that the reports of the two doctors did provide a sound foundation for the conclusion that 'appropriate medical treatment' was 'available' for the patient. Dr B had recommended treatment in a special hospital because, she said on the form, she thought such treatment was likely to alleviate or prevent deterioration of the patient's condition. He needed to go to a unit that could provide treatment for a dangerous and severe personality disorder, and outside the prison system, such treatment was only available at Rampton Hospital. In those circumstances, the judge said it was implicit in the information provided by Dr B that she believed the treatment was available at Rampton. The patient's transfer would therefore be lawful.

The, no doubt inadvertent, use of an old form caused confusion in this case and gave the patient an opportunity to challenge a transfer that most seem to have accepted was clinically appropriate. The changed wording of the new form reflects changes made by the Mental Health Act 2007. It should be borne in mind that those changes were fundamental (as well as controversial) and, as this case perhaps makes plain, affected rather more than the mere surface of the Act.

**Simon Charlton, Associate**  
**Weightmans LLP**

The case mentioned in this article may be found **here**:  
<http://www.bailii.org/ew/cases/EWHC/Admin/2010/1124.html>

---

## Best interests and conveyance to hospital

### The High Court has authorised the use of force to take a patient from her home

The recent case of PS concerned a woman with a learning disability who has been diagnosed with uterine cancer and will require surgery. Because the woman lacks capacity to make decisions about her medical care and treatment, the relevant NHS hospital trust sought a declaration both for the surgery and for the measures necessary to ensure that the surgery took place. The case was heard by Sir Nicholas Wall, the President of the High Court's Family Division (**DH NHS Foundation Trust v PS**, 26 May 2010).

The doctors treating PS felt that the best treatment for her would be surgery in the form of hysterectomy and the removal of her fallopian tubes and ovaries. Without this treatment, they had no doubt that the tumour would spread and eventually lead to her death.

PS had a phobia of hospitals and needles, however, and although she had agreed on previous occasion to undergo surgery, she had failed, and on one occasion refused, to attend hospital. The clinical team had therefore come to the conclusion that special arrangements would be needed to ensure that PS underwent the operation and remained in hospital to recover.

The Trust proposed that a consultant anaesthetist, a learning disability community sister and an ambulance crew attend PS's home in a final attempt to persuade her to come into hospital. If she once again refused, a sedative would be given to her, mixed into a soft drink. Post-operatively, PS would be given analgesics whose sedative effect made it unlikely that she would be able to abscond. It was acknowledged that force might be necessary to ensure PS returned to her hospital bed. It would, however, be used only as a last resort.

Having considered the evidence, Sir Nicholas concluded that surgery was clearly in PS's best interests. He was satisfied that the alternatives had been carefully considered and were inappropriate in this case. Whilst an operation carried the usual risks of death, those risks were no greater in this case. Sir Nicholas was also satisfied that it might be necessary to use sedation, and even force, to convey PS to hospital, but also that such measures would only be used if persuasion failed. In respect of PS's 'detention' in hospital post-operatively, he said it was not necessary to invoke deprivation of liberty provisions: if it was in her best interests to undergo surgery it would also be in her best interests to recover appropriately from it.

This case highlights the importance of approaching cases concerning incapable patients thoughtfully, sensitively and systematically. The Trust was able to demonstrate very clearly that PS lacked capacity to make decisions about her medical treatment. It had fully considered all other options and attempted to persuade PS to attend for surgery on multiple occasions, albeit without success. Though onerous – and though, with its emphasis on coercive conveyance, possibly more draconian than is common in such cases – the judge's decision is understandable. Looking beyond the immediate facts, however, the implication that a patient is not deprived of liberty by measures taken in her best interests might be a contentious one.

**Bethan Bagshaw, Trainee Solicitor**  
**Weightmans LLP**

The case discussed in this article may be found **here**:

## Deportation and mental disorder

### The Court of Appeal has clarified the position of restricted patients who are to be dealt with under the Immigration Act

MJ was a 28-year-old Angolan man who arrived in the UK when he was 12 and now enjoyed indefinite leave to remain. He suffered from a learning disability and had been diagnosed with schizophrenia. MJ had been convicted of a number of offences, most of which took place before he was 21, and this had led to his being admitted to hospital under sections 37 and 41 of the Mental Health Act 1983 (MHA).

The Home Secretary decided to deport MJ under the Immigration Act 1971, on the grounds that due to his convictions, deportation would be conducive to the public good. It was believed that he was highly likely to re-offend. When MJ's appeal to the Asylum and Immigration Tribunal was dismissed, he applied to the High Court for a review, and an order for reconsideration was made. MJ was again unsuccessful, however, so he appealed to the Court of Appeal. The principle issues in the appeal were whether the Home Secretary could decide to deport MJ while he remained a restricted MHA patient, and if so, whether that decision breached MJ's rights under Article 8 of the European Convention on Human Rights (**MJ v Home Secretary**, 20 May 2010).

Section 37 of the MHA applies to a person who has committed an imprisonable offence and has a mental disorder of a nature or degree that warrants treatment in hospital. Section 41 applies certain restrictions where it is necessary to protect the public from serious harm. A 'restricted' patient will continue to be liable to detention until discharged under other provisions of the MHA. Section 86 of the Act provides that a patient who is a foreign national may be removed to his country of origin, provided proper arrangements are in place and removal would be in his interests. MJ argued that he could not be deported under the provisions of the Immigration Act while he remained subject to the MHA.

In the case of a patient in hospital, it was the policy of the UK Border Agency not to deport him until he was ready to be discharged into the community. The Court of Appeal heard that in practice, the patient would be conditionally discharged under section 42(2) of MHA, the condition being that he transfers to the place from which he would be conveyed to his country of origin.

The Home Secretary relied on the case of **R (X) v Home Secretary** [2001], in which a patient who had been refused leave to enter and remain in the UK was removed to hospital under section 48 of the MHA before being made subject to a deportation order. While the facts of that case were different, the Court of Appeal accepted the fundamental point that the Immigration Act regime was not circumscribed by the MHA. It was apparent that Parliament had contemplated the provisions of the Immigration Act when drafting the MHA – there is a reference to it in section 86 – and had not made any express limitation on the application of that Act.

While the Home Secretary cannot disregard mental disorder when making a decision to deport someone, the fact that that person is subject to the MHA will not in itself exclude a deportation order being made under the Immigration Act. The immigration provisions may cut across section 86 and a person may therefore be removed on the basis that such is in the public's interests if not his own.

As to the Article 8 point, the Court applied **Maslov v Austria** [2008] ECHR 546 and concluded that the decision of the Asylum and Immigration Tribunal was flawed. Not only was it necessary to consider the cumulative



effect of the factors affecting a patient's Article 8 rights; where he has spent all or most of his childhood and adolescence in the host country, very serious reasons will be required to justify expulsion. That is particularly so where the patient committed the relevant offences as a juvenile. The tribunal had failed to demonstrate such serious reasons in this case.

**Sallie Harrington, Associate**  
**Weightmans LLP**

The judgment in this case may be found **here**: <http://www.bailii.org/ew/cases/EWCA/Civ/2010/557.html>

---

## Establishing the responsible commissioner

### A service user's 'settled presence' will be a significant factor

A recent decision of Mr Justice Mitting clarifies the position of primary care trusts and local authorities that provide 'aftercare services' under section 117 of the Mental Health Act 1983 (**R (M) v London Boroughs of Hammersmith & Fulham and Sutton**). In particular, it gives additional guidance on establishing the responsible commissioner, who will usually have to fund those services.

The case concerned M, who had been detained under section 3 of the Act. When he was discharged from hospital and became entitled to aftercare services, it was unclear where he was 'ordinarily resident' for the purposes of section 117. He had been living within the borough of Hammersmith & Fulham, but immediately before his admission to hospital, social care services had placed him in Sutton. Once there, M had terminated his tenancy, but he had returned to Hammersmith & Fulham for one night, albeit sleeping rough. He now said he wanted to return there.

Mitting J said 'ordinarily resident' connotes a "settled presence in a particular place other than under compulsion". The correct approach would be to ask the patient where he is resident rather than where he *would like to be* resident. On the facts of this case, M was ordinarily resident in Sutton.

It is rare for a case such as this to reach court, as one would ordinarily expect these issues to be resolved locally. The case shows that in determining the responsible commissioner, it is important to ensure that all of the facts are established. It seems that the 'settled presence' of the service-user prior to detention will be a more important factor than any wish he or she might express. But if they can be, it is infinitely preferable for such matters to be resolved without recourse to the court.

**Emma Galland, Solicitor**  
**Weightmans LLP**

---

## At what cost 'just satisfaction'?

### The obligation that the 'right to life' imposes on mental health services has now been clarified

Much has been written about the decision of the House of Lords, made in December 2008 in **Savage v South Essex Partnership NHS Foundation Trust**, on the issue of whether the trust owed an operational obligation to a detained patient, so that her relatives could recover damages after she killed herself. In March 2010, this

matter was heard by Mr Justice Mackay in the High Court, it having proceeded to trial following the earlier decision.

### **The facts**

Mrs Savage, who was detained in hospital under section 3 of the Mental Health Act 1983, made several attempts to abscond. She had also threatened suicide, informing those caring for her that she was experiencing hallucinations that told her to jump out of a window. On 5 July 2004, Mrs Savage absconded from the hospital, jumped in front of a train and was killed. At trial, the judge, though recognising that the claim had not been brought for financial gain, awarded damages of £10,000 – a sum he considered appropriate for ‘just satisfaction’.

### **Criticisms**

The House of Lords having decided that the trust owed an operational obligation to Mrs Savage, the issue to be determined now was whether there was a “real and immediate” risk that she would harm herself or commit suicide. Mackay J was highly critical of the risk assessments performed on Mrs Savage, and of the actions (if any) taken in light of the assessed risk. He held that she was not at risk of self-harm or suicide when she was on the ward, but that this changed, and there was a ‘real and immediate’ risk, once she absconded. He said the trust should have been aware of this change, and that it had failed to do all that could reasonably be expected of it to avoid or prevent the new risk.

### **Future impact**

The judge emphasised the importance of risk assessments, of members of staff acting upon them, and of regular reviews of the risk posed by individual patients. He said staff should be aware, both from the actions of patients and from information provided by colleagues from earlier shifts, of any risks posed by individual patients and the frequency with which those risks should be reviewed. NHS hospital trusts might wish to consider reviewing their risk assessment policies in that regard.

Whilst the threshold of “real and immediate risk” is relatively high – here, there was held to be a 20 per cent chance that Mrs Savage would self-harm – the test for causation creates a much lower threshold. It is lower than the standard clinical negligence threshold created by the ‘but for’ test. In a claim brought under Article 2 of the ECHR, a claimant merely has to prove that a substantial chance was lost to prevent the deceased committing suicide.

**Emma Galland, Solicitor**  
**Weightmans LLP**

The decision of the House of Lords in this case may be found **here**:

<http://www.publications.parliament.uk/pa/ld200809/ldjudgmt/jd081210/savage-1.htm>

The most recent decision may be found **here**:

[http://www.bindmans.com/fileadmin/bindmans/user/Press\\_\\_judgements/Savage\\_Judgment/Savage\\_-\\_28-04-2010.pdf](http://www.bindmans.com/fileadmin/bindmans/user/Press__judgements/Savage_Judgment/Savage_-_28-04-2010.pdf)



## Mental health law specialists

Weightmans has unrivalled expertise in health and social care law, and the firm's dedicated team provides clear, concise, reliable advice and representation to a wealth of NHS trust, local authorities, regulators and third sector bodies.

The following members of the team are specialists in the law relating to mental health, mental capacity and vulnerable adults.

**Kiran Bhogal**

[kiran.bhogal@weightmans.com](mailto:kiran.bhogal@weightmans.com)

020 7822 1939

**Simon Charlton**

[simon.charlton@weightmans.com](mailto:simon.charlton@weightmans.com)

0121 200 8118

**David Hewitt**

[david.hewitt@weightmans.com](mailto:david.hewitt@weightmans.com)

0161 233 7382

**Morris Hill**

[morris.hill@weightmans.com](mailto:morris.hill@weightmans.com)

0151 242 7990

**Emma Galland**

[emma.galland@weightmans.com](mailto:emma.galland@weightmans.com)

020 7822 1958

**Tony Yeaman**

[tony.yeaman@weightmans.com](mailto:tony.yeaman@weightmans.com)

0121 200 8108

This update does not attempt to provide a full analysis of those matters with which it deals and is provided for general information purposes only and is not intended to constitute legal advice and should not be treated as a substitute for legal advice.

Weightmans LLP accepts no responsibility for any loss that may arise from reliance on the information in this update. The copyright for this update is owned by Weightmans LLP 2010.