MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON MONDAY, 20TH MARCH 2023 - DAY 28

Gwen Malone Stenography Services certify the following to be a verbatim transcript of their stenographic notes in the above-named action.

GWEN MALONE STENOGRAPHY SERVICES

28

APPEARANCES

CHAIRPERSON:	MR. TOM KARK KC
INQUIRY PANEL:	MR. TOM KARK KC - CHAIRPERSON PROF. GLYNIS MURPHY DR. ELAINE MAXWELL
COUNSEL TO THE INQUIRY:	MR. SEAN DORAN KC MS. DENISE KILEY BL MR. MARK McEVOY BL MS. SHIRLEY TANG BL MS. SOPHIE BRIGGS BL MR. JAMES TOAL BL
INSTRUCTED BY:	MS. LORRAINE KEOWN SOLICITOR TO THE INQUIRY
SECRETARY TO THE INQUIRY:	MS. JACLYN RICHARDSON
ASSISTED BY:	MR. STEVEN MONTGOMERY
FOR ACTION FOR MUCKAMORE & SOCIETY OF PARENTS AND FRIENDS OF MUCKAMORE	MS. MONYE ANYADIKE-DANES KC MR. AIDAN MCGOWAN BL
INSTRUCTED BY:	PHOENIX LAW SOLICITORS
FOR GROUP 3:	MR. CONOR MAGUIRE KC MS. VICTORIA ROSS BL
INSTRUCTED BY:	O'REILLY STEWART SOLICITORS
FOR BELFAST HEALTH & SOCIAL CARE TRUST:	MR. JOSEPH AIKEN KC MS. ANNA MCLARNON BL MS. LAURA KING BL **MS. SARAH SHARMAN BL** **MS. SARAH MINFORD BL** **Ms. BETH MCMULLAN BL**
INSTRUCTED BY:	DIRECTORATE OF LEGAL SERVICES
FOR DEPARTMENT OF HEALTH:	**MR. ANDREW MCGUINNESS BL** **MS. EMMA TREMLETT BL**

INSTRUCTED BY:	MRS. SARA ERWIN MS. TUTU OGLE DEPARTMENTAL SOLICITORS OFFICE
FOR RQIA:	MR. MICHAEL NEESON BL MR. DANIEL LYTTLE BL
INSTRUCTED BY:	DWF LAW LLP
FOR PSNI:	MR. MARK ROBINSON KC MS. EILIS LUNNY BL
INSTRUCTED BY:	DCI JILL DUFFIE

INDEX

PAGE

THE INQUIRY RESUMED ON MONDAY, 20TH MARCH 2023 AS FOLLOWS:

INTRODUCTORY REMARKS BY THE CHAIRMAN

09:57

CHAIRMAN: Good morning, everybody. Welcome back the Inquiry, which last heard evidence in December of last year. So that everyone bears it in mind, this session is being live-streamed on our website. Although the cameras will generally be on the speaker of the moment, 09:58 there may be wider shots showing the whole room. So, if people wish to be here but to watch and listen to proceedings without the possibility of being on camera, you are welcome to do so from Hearing Room B.

09:58

I welcome Alex Ruck Keene, who is going to be our first witness. But before we hear from him, just a few things for me to say.

So, what's been happening since we last sat to hear 09:59 evidence? A good deal of work has been going on in the background.

First, the substantial body of evidence that we heard last year has allowed the Panel to identify several 09:59 themes of inquiry which we wish to explore in greater detail. As a result, we've made a number of requests for documentation the Trust relating to those themes, based upon the evidence that we've heard. Now, there's

has been much other significant work being undertaken by the Inquiry staff, by the solicitor to the Inquiry and by the counsel team.

We start evidence today which focuses on the six modules of evidence which we set out in December of last year. This is evidence which will assist the Panel to understand a number of relevant areas of law, procedure, and policy. And, as I said back in December, this is not a time for us to explore whether various pieces of legislation or various policies have actually worked to the benefit of patients - or haven't worked - but, rather, we need to look at what they were, how they were devised, and how they were intended to take effect. 10:00

There will be time in due course to explore how effectively they actually worked, but that time is not yet.

We also want to explore some of the previous work done by others looking into the wider mental health services in Northern Ireland and also the specific reports which are focused on Muckamore Abbey Hospital itself. It is important that we learn what we can from the work which has been done previously. 10:01

Sean Doran KC, senior counsel the Inquiry, is going to speak in more detail about the content of the modules

that we're going to be hearing about over the next couple of months. They've all been published on our website in some detail so I'm only going to touch upon the first module here.

10:01

Module 1 will consider some of the legislation governing the provision of services for mental health and learning disability here in Northern Ireland as well as the law surrounding deprivation of liberty orders and also looking at the Bamford Review of Mental 10:01
Health and Learning Disability, as well as any subsequent developments. The Panel will receive expert presentations on Bamford and the mental health law, looking at the legislation applicable here and also a comparative analysis of the law in the UK outside of 10:02
Northern Ireland and elsewhere.

The first presentation on Module 1 will be delivered, as we know, by Mr. Ruck Keene, King's Counsel. He is a barrister in practice at 39 Essex Chambers in London. 10:02
His practice is focused on mental capacity, mental health and healthcare law and he has appeared in a large number of cases, including some before the Supreme Court and the European Court of Human Rights. He is also a visiting professor at King's College 10:02
London and a visiting senior lecturer at the Institute of Psychiatry, Psychology and Neuroscience with that university. If I get any of this wrong, he'll be able to correct me in a few minutes. He also writes

extensively editing and contributing to textbooks. So we are very pleased to have skewered his services to assist us.

Prof. Roy McConkey will be giving evidence tomorrow morning appearing by video link. He is a expert in the provision of health services to those with learning disabilities. He has held posts within research into learning disability in Dublin and he also has expertise in the resettlement of residents in long-term institutions. In Northern Ireland he held a joint appointment with Ulster University and the then Eastern Health and Social Services Board. He was also a member of the Equal Lives Working Group for the Bamford Review and is a recognised international expert in learning disability services. 10:03 10:03 10:03

Next week, counsel will call Prof. Roy McClelland OBE to give evidence on behalf of the Belfast Trust. He took over as Chair of the Bamford Review of Mental Health and Learning Disability following the unfortunate death of Prof. David Bamford. He is currently emeritus professor of mental health at Queen's University Belfast. He's also a consultant psychiatrist within the Belfast Health and Social Care Trust. 10:04 10:04

I'm not going to introduce each of our speakers in each module which would follow because it would take too

much of today's limited time. But I can say that we've skewered a series of well-informed speakers who are going to address the important topics in each of the six modules which Sean Doran is going to introduce briefly. Some of those speakers are entirely independent in the sense that they're not giving evidence on behalf of an interested body organisation connected to this Inquiry. But others are giving evidence representing interested organisations such as the Belfast Trust who are, of course, Core Participants. It will be made clear in each case what their position is but all witnesses will, I hope, give objective evidence designed to assist the Panel. 10:04 10:05

I also want to thank the counsel team, the solicitor to the Inquiry and her team, and Jaclyn Richardson, the Secretary to the Inquiry and her team for working throughout the time that the Inquiry has not been sitting to put this significant package of evidence together in such a relevantly short time. 10:05 10:05

Now, we aim to finish all of that evidence and revert to patient evidence in May. We intend to end that section of the evidence before the summer break. 10:06

May I just say a few words about that.

I am pleased to say that we've had written confirmation from Phoenix Law Solicitors that their clients who are

members of Action for Muckamore and the Society of Parents and Friends of Muckamore do now intend to make statements in accordance with the directions that I laid down last year. I do want to say this: That if that evidence is to be heard before the summer break, it is essential that they engage now. And I am concerned that we still haven't any of those statements in our hands. The window of time in which we can allow for the statement-taking process from patients and their relatives can't remain open forever, and we have already made significant alterations in the Inquiry's timetable. So I can only reiterate once again that the time for them to engage with us has come. It is now. 10:06 10:06

Now, the current intention is that after the final part of the patient experience, we will start to hear evidence from the members of staff at the Hospital. It is crucial to the Inquiry to hear from the staff of the Hospital so that we get the fullest picture of life at Muckamore Abbey Hospital, and we intend to start the process of gathering that evidence very soon and hearing that evidence in September. 10:07 10:07

Over the past few weeks we've run a media campaign to encourage staff to come forward to the Inquiry. That campaign has run on the radio, in newspaper advertisements and on social media. Last week, we held two remote engagement sessions to explain to members of staff about the work of the Inquiry and how we would go 10:07

about taking witness statements from them.

I have also appointed an independent firm of solicitors called Napiers to provide free and independent advice to members of staff who may not wish to use the services of the Trust solicitors. Of course, not all potential witnesses need legal advice but, for those who do, that is a resource that is now available to them. 10:08

Napiers have been appointed by the Inquiry but they will act independently of the Inquiry and give free and independent advice to those people who may need to know more about their potential cooperation with the Inquiry. I have made it clear, however, that the statement-taking process for staff, as I said previously, will be conducted by our own in-house team of solicitors, all those at Cleaver Fulton Rankin, which is the independent firm appointed to take Inquiry statements. It is crucial, in my view, that for this type of evidence there is an independence to the statement-taking process and that it is overseen by the Inquiry itself. 10:08 10:09

Although I have the statutory power under the Inquiry's Act 2005 to compel people to give evidence, it is generally far better for people to come forward voluntarily with all the assistance that the Inquiry can offer. So I hope to have to use that power 10:09

sparingly, but if I need to use it, I will. I also want to remind all potential witnesses that I will consider carefully any application to remain anonymous and there are several measures that we can take to protect a witness's identity, provided that is justified. There is a form on the front page of our website for staff to fill in and we ask them to do that by 31st March. The fact that an individual has contacted the Inquiry in this way will be kept completely confidential and if anyone needs further advice, support or assistance, please just pick up the telephone to the Inquiry team. 10:10 10:10

The Inquiry staff are here for anyone to speak to, and Napiers are on hand to give legal advice if it is needed. If you are or have been a member of Muckamore Abbey Hospital staff, please engage with the Inquiry now, if you haven't already done so, by filling in the engagement form on the website or speaking to any member of the Inquiry staff here or by picking up the telephone to us, and obviously our telephone number is on the website. 10:10 10:11

I'm now going to hand over to senior counsel to the Inquiry, Sean Doran, King's Counsel, for him to introduce us all to the evidence we'll be hearing in this section of the Inquiry and what his plan is for calling that evidence. Mr. Doran. 10:11

INTRODUCTORY REMARKS BY MR. DORAN KC

MR. DORAN KC: Thank you, Chair, members of the Panel. I would like to make some short introductory remarks before we begin this next phase of the Inquiry's work.

In the previous hearing sessions the Panel has heard a substantial body of evidence relating to the patient experience at the Hospital. The Inquiry has heard from the relatives of present and former patients and also from former patients of the Hospital. To date, we have heard 41 witnesses giving oral evidence to the Inquiry and the written evidence of seven witnesses has been read into the Inquiry record.

The Inquiry will be hearing further evidence relating to the patient experience before we then move on to hear evidence from staff at the Hospital.

The evidence to be heard over the next period of weeks is of a different nature. If one looks at the Inquiry's Terms of Reference, it is obvious that the Panel will need to obtain information about issues such as: The law on mental health and learning disability in this jurisdiction; reform initiatives that have impacted on the life of the Hospital; the policies, procedures and practices that are relevant to the running of the Hospital; the various organisations and authorities that are concerned with the running of the

Hospital and responding to issues that arise at the Hospital; and, of course, previous reviews and reports that have addressed events at Muckamore. Those are the types of issues that we are going to be considering in the forthcoming weeks. 10:13

I would just like to refer everyone briefly to a document that can be found in the key document section of the Inquiry's website. It's titled "Evidence Modules March to May 2003." I hope that that can now be brought up on screen. 10:13

I would just like to make sure that the list of Modules from 1 to 6 at the beginning of the document is clear on the screen. 10:14

CHAIRMAN: We've all got it.

MR. DORAN KC: I'm not going to read through all of the document. Everyone with an interest in the Inquiry will already have had an opportunity of considering it. I simply want to draw attention to the broad subject areas of each module. 10:14

Module 1 is titled "Bamford and Mental Health Law in Northern Ireland". In this module the Inquiry will be looking at the major review of mental health law in this jurisdiction that commenced in 2002 under the chairmanship of Prof. David Bamford. The Inquiry will also be considering the provisions of the Mental Health (Northern Ireland) Order 1986 and the Mental Capacity 10:14

Act 2016 that are relevant to the Inquiry's work. We will also take the opportunity to look briefly at the law in other jurisdictions. I will say a little bit more about Module 1 shortly before introducing today's speaker.

Module 2 will address healthcare structures and governance. This will include consideration of the budget allocated to learning disability and mental health in this jurisdiction. The module will also look at structures that are in place and have been in place to deliver care at the Hospital. This module is aimed at providing the Panel with an understanding of the respective roles of the Department of Health, the Public Health Agency, the Strategic Planning Performance Group (formerly the Health and Social Care Board) and the Belfast Health and Social Care Trust in the management of and the delivery of services at the Hospital. Finally, the module will look at the provision made for community-based services for persons with a learning disability.

Module 3 looks at policy and procedure. This module will include consideration of high-level policies for delivery of care to learning disability patients and policies governing multiple specific matters such as restraint and seclusion, medication, resettlement, complaints, and whistleblowing. The full list of issues to be covered is set out in the document to

which I have referred.

Module 4 will then focus on staffing. This will include matters such as recruitment, training, and development of staff in different disciplines and at different levels. The module will also look at other issues impacting on staff such as turnover and vacancy rates on wards and the impact of suspensions and use of agency staff. 10:17

Module 5 will address regulation and other agencies. This will afford the Panel an opportunity to consider the roles, responsibilities and functions of other bodies that feature in the Terms of Reference. Those are the Regulation and Quality Improvement Authority and its predecessor body, the Mental Health Commission, the Health and Safety Executive for Northern Ireland and the patient and client counsel. 10:17

Module 6 will consider MAH reports and responses. This module has three objectives. The first objective is to provide an overview of four previous reviews and reports relating to the hospital. Those reports were referenced briefly in counsel's opening to the Inquiry. They are the EHS SB/NWBT Review of 2005; the Ennis Ward Adult Safeguarding Report of 2013; the review of safeguarding at MAH, a Way to Go Report from 2018; and the review of Leadership and Governance at MAH from 2020. 10:18 10:18

The second objective of this module is to find out what happened as a result of those reports. What was the response following the issue of the reports?

The third objective is to identify other key reports that the Inquiry Panel will need to consider to assist it in addressing the Terms of Reference. 10:19

That's only a thumbnail sketch of the modules. The document to which I've referred needs to be read in conjunction with the most recent witness schedule that has been published on the website. The schedule runs from this week until week commencing 22nd May of this year, with some breaks and non-sitting days, as indicated in the schedule. 10:19 10:20

As you have said, Chair, the intention is to resume the patient experience evidence after these modules, with a view to completing that evidence before the summer vacation. 10:20

As one can see from the schedule, the Inquiry has invited evidence from a wide range of sources to assist with this part of the Inquiry. Most of the relevant statements for this part of the Inquiry have been received by the Inquiry. Several of the statements have already been disclosed and the remaining statements are being prepared for circulation to Core Participants as expeditiously as possible. It is also 10:20

intended to publish the statements from this phase of the Inquiry on the Inquiry's website.

Before turning to today's presentation, it is worth reminding everyone again of the purpose of this phase of the Inquiry. You, Chair, explained this in your statement of 21st December of last year as follows. You said: 10:21

"The primary objective of this phase of the evidence will be to ensure that the Panel is fully informed of matters such as the legal and regulatory framework, the organisational structures that are relevant to the Terms of Reference, and the relevant policies, procedures and practices that were applicable during the timeframe with which the Inquiry is concerned. It is anticipated that the Inquiry will hear further evidence at a later stage to address the adequacy and effectiveness of the systems and processes in place at the relevant time. There will, therefore, be a time to look in more detail at how things actually worked in practice. But that is not at this stage of the Inquiry." 10:21 10:21 10:21

So it is important to emphasise that we are primarily concerned, at this stage, with ensuring that the Panel has the full picture about the legal framework, structures, policies, procedures and practices at the relevant time. Issues about adequacy and effectiveness 10:22

will be addressed in greater detail at the later stages of the Inquiry when we hear from staff and management and also those working at a higher level with responsibility for the delivery of care within the Hospital. 10:22

This does not mean that the next few weeks are going to be devoid of critical analysis. The Inquiry counsel will be asking questions arising from the statements and questions about the content and scope of the material that the witnesses have exhibited to their statements. Members of the Panel may also have questions for those witnesses. It is, of course, also open to the representatives of Core Participants to propose questions for witnesses to Inquiry counsel, if they so wish, using the procedure that was circulated prior to the commencement of oral evidence last year. 10:22 10:23

I should say, Chair, that when your counsel are taking witnesses during this phase, we do not propose to have the statement read in. 10:23

CHAIRMAN: No.

MR. DORAN KC: This approach would be very unwieldy with evidence of this nature and would simply take too long. Instead, we will be taking the witnesses to passages within the statements and exhibits on which we wish to ask questions. Where appropriate, we will ask for the passages of text under discussion to be displayed on the screens. 10:23

When I gave my opening to the Inquiry last June I made reference to the Bamford Review, the law on mental health in this jurisdiction, and the legal basis for admission of patients to the Hospital. I indicated then that these matters would require more focused attention at a later stage in the Inquiry. These matters are the subject of Module 1, which covers the following specific topics, and I think, if we scroll down the document that's on screen at the moment, we can see topics a to g: 10:24 10:24

"a. Overview of Bamford Review and subsequent developments.

b. Analysis of different models for learning disability services. 10:24

c. Focused Study of the "Equal Lives Learning Disability" Review (September 2005).

d. Focused Study of "A Comprehensive Legislative Framework" (August 2007). 10:25

e. Mental Health (Northern Ireland) Order 1986: key provisions. 10:25

f. The new legislative framework: Mental Capacity Act 2016.

g. Comparative analysis: Law in UK (outside NI) and elsewhere."

As you, Chair, have indicated, we have two speakers who will be delivering presentations to the Inquiry on these topics. Alex Ruck Keene KC today and Prof. Roy McConkey by video link tomorrow morning. These presentations are in reverse order, so to speak. Mr. Ruck Keene will speak on topics d to g and Prof. McConkey on topics a to c. As you mentioned, Chair, there will also be evidence on behalf of The Trust in respect of this module next Wednesday. 10:25 10:26

Mr. Ruck Keeane's evidence is expected to take up both the morning than and afternoon sessions today. 10:26

We will, of course, take suitable breaks. The Panel may have some questions to ask either as the presentation proceeds or at the end of the session. Mr. Ruck Keene is totally content with either approach. 10:26

I should say also say that Core Participants can rest assured that if there are issues or questions that occur to them after today's presentation, Mr. Ruck Keene has indicated that he is more than happy to deal with those questions at a later stage. Now, whether that may be by way of written answers or a short oral session at a later stage is a matter that can be kept under review. 10:26

Without further review, I am going to call upon Alex Ruck Keene KC, who will be assisting the Inquiry with a presentation the governing legislation in this jurisdiction and its broader context.

CHAIRMAN: Just before we start with Mr. Ruck Keene, can I just say this: We've had problems with CaseView this morning but I'm told that if you try to log back on now, you should actually be able to get into the transcript. Apologies for that. Apparently the server address was changed without telling the Inquiry. But these things happen. Anyway, if you log back in now, you should be able to access CaseView. 10:27 10:27

Mr. Ruck Keene, welcome to the Inquiry. You and I met briefly this morning. I'm very grateful, indeed, to you for coming to assist us and I know that you will bear in mind that we have a wide audience for this. You're not speaking to clever university students, you're speaking to somebody like me and I need to understand this material, some of which is entirely fresh as well to me and to the Panel and to the wider audience. I know you'll keep that in mind. Thank you. 10:28 10:28

PRESENTATION BY MR. RUCK KEENE KC

10:28

MR. RUCK KEENE KC: Thank you very much, indeed. Thank you for the invitation. I will do my best to convey what actually - well, you mentioned university students, Chair - what could in fact be the best part

of a term's worth of teaching into something which is hopefully comprehensible looking at the different aspects.

As leading counsel to the Inquiry said, I'm very happy to take questions from the Panel on clarification as we go through or at the end. And if anyone has any further questions I'm very happy to pick them up afterwards. 10:28

10:29

One thing I would just want to say by way of preliminary. I'm not Northern Ireland qualified. I'm a practising English barrister, so I'm qualified to advice and act in courts in England and Wales, so I'm not speaking as a Northern Ireland qualified lawyer. But I am experienced enough in the legislation and have sufficient qualification to be able to talk about the different pieces of legislation in order to inform the Inquiry. I just wanted that to be absolutely clear. 10:29

CHAIRMAN: We share that, Mr. Ruck Keene. Thank you. 10:29

MR. RUCK KEENE KC: If I could get the next slide, please.

That's what I'm proposing to talk to. One thing I just want to say - I'll go to the next slide in a second, I'm taking it very slightly out of order, well not very slightly out of order, I'm following my brief but I want to have a bit right at the beginning about the changing international landscape, because to me it 10:29

seems very important that the Panel understands where, for instance, the Bamford Review sat, where the 2016 Act sat and then also the fact that, for instance, the 1986 Order is now being applied in an international human rights landscape which is almost totally unrecognisable to how it looked when it was enacted and brought into force in 1986. So, if I could get the next slide, please. 10:30

That's just some supporting materials which go along with my presentation. They are live hyperlinks, so anyone who has access to the site can click out. I'm very happy and I understand these materials will be made available. All of them, bar the first, are materials produced by other people. You will notice on the third one, that features Prof. McClelland himself. That's an article there about the 2016 piece of legislation. 10:30 10:31

So the first article there or the first paper there, some people may find helpful. That's a framework document that I've drawn up based on work I've done previously with others at King's College London, which essentially tries to put in bullet point form mental capacity and mental health legislation in Northern Ireland, England and Wales, Scotland and the Republic of Ireland and what's on the horizon. It is very bullet pointed because it's only four pages but it might be helpful as a kind of aide-memoir to people 10:31 10:31

coming back after the presentation.

The second one, just to go through for people, the document by Anne-Maree Farrell and others: Mental Health Policies and Laws on the Island of Ireland, is a very helpful, very recent document with an overview, well in fact what it says on the tin. So, looking both in Northern Ireland and the Republic of Ireland. So helpful in terms of details of the legal framework, but also policies. 10:32

The third one is an overview and an explanation of the background to Sir Bamford but then overview and coverage of the 2016 Mental Capacity Act. Again, for those on the Panel or anyone else who wants to dig a bit deeper below the iceberg of what I'm saying today, that's helpful in terms of an understanding, in particular of the thinking behind it, that piece of legislation. 10:32

The latter two I wanted to really make sure that the Panel had squarely before them, in particular when I come to the very last bit of my presentation as the Panel thinks about the law more widely. So the first is - and that's from the tail end of 2022, the document by Chris Maile and others, thinking about the overview of countries around the world where mental health law has been changed and is changing. I mean, Northern Ireland has been through a major reform process with 10:33

the 2016 Act, it's unlikely Northern Ireland can have further changes any time soon, but just to locate within the international context.

Then the last one, my brief is to talk about the law, 10:33
but one of the things I will be saying, and I'll flash forward to the end, is alongside formal legal changes has been a very important growing international recognisation of things that can be done non-legally to support or to reduce coercion in a mental health 10:33
setting. And that literature review there is a really, to my mind, exceptionally helpful overview internationally of all the various steps which people are taking in different ways either to eliminate or, where elimination isn't possible, to reduce coercion. 10:34
That isn't just, I should say, physical coercion. As the Panel, I know, will be very well aware, coercion takes many different forms. So I just thought it would be helpful. That's, as it were, additional reading material to go back to or to dig deeper into. 10:34

If I could then get the next slide, please.

As I said, it seems to me, Chair, members of the Panel, it's helpful to have an understanding of where we go in 10:34
terms of looking at the 1986 Order and the 2016 piece of legislation to actually have an idea of the wider changing international landscape which, to my mind, really requires consideration of two particular things.

The first is the role of the European Court of Human Rights as the oversight body for the European Convention on Human Rights, which the UK is a signatory to, the European Court of Human Rights is the ultimate court with oversight over the European Convention on Human Rights and, as you'll be aware, Panel, but maybe not everyone else will be aware, it's victims or people who can assert a victim status who can bring a claim to the European Court of Human Rights saying that the State has breached their rights. "Victim" can be quite widely defined but we're generally talking about the individual concerned, rather than a State organisation, State body itself. 10:35 10:35

I'm just trying to do my best to put everything in a context, to give you the contextual picture: The European Court of Human Rights has taken an increasing interest in mental health matters. That interest started in the 1970s, the Convention, having come into force in 1950, there was very little, surprisingly little attention. From the 1970s started to focus in on matters relating to mental health but particularly from the turn of the 20th century, the European Court of Human Rights has really focused in on a range of issues relating to mental health broadly characterised. It seems to me that there are three important aspects to that which require a little bit of consideration. As I said, I put the case references there. Those are all hyperlinks out to the judgments for people who need 10:35 10:36 10:36

to know more or want to know more.

But, to break it down, the first limb of that, the first thing that the European Court of Human Rights has really focused in on is the concept of deprivation of liberty. So, in other words, the right to liberty. The right not to be deprived of your liberty by the State or with the State's knowledge arbitrarily. Whenever I teach or train about that what I emphasise is arbitrary here means without proper checks and balances. Without some independent oversight as whether that deprivation liberty is actually justified. For instance, does the person actually have - and the language that the European Court of Human Rights or European Convention uses is "unsound mind" which is, frankly, offensive, but that's the languages used. Does the person have a mental disorder? Is it really necessary, either in their own interest or in the interests of others that they're detained?

10:36

10:37

10:37

But one of the things that very first case, HL in the United Kingdom, which many people know as Bournewood, one of the things that that case focused in on was that the idea that if you had somebody in an institution, a mental health hospital, who didn't appear to be trying to leave, HL in that case was in Bournewood Hospital in England. He didn't actually try to leave at any point. He was autistic, it was unclear whether actually he appreciated -- well, he undeniably appreciated where he was, all the evidence was he was very unhappy where he

10:37

10:37

was, but he didn't try and leave. There was no legal framework around him. He wasn't detained under the mental health law in England and Wales because he was considered to be an informal patient. He wasn't trying to leave. He was being cared for in his interest. No question of deprivation of liberty arose. 10:38

That case ultimately -- well actually in the House of Lords, so at that point the highest court within United Kingdom, the House of Lords said. 'Not deprived of his liberty, not falsely imprisoned.' His foster carers took the matter to the European Court of Human Rights and the European Court of Human Rights said. 'This man is deprived of his liberty. He is under continuous control, he is not free to leave and any suggestion to the contrary is a fairytale. The fact he isn't attempting to leave is irrelevant.' One of the things the European Court of Human Rights highlighted very squarely was the total absence of any procedural safeguards around HL as an informal patient, compared to a patient detained under the Mental Health Act 1983. 10:38 10:39 10:39

CHAIRMAN: So was he a voluntary patient then?

MR. RUCK KEENE KC: Well the language flickers between -- some people say voluntary patients, some say informal patient. As I'll come on to later, but thank you, Chair. So he was treated as if he was being there of his own volition saying, 'I would like to be here and be looked after.' This was in circumstances where he did not, because of his cognitive impairment, the 10:39

ability to agree or disagree to that admission. The 1986 Order contains provisions for informal or voluntary administration, as does the equivalent legislation in England and Wales. So, the critical point was that the European Court of Human Rights said it's irrelevant that he's allegedly here informally because he doesn't have the cognitive ability, because of his impairments, to give that consent. He is under continuous supervision and control, so he is confined. If someone is confined, they have to be able to consent. Otherwise, there has to be some legal framework around them to make sure there are proper checks in balances. They were very struck by the contrast between HL's position and other people in the same Hospital who were formally detained. Who could get access to, at that time, the Mental Health Review Tribunal. 10:40 10:40 10:40

One of the reasons I just want to talk about the case right at the beginning, is that that really is the European Court of Human Rights flagging power differentials, flagging the fact that individuals within mental health hospitals are in a vulnerable position and the fact that there needs to be, in the European Court of Human Rights' view, procedural safeguards to identify is the person deprived of their liberty? And, if they are, to give them effective rights of access to challenge. 10:40 10:41

So HL was looking at the concept of deprivation of liberty, and it certainly provoked considerable legislative consternation in both Westminster and here. We'll come on to in a little while just to have a look at some of the things that then tracked through. 10:41

A bit more recently, so HL was 2004, the case of Fernandes de Oliveira, 2019, that was looking at - and, again, this is by way of context, and I will drill back down but I think it's is helpful just to have a broad 10:41 picture in one's mind to start with - that was identifying the fact that, in crude terms, risk aversion can lead to overly restrictive measures very quickly. So, in other words, people being risk averse can lead to a situation where deprivation of liberty is 10:42 taking place either in circumstances where it is just not necessary or in an overly restrictive fashion.

CHAIRMAN: Sorry to interrupt again. When you say risk averse, co you mean averse to the risk of the individual causing harm? 10:42

MR. RUCK KEENE KC: Well, Fernandes de Oliveira was about the risk that might have been posed by the person to themselves. In that case it was suicide. In particular Fernandes de Oliveira was about risk of harm to the person and what the European Court of Human 10:42 Rights pointed out is the modern paradigm of modern mental health care or mental health care is to deliver care in the least restrictive fashion possible. If you start getting too risk averse, you might start

equating, for instance, very crudely, detention in hospital, therefore zero risk to life which, unfortunately, we know just isn't true, and that might leave you therefore in a situation where you're not allowing a patient to go out on leave or to have some form of lesser restriction. So there they were really talking -- they expressly used the term the modern paradigm of mental health care.

10:43

So HL was thinking about the concept of deprivation of liberty, Fernandes de Oliveira is talking about we're trying to deliver mental health care in the least restrictive way possible and risk aversion can get in their way. And then the last one, Rooman -v- Belgium, the last piece of the puzzle there, contextual puzzle, there the European Court of Human Rights said, in terms, and actually does something for anyone familiar with what the European Court of Human Rights does, did something quite unusual, which was to say we're going to go back and look over everything we've ever said about deprivation of liberty in the presence of mental illness and recalibrate it. The European Court of Human Rights doesn't normally say expressly we're recalibrating. But there they said, we now need to take stock and say deprivation of liberty, in the context of mental disorder, requires that the person be given appropriate care and treatment. So, in other words, you're only allowed to deprive someone if they are receiving appropriate care and treatment. They

10:43

10:44

10:44

were concerned - and many people for many years have been concerned about people being warehoused, to use that extremely offensive, but I have to say, frankly, useful term, because you get a very strong sense that what actually is being delivered by way of appropriate care and treatment. So they made that point.

The other point they made is that you can't necessarily assume that a psychiatric hospital or a mental health hospital is always an appropriate place. It might be but because of that person's particular characteristics, it may be the mental health hospital is not appropriate for that person. So the European Court of Human Rights, it was a Grand Chamber decision, so that's, as it were, the most senior court within our human rights system, says we're recalibrating, deprivation of liberty in the context of mental disorder requires appropriate care and treatment to be available and it needs to be an appropriate placement. One of the reasons I think it's, if I may say so, incredibly important for the Panel to have that by way of opening context is that really starts changing how conventional mental health law starts to be talked about. A really strong focus of have we actually got people deprived of their liberty without proper safeguards? Are we actually having people being deprived of their liberty in overly restrictive settings? And are individuals actually receiving appropriate care and treatment? My job, I'm very

aware, is not to comment on the facts here but I can certainly say that one of the things that is being grappled with in the reform process in England and Wales is what about autistic people or individuals with learning disability? Detention in hospital - hospital itself may not be appropriate, and what does appropriate care and treatment look like for an autistic person or a person with learning disability? 10:46

So, the second thing that the European Court of Human Rights has really emphasised in its kind of zooming in, this really narrowing in, is the importance of procedural protections in relation to compulsory treatment. So, in other words, situations where somebody is having treatment, predominantly medical treatment, medical treatment for mental disorder, but it could be some other kind of treatment, where that's being imposed in face of their disagreement, against their will. And that LM -v- Slovenia case is an example - there have been a couple, but that's the most useful one - that's an example of the European Court of Human Rights dealing with Slovenia where the individual in question had medical treatment for a mental disorder imposed on her against her will. The particular legal framework within Slovenia didn't give her sufficiently easy access to some form of independent body to say, as the Strasbourg Court said, with the ability to influence her care and treatment. 10:46 10:47 10:47 10:47

As we'll come on to, the 1986 Order has provisions for people to challenge, to say, 'I am being treated against my will.' It's certainly the case that since the 1986 Order was enacted the European Court of Human Rights has focused in very closely on how effective are provisions where someone is particularly -- particularly where somebody with capacity, so the idea, the ability to understand, to retain, to process what is going on, is saying "no, I don't want." The European Court of Human Rights is ever more concerned about treatment being administered in the face of someone's capacity as refusal. They don't say it's not allowed but they say this really, really has to have a set of proper procedural safeguards. That's all framed around Article 8 of the European Convention on Human Rights, the right to autonomy or the right to a private light encompassing he right to autonomy. 10:48 10:48 10:48

The last one there, AMV -v- Finland, that's the European Court of Human Rights also being concerned around protections where somebody might be having their capacity challenged, their capacity to make a decision challenged, and to have frameworks put in place around them to have decisions made on their behalf or in their name. 10:49 10:49

So that's the kind of first bit. The second bit of the contextual picture, I do think it's very important that the Panel are fully cognisant of is the UN Convention

on the Rights of Persons With Disabilities. That's not like the European Court of Human Rights, which the UK signed, brought into domestic law through the Human Rights Act. So I as a lawyer could rely on the European Convention on Human Rights on behalf of one of my clients before the courts of England and Wales, an equivalent lawyer could do so in Northern Ireland. The CRPD is a State level obligation. The United Kingdom has signed, has ratified and has effectively committed itself to bring law and practice within the United Kingdom into compliance with the CRPD. Not brought into the domestic law, therefore its precise status before the court is -- I could spend all day talking about, which won't assist you, Panel, but what is important is that it has really triggered a sea change, and actually triggered a lot of the European Court of Human Rights' more recent thinking in terms of how we think about the treatment of individuals with disability. I mean this is not just cognitive impairment, this is any kind of disability. And it's firmly founded on the social model of disability. The Committee on the Rights of Persons with Disabilities quite often talks about the human rights model of disability but the basic idea is, it's not the impairment that's the problem, it's society's failure to respond to the impairment which creates the problem.

10:49 10:50 10:50 10:50 10:51

And the Committee, the CRPD, has placed, for instance Article 12 of the CRPD makes it an obligation on a

State's party to recognise that everybody with disabilities has the right to legal capacity. Everybody needs to be recognised, at the very minimum, as a rights bearer. Where things get a little bit more complicated - and I will come back to this right at the end - is precisely what that then means for legislation such as the 2016 Act which says some people some of the time may not have capacity to make their own decisions. The Committee on the Rights of Persons with Disabilities, which is the treaty body overseeing the CRPD at UN level, has taken a view that the CRPD also outlaws compulsory detention and compulsory treatment in the context of mental disorder. As I say, on that slide there, that is a contested interpretation. But the Committee says you are never allowed to detain on the basis of mental disorder, at which point you can imagine 1986 Order goes out the window, the 2016 Act would actually go out the window.

10:51 10:52 10:52

Can I just sort of pause, leave you hanging there, Chair, and come back to it at the end because that will explain some of the ways things are going next. But I just think one of the things to understand, just for now, and to sort of have in the back of your mind during the balance of my presentation is driven very, very strongly by individuals with impairments. The Committee body is comprised, the last time I checked, everybody on the panel bar one, or at least the most recent composition had an impairment, a disability of

10:52 10:52

some kind, driven very strongly by a body which says the way in which the law and practices and procedures in States has worked over time simply does not benefit individuals with impairments and disabilities, driven by that very strong model and a very strong challenge to the stereotypical model of disability, in other words, we'll just respond with a medical process. That has really prompted the European Court of Human Rights to start talking about the modern paradigm in mental health care. We don't just detain as a first -- you know, don't go straight to detain. Don't do straight to compulsory treatment. So that's the sort of background. 10:53 10:53

So, I wanted to spend, Chair, if that was acceptable, I wanted to spend a bit of time really just giving that wider context because once you start looking in at the legislation, unless you know where it's sitting, it can seem, not abstract, but it is only a very small part of the picture. 10:53 10:54

CHAIRMAN: A lot of this is really the foundation, you're saying, for the legislation that followed.

MR. RUCK KEENE KC: Completely. Yes.

CHAIRMAN: Are you okay to keep going for another 15 minutes or so? 10:54

MR. RUCK KEENE KC: I can keep going more or less indefinitely.

CHAIRMAN: I was slightly frightened you were going to say that! I think we'll give everybody a break but

after about 15 minutes.
MR. RUCK KEENE KC: That's absolutely fine. If I could get the next slide, please.

My poor students are very well aware I can keep going. 10:54

So, I now want to zero in on the 1986 Order, the Mental Health (Northern Ireland) Order 1986. Can I just sort of preface what I'm going to say over the next slide. I try to strike a balance between giving you the 10:54
references to the articles within the Order and trying to explain what they mean. I've erred where possible more on this is what it's doing, rather than here is the grindy detail on the basis that if you need the grindy detail that's much more readily accessible. 10:55
I hope it's helpful to sort of do the kind of how it's workingness. So, I perhaps should just preface also this by an apology to those who might be listening or those who might be watching, if there are any points which sound, well you haven't got it exactly 10:55
grammatically correct. You haven't got the exact thing. I'm doing my best to do the kind of, not quite helicopter view but the contextual view.
CHAIRMAN: We'll keep that in mind. Thank you.
MR. RUCK KEENE KC: So, I think the first point to 10:55
make, Panel, is the first bullet point there, the 1986 Order is really very typical mid 20th century mental health legislation. It's of apiece with the Mental Health Act 1983 which was the criminal legislation in

England and Wales. It looks similar very similar to lots of other bits of legislation in other jurisdictions. As I say, its primary purpose, when you actual get down to its business end, is about the regulation of coercion in relation to admission and 10:56
treatment for mental disorder. I mean, it doesn't sound very nice, but that's what it is. So, that's its kind of mechanics of it. It's obviously got lots and lots of other important bits, but if one thinks of it in that way, that to me is probably quite a helpful 10:56
starting point.

It doesn't mean, of course, that coercion is unjustified, it just means that the idea is to think carefully well, does this person need to be admitted in 10:56
circumstances of coercion, if so, what safeguards are there? Does this person need to have treatment, medical treatment for mental disorder administered against their will? If so, what safeguards are there? One point I should say, I cannot resist saying because 10:56
I just need to say it, having been the legal adviser to the review of our mental legislation, which talks about the Mental Health Act, it always struck me as a fundamental irony that, actually, the legislation is not a mental Health Act or a Mental Health Order at 10:57
all. If it really was, that would be legislation designed to support people's mental health. That would be about providing people with rights to community support, and things like that. The legislation just

doesn't do that, it does something very important but really substantially different.

So it's an all ages piece of legislation, from 0 upwards. There were some quite important, very important modifications introduced with effect from 2019 by the 2016 Act, the Mental Capacity Act in relation to those aged under 16 because the 2016 Act, as we'll come on to later, seeks to be, in due course, a unifying piece of legislation, with no separate mental health legislation, one piece of legislation to think about care and treatment for all people within Northern Ireland, capacity-based, but the decision was taken that it wasn't going to replace the Mental Health Order for under 16s. The compromise was some of its kind of substantive stuff would be introduced to try and bring under 16 provision feeding a bit closer to over 16 provision. 10:57 10:57 10:58

If it's acceptable, Panel, I'm not going to spend much time thinking about under 16s, partly for time and partly because it does get quite complicated. So, predominantly what I'm talking about here is 16 plus and, actually, really more 18 plus. But if there are specific issues which concern you or concern others which relate to under 16s, then I can certainly -- it would probably be easier if I address that separately, at some other point. 10:58 10:58

CHAIRMAN: Okay, thank you.

MR. RUCK KEENE KC: Otherwise the 1986 Order has basically remained substantively mostly unamended since it was enacted. I've given some of the changes there. I actually realised this morning I missed out one change, one other change, a temporary change during the pandemic about extending administration periods. That's now gone. The only really substantive changes so far have been one to bring it into compliance with the European Convention on Human Rights to make it clear it's always on the detaining body to prove the person needs to be detained. 10:59 10:59

CHAIRMAN: So that's your first bullet point?

MR. RUCK KEENE KC: Yes. Then the second was a sort of technical but very important change to align the criteria for discharge by the tribunal with the criteria for admission. There had been a mismatch before. 10:59

Can I have the next slide, please?

10:59

So, just to kind of frame the legislation, it's not a capacity or competence-based piece of legislation. Just to explain those terms. Competence is what people nowadays tend to talk about when they're thinking about under 16s. Competence tends to be; is a child competent to make the decision? Nowadays we tend to talk about somebody 16 plus, as do they have the capacity to make the decision? But you may still come across materials which talk about an adult being 11:00

competent. But the critical thing for these purposes, it's just simply not dependent on that. It's not dependent on the person's decision-making abilities, substantively, about whether or not they have capacity to agree to come in. 11:00

So its entry point is mental disorder. That's your starter for ten, is does the person have a mental disorder? I need to say, because I know many people find the concept of mental disorder, the words mental 11:00 disorder insulting and I completely understand and respect that. This is what the law says.

CHAIRMAN: You're using the language of the statute, not your own language.

MR. RUCK KEENE KC: Exactly. 11:01

CHAIRMAN: We understand.

MR. RUCK KEENE KC: I think it's also important the Panel understands how offensive that language is to many people. And the 1986 Order actually contains even worse language when it talks about "mental handicap". 11:01 I mean it really is --

CHAIRMAN: There are lots of expressions that have been used in the past that obviously we no longer use, but people understand your use of them now if you need to.

MR. RUCK KEENE KC: Exactly. And one of the many 11:01 things that we'll come on to is that what Bamford was trying to do was try and actually have a piece of legislation which didn't include such offensive language.

So, it's quite broadly defined:

"Mental illness, mental handy company and any other mental disorder or disability of mind."

11:01

One of the things it does is, have an exclusion, so you might be able to get someone within that framework but if the person has a personality disorder, personality disorder doesn't count for these purposes. It also excludes promiscuity or other immoral conduct, sexual 11:02 deviancy, or dependence on alcohol or drugs. I don't want to do a running commentary, but one thing there, Panel, you might see is that can be seen as a societal decision about there are some types of behaviour that we don't wish to label as mentally disordered. 11:02

When you start thinking about, what, as I say, in modern terms would be called learning or intellectual disability, but within the language of the Act is much more mental handicap/severe mental handicap, the Act 11:02 provides there's a distinction between someone being admitted on a very short-term assessment and longer term -- when I say Act, I apologise, I will slip every so often into Act, I mean Order, the Order provides that -- 11:03

CHAIRMAN: Can you just explain, very briefly, the difference between an act and an order?

MR. RUCK KEENE KC: Yes, of course.

An order is, effectively, the mechanism by which this sort of legislation is enacted in Northern Ireland. So you've Northern Ireland Order. It's the function of how the mechanism works within the Northern Ireland Framework, whereas an act, and it's my parochial bias, I'm afraid, Act is Mental Health Act 1983. So I'll make sure I use the word "Order". 11:03

But on that second bullet point, what happened or what that's making clear is if somebody is going to be present in hospital compulsorily on a longer term basis, on the basis of what we would nowadays say is learning disability or intellectual disability, it has an additional requirement, it's not just this person has got a mental impairment or a severe mental impairment, it has to be a accompanied by abnormally, aggressive on seriously irresponsible conduct. 11:03 11:04

PROF. MURPHY: Can I just ask, you say in the overhead "severe mental impairment" but you just said just now "mental impairment". So they didn't have to be severe mental impairment? 11:04

MR. RUCK KEENE KC: Very short term -- there's short term admission for assessment and then when someone has been admitted it can be that they then are identified as requiring admission for long-term basis for treatment. There, if it's learning disability, as it is called nowadays, it would have to be severe mental impairment accompanied by abnormally, aggressive or seriously irresponsible conduct. So it's quite a high 11:04

threshold for detention.
PROF. MURPHY: If you had mild mental impairment and abnormally, aggressive or seriously irresponsible behaviour it wouldn't cover that.
MR. RUCK KEENE KC: It wouldn't cover it, but in my experience based on -- you'll see the bottom bit there says you've to be careful about reading across from England and Wales directly to Northern Ireland. In my experience operating the - there is a sort of equivalent in England and Wales - it's very unlikely -- 11:05
if you start getting people being concerned about abnormally, aggressive or seriously irresponsible conduct, the application of the legal framework quite often ends up with the person's impairment being identified as being more serious, if you see what 11:05
I mean?
PROF. MURPHY: So not in IQ terms, in other words.
MR. RUCK KEENE KC: This is obviously one of the critical aspects, and I know you will be hearing evidence about this from multiple different sources in 11:05
multiple different ways as you go through, you've got the legal framework and then a legal framework having to be operated by people on the ground, both clinicians, approved social workers and other individuals trying to think things through. But the 11:05
kind of legislative importance is that there's supposed to be a high threshold if you've got somebody with what is now called learning disability in hospital on a longer term basis. Which, in a way, reflects, albeit

this long, long predates the decision in Rooman, the European Court of Human Rights, the idea that - and you'll hear clinical evidence about that - that by and large being in hospital, it's not immediately obvious what care or treatment is being delivered to somebody with learning disability in hospital. If that makes sense? But any further than that I would start straying outside my remit as the lawyer trying to assist with the kind legal framework. But it's one of the point you might want to have in mind when you're interrogating the legal framework as against clinical and social work practice, if that makes sense? 11:06 11:06

CHAIRMAN: Yes. And since we've interrupted you, can I just ask: How are "shorter term" and "longer term" defined? 11:06

MR. RUCK KEENE KC: So short term is up to -- it's a maximum of 14 days for the assessment. I'll come on to that. Longer term is essentially indefinite thereafter. I mean it's very important, it's not just write-off indefinitely, but there's a period and then it can be renewed, and renewed, and renewed, if you see what I mean. 11:07

CHAIRMAN: Thank you.

MR. RUCK KEENE KC: Panel, I should say, I am very, very happy to proceed with the basis of clarification questions, as we've just been doing. It might be much easier because otherwise we'll get to the end and you'll say hang on a minute. 11:07

CHAIRMAN: I think it helps, if we can occasionally ask

questions.
MR. RUCK KEENE KC: Yes, please. Some of this is technical and some of this is so obvious to a lawyer immersed in it that it may not be as obvious to, and I'm doing my best to ensure that it's clear, but if it isn't clear to one member, I am sure it's clear to others. 11:07
CHAIRMAN: Thank you.
MR. RUCK KEENE KC: The other just last point, and this is just really for context, more than anything else, there's very recent confirmation from the Court of Appeal here that the 1983 Mental Health Act and the Northern Ireland Order are not the same things and people should be careful when they're just reading across one to the other. There's an appeal, actually, to the Supreme Court outstanding. I don't know when it's going to be heard. But every so often, if you start reading -- if you were taken to or start reading judgments prior to 2022 from Northern Ireland courts, you might sometimes get people reading across saying, 'well, they say this in England and Wales under the 1983 Act, therefore that's what we do.' And the Court of Appeal here has just made that quite clear. They are different pieces of legislation. Don't necessarily be suckered in by the same words. Which is why I preferred my observation about learning disability and abnormally aggressive, the caveat there, if that helps. 11:08 11:08 11:08
CHAIRMAN: Can we just deal with the next slide and

then perhaps we'll take a break. Or do people need a break earlier than that. Another 10 minutes or so, probably, is it?

MR. RUCK KEENE KC: So, as I say, the entry point is about mental disorder, and the other entry point is about the concept of serious physical harm. That's when people are going to be thinking about deploying the compulsory powers. So if the risk is -- stereotypically, Chair, we had that brief exchange in relation to the Rooman case about risk, and stereotypically risk is divided into one or other, risk to the person or risk to other people. You might well have a situation where there's a risk to both aspects but this legislation, as with most other legislation in this area breaks it out into two forms. 11:09 11:09 11:10

So, if the risk is to the person to focus on actual, attempted or threatened harm or that person's judgment is so affected by their disorder that the person is or would soon be unable to protect themselves against harm. And you can sort of see that last bit there is obvious because otherwise you would have a situation where you couldn't intervene because actually there was no harm which had eventuated, but if you didn't do something it would be absolutely obvious to everyone that it would. 11:10 11:10

Then the second is if the risk is to the person, the focus is on violent behaviour. Someone has actually

done something. Or other people having been placed in reasonable fear. So there might well be a circumstance where, actually, other people -- the violence hasn't taken place but other people were placed in sufficient fear. 11:11

CHAIRMAN: So fear, not danger, as it were?

MR. RUCK KEENE KC: Well, in a way it's important, that's characterising the fact that it's the individuals who might have been at risk from the violence. Have they been placed in reasonable fear? 11:11

CHAIRMAN: Yes.

MR. RUCK KEENE KC: I can do another slide. That one was quite quick.

CHAIRMAN: Shall we take a break there? If we just take 15 -- if I say 10 minutes it always turns into 15, 11:11 much like court, I'm afraid. So if we say 15 and we will try to come back at half past 11. Thank you very much.

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS: 11:26

CHAIRMAN: It's inevitable, isn't it? It's just like court. If you say 15 minutes, it's 20. But that was our fault. So, thank you very much for returning and we're on your next slide. 11:32

MR. RUCK KEENE KC: Thank you. If we could move to the next slide, please.

So, one thing to flag, so this is the slide which has

Mental Health Order principles. I'm doing this partly in order to enable a kind of compare and contrast with what happens with the 2016 Mental Capacity Act which starts with a set of principles. The 1986 Order doesn't have a set of statutory principles. But, there is a code of practice dating from 1992 which does include a set of principles about how people with mental health problems should be treated. Chair, I wasn't proposing to read them all out. It was really more for your reference. But one thing -- and it is just important to note is the legislation in Northern Ireland doesn't start with: Here is a set of governing principles as to how to apply this legislation. That has had to be retrofitted on through a code of practice, statutory code of practice. 11:32 11:33 11:33

CHAIRMAN: Is CaseView working for everybody? It is. Sorry to interrupt. Carry on.

MR. RUCK KEENE KC: Just to reiterate, they're a set of principles but they've had to, as it were, be slightly retrofitted on to the 1986 Order rather than existing on the face of the order. That's to be contrasted with the 2016 Act which, as we'll see when we come on to it later, starts upfront with a set of here is how this legislation should be applied. 11:34 11:34

So if I could get the next slide, please.

So, I sort of talked a little bit about this in answer to a question from you, Chair, earlier, about how long

administration for assessment lasts. This is now just getting down to the more nuts and bolts. One thing just to say now, and I'll come back on one thing to be clear, the Mental Health Order contains two separate strands. One is thinking about what we tend to call civil patients and then the other is talking about what different people call different things. I sometimes call them forensic patients, so in other words, people who have been diverted from the criminal justice system one way or the other. Looking at this slide and the next few slides, we're thinking here about people who are coming into hospital not because that they've been in contact with the police or diverted by the criminal justice system or not in contact with the police in the circumstances of fear of thought of some kind of criminal offence having been committed, 11:34 11:35 11:35

So, the first sub-bullet point there saying:

"Article 127 envisages voluntary admission..." 11:35

This is one of the areas where the Panel will need to think very carefully, if I may say so, in due course about locating evidence that you're hearing because, as I said right at the beginning of the day, Strasbourg, the European Court of Human Rights, looking carefully at the concept of deprivation of liberty in the presence of mental disorder. The Mental Health Order provides for the ability for people to go in and 11:35

treated voluntarily or informally in a mental health hospital. So at just a pure principle level, one can see why that's important. It would be very peculiar if you could only ever receive assistance with your mental illness by being there compulsorily. It would be radically at odds with how we treat people with physical disorder. And eve, as it were, as far back at 1986, that was very clear. But this is one of those areas where the legislation needs to be seen in its wider context. 11:36

You've got European Court of Human Rights, Bournewood, says if you've got somebody subject to continuous supervision and control and they're not free to leave the place, they're confined. You then need to ask can that person consent to that confinement? If they can't consent to that confinement, you have a problem. There's a deprivation of liberty. 11:37

The other decision to flag there, that Cheshire West decision is more recent, that's the Supreme Court decision in 2014, and that was a case, again, reiterating the importance of the concept of deprivation of liberty and the need to apply it to individuals with impairments in a nondiscriminatory fashion. So Lady Hale, for the majority in the Supreme Court case says there is an acid test to determine if someone is confined. Are they free to leave, in the sense of just pack their bags and go? And if they're 11:37

not free to leave, are they subject to continuous supervision and control? One point just to identify there, presence or absence of locked doors is not actually determinative. A door could very easily be locked for all sorts of sensible reasons, but if that would be opened, if the person stood back and says I want to go, fine. Conversely, a door may not be locked but if the person is going to be brought back if it is not considered safe, the analogy I sometimes use is they're on a leash. It can be quite a long leash, but they're on a leash. 11:38 11:38

So, that was the first point. And the second point that Lady Hale made clear for the majority in the Supreme Court was if the person doesn't have the ability to give consent, then the fact that they appear to be acquiescent is completely irrelevant, which really comprehensively -- well, put it this way: It is remarkably difficult to envisage many situations in mental health hospitals which don't amount to a confinement because it simply wouldn't be safe for the person to leave, and then if the person doesn't have capacity to agree to be there, it's very clear on the basis of Cheshire West that there is a problem, there is a deprivation of liberty arising because the State knows or ought to know. And that's even if the person appears to be content or happy or acquiescent. One of the reasons why Lady Hale said it was so important to make that point was otherwise you start giving liberty 11:38 11:39 11:39

a different meaning for people with impairments. So, you always have to ask what would happen if the person tried to leave? If the person tried to leave and they'd be stopped, they're confined. Judges in England and Wales - and I'm sure their counterparts in Northern Ireland - have quite often, subsequently, said, well the easiest way to test if you're confined is imagine you yourself are subject to that. If you were subject to a plan which said: I want to leave, we're going to have to hold a meeting - which is what happened. Or we'll have to consider invoking the holding power, Article 7, it's not safe for you to leave, we're considering invoking that holding power. Well, you're confined. So that's one of the reasons I just wanted to flag, because this is not the legislation itself. This is the legislation being operated within a changing framework and UK Supreme Court, which is just as binding here, jurisprudence, about the concept of deprivation of liberty. 11:40 11:40 11:40

I think it is appropriate to say I did ask in the context of preparing for this, I said I would quite like to know is it possible to find out how many people were at Muckamore Abbey Hospital informally in a relevant period? And I understand there were some people there who were there informally. I'm not going to comment on that because it would be completely inappropriate, but that's something the Panel might want to be thinking about later in due course. That's 11:40 11:41

why it's got the word "feasibility." How realistic is it actually to say you that you have people who are genuinely present in mental health hospitals informally, or voluntarily, especially in the presence of cognitive impairment. 11:41

CHAIRMAN: So, for "informally" we can always read "voluntarily"?

MR. RUCK KEENE KC: One reason that people sometimes use the language -- well there's different reasons people use the different language, one reason to 11:41 perhaps caution about "voluntary" - although I've used the word there - is that voluntary might suggest the person actually wants to be there, a voluntary admission. Informal admission is the person is there outside a formal framework of safeguards. If you see 11:42 what I mean?

CHAIRMAN: Yes.

MR. RUCK KEENE KC: And I'd have to just double-check whether the language in 127 talks about voluntary. Do you mind if I just do that very quickly? 11:42

CHAIRMAN: No, of course.

MR. RUCK KEENE KC: I'm just trying to remember whether it is me editorialising or whether it was... yes, it's "voluntary" in Article 127.

CHAIRMAN: Right. 11:42

MR. RUCK KEENE KC: So, you can see this language then nudges people towards thinking that's because the person wants to be there. I would, Chair, really want to emphasise: There may well be situations where

someone says I'm in mental health crisis, I want to be in hospital, so there is a genuine sense of voluntariness. Could I maybe though, just flag, as we're here, there's a Supreme Court case I haven't listed there, but a case called Rabone, R-A-B-O-N-E, 11:43
Melanie Rabone's case where --
CHAIRMAN: When was this?
MR. RUCK KEENE KC: Rabone was 2014/2015. It might be a tiny bit earlier than that. But it's that sort of zone. A Supreme Court case, and there one of the 11:43
things that was said by the Supreme Court was we have to be very careful when we're thinking about describing patients in mental health hospitals through the prism with informality because of just the frank, sheer power imbalance that's going on. In reality, the distinction 11:43
between someone who is there informally and someone who is there under compulsion may not actually be all that great. So, yes, the language is important. That's the language from Article 127. Informal, as it were, assists because then it's really clear you are outside 11:44
the scope of formal safeguards verses informal.
CHAIRMAN: Okay.
MR. RUCK KEENE KC: So you can come into hospital by an application for administration for assessment. There are some slightly complicated stuff about precisely how 11:44
long the periods are, which for your purposes aren't necessarily relevant, but the maximum period is 14 days. Once upon a time, I mean the 1986 Order has a legacy of almost a 19th century mindset which is the

application for administration might be made by your nearest relative. So there's a statutory list of people, really family members. So the 19th century idea, family members admitting loved ones to asylums. You can imagine all the sort of friction there. 11:44
Nowadays, it's unusual for nearest relatives to do that. This tends to be of the operation of a beneficent State power, so it's done by an approved social worker rather than a family member.

11:45
So there has to be a medical recommendation, then a further medical examination by a different doctor immediately upon arrival at hospital. So, part of that is making sure - although this isn't just designed to deal with deprivation of liberty, this is making sure 11:45
there's more than one pair of eyes on, and, crucially, also multi-disciplinary eyes on. So, in other words, it is not just a medical view, there's a view from an approved social worker, so you've a social work perspective. So, it has always been very important to 11:45
have that idea. It's not just more than one head, it's more than one head with a different type of discipline. Because you might have -- the social worker is almost invariably going to be bringing to the pitch something slightly different to a medical professional, just 11:46
because of their professional backgrounds, cultures, experiences.
CHAIRMAN: Then presumably the doctor would need to have some approval under the Mental Health Order or

Act?

MR. RUCK KEENE KC: Yes. There are different forms of approval depending on precisely what the doctor is doing. But, yes, ultimately if you are going to have approvals from medics they have to be approved to do certain tasks. 11:46

Then you've got an ability -- if you've got somebody who's already present in hospital but there's reason to think their mental health, for instance, condition is deteriorating, then there's ability to make application right there and then. So, in other words, they don't have to leave hospital and then come back in again. So there's the shorter term and then there's the longer term. When you asked me before, then this can be -- and there that's very clear there has been medical opinion from an approved doctor, then it can be up to six months, up to six months, then ever year that the authority to detain extends. So, you will have people, and you will have people who I am I'm sure have given evidence to you who will have been detained indefinitely. And I think I would use that language because it's important to understand it is indefinite detention, so long as it is justified on the criteria contained within the Mental Health Order. 11:46 11:47 11:47 11:47

So next slide, please.

There isn't a specific provision. I just think it's important to understand this, if I may say it's important to understand the 1986 Order is very, very firmly focused on administration and treatment within hospital. It's a very hospital-based piece of legislation. Unlike others, for instance, in England and Wales there's the idea of Community Treatment Orders where you can be in the community within a framework, that doesn't exist in the same way under the 1986 Order. But you can have a situation where the person is put on leave by their responsible medical officers. So they can be out from hospital but they're, as it were, just on leave from the hospital, not necessarily meant to be out there with a kind of purely community treatment-developed framework. 11:48

CHAIRMAN: So, a hospital doctor who gives the patient leave from the Hospital, presumably under certain conditions.

MR. RUCK KEENE KC: Yes. I mean sometimes that might be because they need to go to an acute hospital to receive physical treatment, say. Or - and actually this is extremely important - it might be, we're trying to work out how to step down, you know, we're working towards discharge but in order to work towards discharge we need to have some step down. It can't be just be all or nothing. So it can be that kind of testing the waters. 11:49

CHAIRMAN: You can go home provided...

MR. RUCK KEENE KC: Exactly, yes. Standing alongside

it - and you may want to receive evidence about how much this is thought about - is the concept of guardianship, which is a much more limited framework. So, it's an alternative to hospital administration. It's a much more limited framework which really provides the ability for somebody, normally a local authority employee, to identify, really, a very bare bones framework around that person. Really making sure we're identifying roughly where they're living and hopefully making sure that they attend for medical treatment. But one thing - and you can see that the timing of that case there, that Health and Social Care Trust -v- Mr. X case, 2019, this is in the kind of modern understanding of why the concept of deprivation of liberty goes, it's made very clear that a guardianship doesn't provide power to detain someone, say, in their own home. But I think one thing -- again to come back to the kind of, not the minutia but the kind of framework, the 1986 Order is really very heavily based in hospital and anything outside of hospital is ancillary to that. I just want to emphasise that because when you come to think about the 2016 Act later, we will see that isn't just hospital based, it's a much broader framework.

11:49 11:50 11:50 11:50

CHAIRMAN: But this case you cited here was purely based on the order even though the Act by then was just about coming in.

11:51

MR. RUCK KEENE KC: The Order is still in force. Just to flash forward. The Order is still in force.

CHAIRMAN: I understand, they work --
MR. RUCK KEENE KC: They work in parallel. What was essentially an issue there is does guardianship under the Order give authority to the guardian to deprive someone of their liberty? To which the answer is no. 11:51
Apart from anything else, at that point you would -- well, it would start meaning great chunks of the 2016 Order might be completely irrelevant because you could have guardians depriving people of liberty in the community, which would rather blow a massive hole 11:51
through what it was that the Bamford Review were seeking to achieve.

Obviously, once you're in hospital, continuing to remain in hospital always has to remain justified. It 11:52
can't be just a once for all; once you're in you're there. So, it's meant to be that the patient's responsible medical officer is at all times supposed to be considering are the criteria for administrations still met? And if not they're not, they should 11:52
discharge. The nearest relative, so the patient's nearest relative can say I don't think this is appropriate, the patient should leave. But they can be what's called barred. So, in other words, they have to give notice to the responsible medical officer that 11:52
I don't think my wife, say, or husband should be here anymore. Have to give notice to the RMO, and the RMO can say, no, it would be improper for that to happen or dangerous for that to happen. Or upon a successful

appeal to Tribunal. So obviously the Mental Health Tribunal plays a massively important role in terms of the independent oversight.

CHAIRMAN: I'm sorry, this is very basic, but the route, presumably, is always to the RMO first? 11:53

MR. RUCK KEENE KC: No. You can appeal directly to the Tribunal.

CHAIRMAN: Right.

MR. RUCK KEENE KC: I suppose one of the -- no, it's not a basic question at all. I think it's important, 11:53 as it were, to keep the two functions separate in one's mind in the sense that the RMO is supposed, at all times, to be keeping actively in their own mind does this person actually have to be here? And good RMOs will always do that and they will always, as it were, 11:53 be consistently reviewing. That's for multiple reasons, not least because with very stretched services, bluntly, if you've got somebody who doesn't need to be there, it's not like other people wouldn't be needing it. But it's always supposed to be focused 11:53 on the interests of that patient, or if the person doesn't pose a risk to others which can't be managed safely in the community. So, no, it's not that you've got a direct right of appeal to the Tribunal.

11:54

One point, perhaps just to emphasise in relation to the Tribunal, is that the European Court of Human Rights have made it very clear that the fact you haven't got the slightest hope of being discharged is irrelevant.

You've got an absolute right under Article 5(4) of the European Court of Human Rights to challenge your detention before a body which is able to order your discharge. So, there are always endless debates about how effective tribunals are because their discharge rates tend to be very low. But that's, as it were, at one level -- it's not meaningless, but it's a thing which just raises more questions than it answers because that might well mean, actually, the majority of people who are coming before the Tribunal are actually getting care in a least restrictive way, they need to be there. But they've got an absolute right to bring their case before the Tribunal. And there are backstop provisions, which if you haven't brought your case before the Tribunal in a sufficient time, it will get this automatically. So the Tribunal is maintaining independent oversight. 11:54 11:54 11:55 11:55

One thing I'm duty bound to say, wearing my sort of academic/policy hat is, as I put in that bullet point there, Tribunal hearings take place in private and they don't give public judgments. So, we don't know, one doesn't know - and we have the same issue in England and Wales, we don't know exactly how things happen in tribunals. So it's different to proceedings before many other courts. Not all other courts, but any other courts. I mean, there are obviously very sound and very proper reasons why you would not want necessarily someone who is in the midst of a mental health crisis 11:55

going before a tribunal which is held in public. And even if they're not in the midst of a mental health crisis, a tribunal hearing extremely personal, very personal information, you wouldn't want necessarily that to be heard. But it does have an impact on when one is thinking about all the pieces of system, the way in which they are exercising oversight. So, I don't think it's appropriate for me to then comment too much further, but I just think it is a data point to know that something. 11:56

CHAIRMAN: Again, I'm sorry, this is very basic, but how often are lawyers involved in those hearings?

MR. RUCK KEENE KC: I am going to defer that question to somebody within Northern Ireland who can give you that evidence because I don't know enough about the lawyers before the Mental Health Review Tribunal in Northern Ireland. It would be unhelpful of me to give that answer. I'm sure someone can give you -- traditionally, though, certainly the idea has always been that they are meant to be much more informal. But with informality that slightly creeps out the window. It would be sensible if somebody gives you that --

CHAIRMAN: Sure, I understand.

MR. RUCK KEENE KC: I mean, there's certainly legal aid available for legal representation and the European Court of Human Rights has always made it clear people who have mental health conditions are very vulnerable, Article 5(4) has to be effective. So, in other words, your right to challenge has to be effective. That

means there have to be procedural safeguards to make sure that someone is actually able to have effective representation. And they have given very rude judgements where either the person has not been represented or the person has been represented by somebody who simply turns up and agrees with everything that the detaining authorities say. But I think in actual fact your question is probably best directed to somebody else, if that's okay. 11:57

CHAIRMAN: That's fine. 11:57

MR. RUCK KEENE KC: So, turning to the next slide. We're still on civil patients. Thinking about treatment. So if we go back to it, as I said at the opening remarks about the 1986 Order, the best way of thinking about it, or the crude way of thinking about it is a framework for the regulation of coercion around admission and treatment. So, we've dealt with the framework for when it is necessary to have someone admitted potentially against their will. Now, we're thinking about treatment. So, obviously -- I mean to really just frame it without looking at the legislation, the conventional idea is, at least in relation to an adult, you couldn't provide treatment to an adult person without their consent. I mean that would be assault, it would be battery, it would be all sorts of problems. And it is definitely the case that wherever possible - and I know you'll get clinical evidence about this, RMOs and anyone else involved will seek to proceed on the consent of their patient. But 11:58 11:58 11:58

the really important bit where the legal formalities hit are the circumstances where the patient - can I just say, I'm using "patient" here the whole time because this person is a hospital patient. One thing I perhaps should have just said at the outset, language is really important and I know various people would use different terms. I'm using "patient" here because we are now talking about somebody who is a patient in a hospital, if that's okay? 11:59

CHAIRMAN: That's fine. 11:59

MR. RUCK KEENE KC: So where the rubber really hits the road is that the 1986 Order, in line with most other mid-20th century legislation says: There are circumstances where we will treat you, even in the face of your capacitous refusal. You've got the ability to understand what this medication might do, you've got the ability to retain it, to use and weigh that information, and you are saying no. There is legal authority to treat in the face of that, subject to safeguards, it's not just unconstrained. 12:00 12:00

There's also the ability to treat where the patient can't consent, their current condition -- either because they're in the midst of a mental health crisis or their cognitive impairments, their longer term cognitive impairments mean that they can't give that consent. 12:00

It's fair to say that the first of those, so in other

words treatment in the face of capacitous refusal, that's the one that is much higher octane in human rights terms, because that's the bit which is the most obvious disparity between someone who is detained under mental health legislation and somebody would is not subject to mental health legislation. 12:00

So, one of the safeguards, and a very important safeguard that exists, is the idea that after a sufficient period of time -- so it's not immediate, it's not like as soon as you enter into hospital and there may need to be treatment against your will you automatically get a second opinion, but after a specific period of time somebody else, external, second opinion appointed doctor, has to come along and check. 12:01 And, again, just one point, hopefully of potential assistance to you, when you're interrogating evidence you might hear later or contextualising evidence you might hear later is how often does SOADs, as people always seem to call them, a second opinion appointed doctor, how often do they agree with the review of the RMO? The fact that it might be that there's a very high, a concordance rate doesn't necessarily mean that actually they're not doing their job. It might just mean that the RMO is doing the right job in the first place and the second opinion appointed doctor is saying that, you know, because they're doing a right job -- I'm just very conscious in saying that, having been involved in the independent review of our mental health 12:01 12:01 12:02

legislation, there was quite a lot of, to use a never nonlegal term, twitch around, well, doesn't it seem that SOADs quite often agree? What actual additional safeguard are they giving? That might well mean that the initial clinical decision making is correct. 12:02

Even, actually, where a SOAD should be involved (second opinion appointed doctor), it might simply just not be possible to get that SOAD out in time. It might be an actual emergency. The 1986 Order provides actually 12:02 there should be one, but actually it's too urgent.

Then, additional treatment safeguards around ECT, so electric compulsive therapy, neurosurgery, male sex drive reducing hormones. I mean they are reflecting, 12:03 not just the severity of the implications, I mean neurosurgery being literally what its name suggests.

ECT clearly also -- well, not clearly. From a legal perspective ECT, the reason it appears to be singled 12:03 out is because of the very strong place it has in popular perceptions of treatment. Then, there are provisions where there has to be some kind of, there's an emergency, treatment needs to be delivered to ameliorate a real risk to a person's life or a serious 12:03 deterioration in their condition. You can go through and if you need you can pick out all the specific articles. But having taught this for many years, you lose very quickly if you go straight down into all the

articles.
CHAIRMAN: I was going to say, we probably don't need to know, certainly at this stage, what each of those additional measures were, but you are saying there are additional measures and therefore additional safeguards before certain types of treatment can be administered?
MR. RUCK KEENE KC: Yes. Obviously, if you'd like more detail I can look over lunch and tell you. But it's more -- I think it's the -- and one of the reasons I really wanted to emphasise this point is both so you can place the evidence that you might hear in context but also to line you up in terms of then thinking about what was Bamford trying to do and what does the 2016 legislation try and do is emphasising the fact that that top bullet point there, this idea that the framework of the 1986 Order allows treatment in the face of the person's capacitous refusal. That's the kind of very, very striking -- I mean it's conventional within 20th century human rights thinking but that's the thing which feels very, very challenging to many people nowadays and that's where the challenges come in.
CHAIRMAN: That's what you're eventually going to tell us about, the sort of paradigm shift.
MR. RUCK KEENE KC: Exactly. I was not proposing to say anything else on that slide.
CHAIRMAN: Thank you.
MR. RUCK KEENE KC: If I could get the next slide, please.

So, just to tell you a little bit, or sort of give you a bit more information about the nearest relative. I mentioned them earlier as one of the things they can do is bring about the person's admission, admit a family member. So there's a sort of statutory list, 12:05
well there is definitely a statutory list and the way I tend to teach on it is this reflects a very 19th century view of traditional family units. And it reflects -- it doesn't sit very comfortably with situations where, for instance, the family member might 12:06
in fact be the problem. Because the idea is normally the family member, say the spouse or the adult child is there supposedly acting as a safeguard, but I'm afraid we all know situations where that's just not the case. That's one of the reasons why you can see that bottom 12:06
case there, re RM's application for judicial review, the court had to read in to the provisions of the order the ability of the patient themselves to say, the person themselves to say: I don't want X to be my nearest relative. Because they're meant to play this 12:06
incredibly important function as part of the safeguards. So they could apply for admission but they can't block admission in an approved social worker is seeking to bring about the admission, but the objection has to be noted and, as it were, taken into 12:06
consideration. They can bring about discharge. But if you've a family member who is part of the problem, or you're alienated from or you're estranged from them, then it's very challenging in human rights terms. And

just a spoiler alert, as it were, that's one of the thing the 2016 Act is doing, is saying in principle people should be able to appoint the person who they want to be their champion, in the sense of a nominated person. But whilst the 1986 Order is still live, people are still navigating that hurdle of the nearest relative. 12:07

I was going to move on, unless there was anything...

CHAIRMAN: No. Thank you. 12:07

Just going back to the nearest relative and the ability to apply to the County Court. Can the individual, the patient, make an application as to who they want their -- 12:08

MR. RUCK KEENE KC: Yes, they can identify I don't want this person. It's not automatically going to be the case that that person will be appointed, if you see what I mean.

CHAIRMAN: It's a judicial addition. 12:08

MR. RUCK KEENE KC: Yes. So there has to be the appointment of an acting nearest relative and the acting nearest relative would have to be somebody who could consent. And you could image a situation under which someone says 'I want so and so' and the judge will go, 'well, I just can't.' 12:08

CHAIRMAN: Yes. Sorry. Thank you.

MR. RUCK KEENE KC: It's an important point. Again, to just put it in its context under the 2016 Act there's a

mechanism by which if someone has appointed someone that's wildly unsuitable to be the person, steps can be taken to address that.

So turning then to forensic patients. Again, you'll see here on this slide I'm trying to do my best to kind of keep it relatively helicopter level rather than descend to all of the individual section numbers just because I think if we don't do that or if that doesn't happen it can get a bit too thick, deep, into the thickets of some quite deep woods here. 12:08 12:09

There are sort of two critical categories that we're thinking about here. The first is those where there's been a kind of -- they've been diverted from the criminal justice system when they're going at the court stage, so it's either before or after sentencing. That might be that the person is found, for instance, not fit to stand trial or there might be something which means that actually they are -- so there's something which is going on there which means they're not appropriately to be considered culpable or it might be that they've been convicted but, actually, the appropriate disposal isn't to go to prison because actually their mental -- for whatever reason there is something that suggests that the appropriate disposal is a Hospital Order, so they can be diverted and sent to a forensic hospital. And that's reflecting very long standing, I mean multiple things, not the least of 12:09 12:09 12:09

which is the very long-standing idea that culpability in some way can be diminished by the presence of someone's mental disorder. So, in other words, they committed an act which is wrong and hurt other people, or done something, but they should be seen in some way not to be held -- to require to serve a prison sentence or receive a criminal disposal.

The other category of people are the category of people who have, as it were, gone into prison conventionally. They've been sent to prison, they've been convicted and sentenced to improvement, but their mental health has deteriorated and so they have to be transferred in. I mean conceptually they were completely different.

To try and summarise the main differences to civil patients --

CHAIRMAN: I was thinking about that earlier because, of course, in the criminal law, similarly to what you were saying earlier somebody has to be treatable, I think.

MR. RUCK KEENE KC: Sorry, I missed what you said.

CHAIRMAN: For a criminal court order to be made, the person has to be treatable.

MR. RUCK KEENE KC: Yes.

CHAIRMAN: Treatment can be offered before a restriction order can be made, I think.

MR. RUCK KEENE KC: Yes. It's inappropriate to smile but the reason for the slight smile on my face is this

is one of those areas where one gets into very challenging waters in terms of appropriate treatment because -- especially in circumstances where the sort of appropriate treatment which might -- the only sort of appropriate treatment is unlikely to be, for instance, medical treatment, drugs, the only sort of treatment might be talking. I mean very important things, like talking therapy, you can't require someone to undergo talking therapy. 12:11

12:12

I mean one important point of difference, if you've any familiarity with the English system, Chair, is because the Northern Ireland system doesn't allow admission under the Mental Health Act in the context of personality disorder, that's where the real issues arise in English law because personality disorder, frequently the sort of treatment which is said to be appropriate is what's called Milieu therapy, which is being in a situation where you are with other people and learning how to be with other people. People have strong views about that as to whether or not that's appropriate treatment. But, yes, the idea is there's disposal and there has to be appropriate treatment available. Whether the person is necessarily willing to avail themselves of that treatment is a conceptually different question. Certainly the Strasbourg Court, in the Rooman case we talked about right at the beginning, Rooman -v- Belgium, where they were saying detention on the basis of mental disorder has to include appropriate 12:12 12:12 12:12

treatment, they weren't saying if got treatment which is appropriate but the person is declining to engage, that means there is no appropriate treatment available. Because otherwise you could easily have a situation where the person is saying, 'I'm just not going to engage', therefore, there's no appropriate treatment. 12:13

Certainly, in England and Wales, I can say from my own experience there are situations where that's exactly what the person might say to the Mental Health Tribunal. 'I know you're saying this is the treatment, I'm not engaging', therefore there is no appropriate treatment. And especially where the real risk is risk to members of the public or other people, tribunals normally give that fairly short shrift. But, yes, the idea is that there is some treatment option, some treatability going on. 12:13 12:13

So some of the main differences to civil patients, I'm particularly here thinking about people who were not transferred in where their mental health has deteriorated but sent by the criminal courts in the first instance. So, different, longer periods of detention in many instances because the court will have set the framework. Then there are some variations about the kind of treatment framework reflecting the different lengths of periods. It just had to be to mechanically tracked through. 12:14 12:14

The third bullet point is really important. In some cases if the patient is being put there with a restriction order, there's going to be a limit upon their ability simply to leave, even if the RMO thinks this person is no longer fit for discharge. The Secretary of State, effectively as guardian of the public interest, has a role. So it may be the Secretary of State has to consent. It may also be that there's a combination of the Secretary of State and the Tribunal, unless the Tribunal thinks actually this person should just be absolutely discharged. 12:14 12:15

I'm taking this relatively rapidly, Chair, because some of these are incredibly complicated when you track through and I think it may be of most assistance to you when you get -- if there's a group of people where you need to know the mechanical details that you're given, as it were, a specific briefing about well this is what the provisions are, which would apply. 12:15

CHAIRMAN: We have to remember that we're largely focusing on learning disability. Not entirely, but that's been the majority of the issues that we've been looking at. 12:15

MR. RUCK KEENE KC: Yes. Although, interestingly and importantly, the last two cases there both featured Muckamore Abbey Hospital patients. So the Health and Social Care Trust, Mr. O and Mr. R, where one of the things which is happening -- it's a remarkably complicated case legally, I have to say, but the bullet 12:15

point for you is you are going to have situations or there are situations where the Tribunal would like to conditionally discharge somebody into the community, so in other words they're satisfied they don't actually need to be in hospital or in principle don't need to be in hospital and it would be right that they're not, but there is a level of concern whether about that be risk to the person in this sort of situation, it might well be risk to others. I'm not commenting on the individual facts of those cases. But the risk of harm to others, that there would have to be some conditions placed on them on their discharge. It's not an absolute discharge, it's a conditional discharge. This is where we then get tangled up in the fallout - not fallout - this is where we get tangled up in the recognition of the breadth of the concept of deprivation of liberty, because if you remember, combination of HL Bournewood and Cheshire West, confinement arises where you've got somebody who is not free to leave, subject to continuous supervision and control. If they're not free to leave and subject to continuous supervision and control and they can't consent or don't consent there's a deprivation of liberty where the State knows, or ought to know. There may well be situations where somebody is being subject to discharge into conditions which cross that threshold. And there has been a Supreme Court case called MN, the reason I didn't give you a reference is it then gets tracked through into the Northern Ireland

12:16 12:16 12:17 12:17 12:17

context here in this case, where the Supreme Court had said the mental health legislation in England and Wales and the equivalent here doesn't provide for conditional discharge into circumstances of detention. I mean, to reduce it to its simplicity, either you are detained in hospital or you are free. And conditional discharge can't give rise to a halfway house of detention in the community. So, the conditions can be quite light touch things like you have to reside here. But they can't be you have to reside here, you need to be subject to one-to-one supervision, or you need to abide by the rules of the care facility. If you leave without our agreement, we'll find you, there's a care plan which says we'll be monitoring. Because those things cross the line to deprivation of liberty. 12:18 12:18 12:18

PROF. MURPHY: But presumably that's because there's no equivalent to the Community Treatment Order here?

MR. RUCK KEENE KC: No, actually, because the equivalent -- so, the Community Treatment Order in England and Wales, the Supreme Court at almost exactly the same time it give the decision in MN saying you can't have conditional discharge into circumstances of detention, said you can't use conditional treatment orders to detain someone in the community. So they had an individual, actually, in that case with a learning disability who posed a risk to children. He was in a care home subject to all the sort of things you would image would be in place to protect against that risk, and the Supreme Court said that's unlawful, you can't 12:19 12:19

have that. If Parliament had wanted to allow for community detention, Parliament would have provided for community detention. It didn't, therefore you can't have it, at least within the four walls of the mental health legislation. In England and Wales you then get into some very complicated things where you've parallel authority to deprive individuals lacking in their capacity through a court order. In Northern Ireland, you've the DoLS under the 2016 Act which might be relevant there. Just on the -- 12:19 12:20

DR. MAXWELL: So, are you saying in England the Community Treatment Orders are about treatment but not about deprivation of liberty?

MR. RUCK KEENE KC: Exactly.

DR. MAXWELL: So, this isn't about treatment, this is just about deprivation. 12:20

MR. RUCK KEENE KC: Yes.

DR. MAXWELL: And the only place you can have deprivation of liberty is in a hospital?

MR. RUCK KEENE KC: Just to be clear, the only place where you can have deprivation of liberty which is being authorised by the relevant mental health legislation. 12:20

DR. MAXWELL: Yes.

MR. RUCK KEENE KC: Yes. 12:20

DR. MAXWELL: It can't apply in a residential home or nursing home, either in England and Wales or Northern Ireland?

MR. RUCK KEENE KC: No, because -- the easiest way of

thinking of it is, these were intended to be hospital-based pieces of legislation.

DR. MAXWELL: Yes.

MR. RUCK KEENE KC: And the other way of thinking about it or the other important point is, this is sort of why I wanted to start with the changing international framework because I'm absolutely sure that when people were thinking about this back in 1986, they were just not thinking that deprivation of liberty was something which was really going to be happening outside a hospital. You know, they weren't thinking deprivation of liberty is the sort of thing which might happen in a care home. There was such a focus on deprivation of liberty as a really kind of hospital-based institutional thing. By the time we get to Cheshire West - and maybe one thing I should have just made also clear about Cheshire West, none of the three people in Cheshire West were in conventional care settings; one was in a supported living placement, one was in an adult foster placement, and one was in a very small NHS facility, but it wasn't a hospital care home. And Lady Hale goes, 'it doesn't matter where you are, the concept of deprivation of liberty applies anywhere.' So, one of the things that court was having to do there in the O -v- R case is navigate the fact we've have a definition of deprivation of liberty which applies very broadly. Does that make sense?

12:20 12:21 12:21 12:21

DR. MAXWELL: Yes, thank you.

MR. RUCK KEENE KC: So as to not leave you hanging too

badly, the 2016 Act provides for deprivation of liberty where the person lacks capacity in any place where care is available. So the 2016 Act could apply in a care home, it could apply in a community placement. But that's only for people who lack capacity to agree to being admitted there.

I fully understand this is the point where everyone starts going, my gosh, this is complicated. Really annoyingly it's complicated. One point just to make, and I'll come back to, is part of this, the reason it is feeling complicated for you at the moment is this is a legacy of the fact that you only had partial implementation of your 2016 Act. Had the 2016 Act been enacted in the way it was intended to have been, or implemented, you wouldn't have had the 1986 Order anymore and everything would have been capacity based. You wouldn't be having to grapple with, well, is it the 1986 Order to which it is authority for detention, is it some other piece of legislation? So you are living with that. Which I know people are working hard on, it's not for me to make comment on that. But you just factually are living with that as an issue at the moment.

12:22
12:22
12:23
12:23
12:23

I'll come back to the interface which has been created a little bit later, if I may. Does that make -- dare I say, does that make sense?

CHAIRMAN: Yes.

MR. RUCK KEENE KC: For anyone watching or just to reiterate again, it's a combination of the 1986 Order being very firmly based on an order which thought about care and treatment being hospital-based and an understanding that the concept of deprivation of liberty, which was only ever really related to hospital, and I should say, also, only ever seemed to relate to hospital if people were actually objecting and trying to leave, which isn't legally the case anymore. 12:24

Okay, I think that was all I was going to say on that slide, if that was okay?

CHAIRMAN: Yes.

MR. RUCK KEENE KC: If I could turn to some sweep-up about the 1986 Order. I mean that first bullet point is covering a whole lot of stuff which I know, Panel, you would be thinking about in much more detail later so I thought it didn't seem to make a great deal of sense in trying to set out the whole framework there because you'll obviously have to think about that. But it's just providing for monitoring of mental health patients by now the RQIA and previously Mental Health Act Commission, now RQIA. Which is obviously a hugely, hugely important role. So it is not just looking at RQIA, and not just thinking about their role in terms of authorising SOADs, it is actually monitoring what's going on in relation to mental health patients, but I -- it would be better, I think to get that in more 12:24 12:24 12:25

detail at the point where you need to get to it in more detail.

And then there is a range of offences which the Mental Health Order created about, for instance, the ill-treatment of mental health patients. So just -- which are recognising societally the fact that people who are mental health patients -- and that's the language of the Act, and we're particularly thinking about people who are detained under the Mental Health Order, are immensely vulnerable or at risk. Vulnerability is a word which is challenging, but they are definitely in situations of being at risk. 12:25 12:25

Then there's a completely separate set of provisions, which I don't know whether you're going to have to think about at all, which provides a mechanism for managing people's money, and property and affairs, where they're incapable of doing so. So you've gotten really -- this is, this is really just a complete legacy of a world in which they -- the world was status based. A world which was status based. People with mental health conditions just couldn't do things. They couldn't make decisions about their care and treatment, they couldn't make decisions about their money. A very, very antique view of the world. And that's why managing property and affairs got lumbered or lumped under the same bit of the legislation as dealt with managing appropriate and affairs. 12:25 12:26 12:26

CHAIRMAN: Did this make provision for who would be responsible?
MR. RUCK KEENE KC: Yes. You can get a receiver appointed and then that person gets authority to make decisions. I mean it is -- in a way it has got nothing to do with what you're having to think about. I just wanted to make sure that you knew it existed. 12:26
CHAIRMAN: Yes. Okay.
MR. RUCK KEENE KC: So that was all I wanted to say about the 1986 Order. If there were any points which came to you over the lunch adjournment -- I'm not trying to get out now, but I'm just saying if there are any points which came to you over the lunch adjournment then I'd be happy to come back on it. But I was sort of proposing to move off to then move on to think about the 2007 Report. 12:26 12:27
CHAIRMAN: No. Thank you.
MR. RUCK KEENE KC: Yeah, and just before I leave, just to reiterate, that's -- I've given quite a helicopter-level view. It deliberately wasn't citing all of the articles because it seemed to me more important that you got the kind of context, the core bones of it, and then if you need specific reference to articles in relation to "Did a policy say X, Y, or Z, or was it applied?", then that's the point at which you can receive them. 12:27 12:27
CHAIRMAN: And so far, up until now, we haven't been looking, obviously, effectively looking at capacity, because that's what changes - the point you're about to

move in.
MR. RUCK KEENE KC: Yes. I mean legislative, yes.
CHAIRMAN: Yeah.
MR. RUCK KEENE KC: I mean of course those applying the legislation over time, and I'm sure you'll hear clinical evidence about this, there's nothing to stop them saying, "Well, I'm fairly convinced that my patient has got capacity to make this decision and, yes, they can consent, and, therefore, let's just proceed on that basis". 12:27 12:28
CHAIRMAN: But nothing legislative.
MR. RUCK KEENE KC: No. Well, except it is the other way around -- I suppose it is the other way around, saying if the patient doesn't have capacity then there has to be safeguards. If you see what I mean. If you can't provide treatment on the basis of capacity to consent. And the other way around, if the patient -- well, sorry, the legislation being silent as to what happens if the patient doesn't, or the person doesn't have capacity to agree to come into hospital in circumstances of confinement. It's just silent. And that's the discussion we had about informality and how feasible it is to have someone - I mean legally it is a nonstarter now to have somebody confined in a mental health hospital who doesn't have capacity to agree to be there in circumstances of confinement. Because they're confined, they can't consent, they're deprived of their liberty. And deprivation of liberty requires a framework. If that makes sense? 12:28 12:28 12:28

CHAIRMAN: Yeah.
MR. RUCK KEENE KC: But that's not to be found in the 1986 Order at all, because the 1986 Order wasn't thinking about how, you know -- it wasn't predicated on that idea. 12:29
CHAIRMAN: No. Quite. Well that's the point I was --
MR. RUCK KEENE KC: Yeah. Yeah. Thank you, Chair.
CHAIRMAN: Yeah.
MR. RUCK KEENE KC: So if we could have the next slide, please? 12:29

So as leading counsel to the Inquiry pointed out, to some extent I'm out of sequence in the sense of you're going to be hearing an awful lot more about the Bamford Review tomorrow and the context, it's just really the 12:29 sequencing of how things worked out.

So what I'm going to try not to do is talk too much about the thinking of Bamford and the process of Bamford and all of those aspects. But I'll just -- so 12:29 what I'm going to focus on is the final report, which was the comprehensive legislative framework, and then taking that forward into the 2016 legislation.

So I think it is just helpful, if I may, to just think 12:29 again about the context within which this was happening.

So by the time August 2007 rolls round, this is towards

the end, and it is a very long and very comprehensive piece of work, the Bamford Review. And from an interested outsider perspective, one thing, I think -- if I can just put on record how impressive it was to have a piece of work done with such heavy-duty focus on the involvement of people who might be affected by it. It certainly provided a really important model for thinking about, for instance, when we came to do in England and Wales thinking about our mental health legislation. How do you think about it? Look to how the Bamford process was done, completed by Prof. Roy McClelland. So I just, I wanted to just say that, if I could. 12:30 12:30

So just thinking about the context which you can sort of draw as much as anything else from the framework document itself. We've got Bourne Wood laying down this marker that you need to be very, very concerned about the situation where you've got people allegedly informally in your hospitals. You know, they just can't be there if they don't have capacity. There has to -- or they don't have capacity to agree to be there. 12:30 12:31

Then the 1986 Order was there. But there had been, as it were, the next generation of law reform had come along. That was led in - Scotland really led the charge. The Adults with Incapacity Act 2000. I'm going to talk about that a little bit more later, but just as a broad context, Scotland had passed that 12:31

legislation as well as the Mental Health (Care and Treatment) Act 2003. So Scotland had been moving down a track which wasn't towards fusion, to fusing mental health and mental capacity legislation, but a very firmly recalibrating the idea of mental capacity, adults with incapacity, and really recalibrating mental health law, that was the Mental Health (Care and Treatment) Act. 12:31

Then there was the Mental Capacity Act 2005 in England and Wales, which actually really -- well, that was a culmination of a piece of legislation which had started being thought about 10 years previously. That was really law commission work back in the 1990s. It took 10 years for that to get on to the statute book. 12:32 12:32

The other contextual thing was that in 2007 the CRPD, the Convention on the Rights of Persons with Disabilities, was really only just coming into view. The CRPD had been concluded in 2006 and it was only really coming on to people's radar. I was quite -- actually reminding myself, rereading that 2007 Report, there's only one mention of it. I mean had the Bamford -- had that document been published in August 2017, the CRPD would have been referenced throughout. 12:32 12:32

So, as I say, it is the final report at the end of a very long processes. I, sort of, as it were, don't want to spend too long talking about it. I won't get

into it because I think it is going to be much better for the Panel to get a sense of it from --

CHAIRMAN: Sorry, just remind me of the date CRPD actually --

MR. RUCK KEENE KC: 2006. UK ratified 2009. So it is, well I don't want to say unfortunate, it is just a matter of timing that the two pieces of thinking didn't correspond directly. And I'll make one further point about that in a minute, if I may. 12:33

12:33

Could I get the next slide, please?

So it was very firmly principles based, this framework document, as, indeed, the entire Bamford Review had been. It was very firmly principles based. The four principles being autonomy, justice, benefit, and least harm. I mean there's a sort of constellation of principles which occur in different language often when trying to think about law reform in this area. But autonomy is one really which sits highest for most people most of the time. 12:33 12:34

What it wasn't trying to do was sit down and draft legislation. I mean it is a long, long document. It runs to - I don't know how many pages it runs to now. It runs to 102 pages, but it was very specifically saying "We're not trying to draft legislation here. What we're trying to do is set a direction of travel". And the radical thing it did, or for many people the 12:34

radical thing it did was say "We think that there should no longer be standalone mental health legislation. There simply shouldn't be the equivalent of the 1986 Order going forward", at least -- well, actually, no, the 2007 was zero upwards. You'll hear more about why that is the case tomorrow. But as a sort of very interested outsider, it was two aspects. One was the massive stigma of having separate mental health legislation. Having someone being subject to the Mental Health Order. And you only need to see any popular media or the myths about "Are you allowed to go to America if you've ever been detained?", things like that. This massively stigmatic idea. So just this is a profoundly bad idea to have separate legislation. 12:34 12:35 12:35

And the second being "Well, what should the organising principle be?". Well the only fair, just and appropriate organising principle is the idea of someone's decision-making ability, and that should apply across the piece insofar as possible for both physical healthcare and mental health care. Otherwise you will never have parity between the two. 12:35

The reason I say there "(near complete)" is they recognised in the 2016 Act, and then it sort of tracks through, some complexities arise with diversion in a forensic system. So in other words you've got someone being diverted in the criminal justice system on the basis, for instance, they've been found not guilty, not 12:36

guilty by reason of insanity, or diverted in for some other reason, there may be circumstances under which capacity is, as it were, not the sole criteria. But, otherwise, as much as possible, a single one act to rule them all and, importantly, an all-age act. That's what the framework was thinking about. As I say, you'll hear a lot more tomorrow about the kind of -- the working process and the thinking process behind Bamford. 12:36

I was then going to move on, if I may, to the next slide. I mean, I wasn't proposing to say anything more about that 2007 framework, because I think it is easiest if you hear -- that was my sort of 5-minute take on what I got from it. 12:37

CHAIRMAN: Well as you say, we're going to hear much more, I imagine, tomorrow. We can skip forward to the legislation which actually arose effectively out of that.

MR. RUCK KEENE KC: Exactly. Exactly. Yeah. So the first point there, it was a long journey from the Bamford Reports -- I know I've always just said Bamford, I mean that's -- I've just fallen into using that language. The Bamford Report is delivered in - the final delivered in 2007, and then it is a long legislative road. I should declare -- not really an interest, but I should declare I did give evidence to the Northern Ireland Assembly when it was thinking about it, and one of the things, there was a panel of 12:37 12:37

external experts, and one of the things they were thinking was: Is this all a bit radical? You know. In other words, is this idea of moving straight across the piece to fuse legislation, is this radical? Where do we sit in terms of the kind of wider framework of 12:37
thinking. And the other thing which was happening was the CRPD coming increasingly into focus. People being much clearer about well, actually, what does the CRPD require? Does the CRPD, does it require elimination of mental health detention, you know detention in the 12:38
presence of mental disorder? Does it require elimination of models which allow for someone's capacity to be removed, in effect, on the basis that they don't functionally have the ability to make that decision and to be deprived of their liberty at that 12:38
point? And that was an issue which the civil servants really had to grapple with, because around that time, just towards the closure at the end of the legislative process, the CRPD Committee start issuing very strong comments saying "The very concept of mental capacity is 12:38
flawed because it presumes that you can judge the working of another one's -- someone else's mind", and all -- I mean effectively all mental capacity does is reflect the biases and professional disciplines of those people involved in assessing capacity. 12:39

So there's a general comment one which is issued saying that in terms, and general comment one also says you're not allowed to have decision making frameworks based on

best interests. Because a decision making framework based on best interests is always going to be paternalistic. It is always going to represent the view of what the professionals think is in the person's best interests, it is not actually sufficiently going to respect the rights, will and preferences of the individual. 12:39

So you had a very, very adhesive law reform coming from a very long seven-year process within Northern Ireland, self-generated, really thinking through about stigma, really thinking about capacity being the right Touchstone. As this is moving towards, you know, the legislative books, you get the CRPD Committee saying "We don't like the idea of mental capacity and we don't like the idea of a best interests". The 2016 Act contains express references to capacity, it is all hooked off capacity, and it is hooked off best interests. This is one of the reasons why, as I said right at the beginning, the issue about precisely what the status of the CRPD Committee statements have, their general comments have, is a challenging one. 12:40 12:40

Our Supreme Court -- I mean "our" as in UK Supreme Court -- has said their statements are authoritative but not binding, and that's one of the reasons why this legislation, as it were, can be enacted, notwithstanding the fact the CRPD Committee actually reported in 2017 on the UK's compliance with the 12:40

Convention. So they did -- we have to report in as a reporting cycle, UK reports in, not just about England and Wales, England and Wales, Scotland and Northern Ireland reports in, CRPD Committee come back saying "We are extremely concerned about legislation which allows for removal of legal capacity and deprivation of liberty in the presence of mental disorder. We're very concerned about subterfuge decision making regimes such as the 2016 Act. I mean that's all been dealt with at, as it were, national level. I just thought it was important you know that, and I will come back to some of the implications of that just at the end. 12:41 12:41

But within the four walls of the 2016 legislation there's one particular thing that was included to try and really head off that CRPD challenge, which I'll talk about in a minute, but one big -- sorry, Chair. 12:41

CHAIRMAN: No, just in the formulation of the Act, they plainly must have considered the views of the CRPD, as it were, and, as it were, went ahead. 12:42

MR. RUCK KEENE KC: Yes. Yes. I think it's -- this is a zone where the State's parties to the Convention have a very clear view of what it was that they had signed up to. The CRPD Committee are saying "You're getting it wrong, this is what we think it means", and there is a debate going on. But, no, the Northern Ireland Assembly was acutely aware of what the CRPD -- and it was very, very squared -- I mean I remember -- I'm not giving away confidence because I remember being at the 12:42

Northern Ireland Assembly giving evidence and it was really very clear people were going "oh" -- not "Oh, help", but it was "Right, this is being really grappled with right here right now. One of the things we need to be thinking about is should we be passing legislation in circumstances where these concepts are under challenge?". So, yes, it is contested terrain.

At one point, I suppose just to nail that down, there was a case called A Local Authority -v- JB, decided by the UK Supreme Court in 2021, where a challenge was brought to the English Mental Capacity Act in the context of capacity to make decisions about sex, saying the MCA does not comply -- is discriminatory and doesn't comply with the CRPD because it places a higher -- places higher requirements on people with cognitive impairments than it does on everybody else, in terms of whether or not one has got the ability to consent to sex, and the Supreme Court says no for two reasons. (A), the CRPD is not binding in the same way as ECHR is, and that must apply across in Northern Ireland as well. I mean that -- it's a matter of national, as it were -- the Supreme Court making that clear. Then, (B), in any event it is not discriminatory, all it is saying is the same test applies to everybody. Everybody needs to be able to understand the person you're wanting to have sex with has to consent. So it is not placing a higher hurdle on somebody who has got a cognitive impairment.

So, yes, I mean I could -- I will not go on for hours, Chair, I could go on for hours about this, but it is -- the short point is it was very clear when this legislation was heading towards its final stages that there was a substantial challenge from the Committee on the rights of persons who have disabilities to two foundational concepts, i.e., the idea of mental capacity as a legitimate concept and, (B), the idea of best interest decision making as a legitimate concept. And this legislation was passed in full awareness of that. And, for instance, one thing that they did was say your legislation, so the Northern Ireland 2016 Act, compared to the English legislation, the 2005 Act, says special regard has to be had to the person's wishes and feelings. The 2005 Act in England and Wales says you have to take into account all the factors, including wishes and feelings. 2016 Act says special regard, and that was explained to the assembly as being "This means we are properly taking into account our obligation to respect the person's rights, will and preferences". So, yes, it was squarely on people's radar at that point.

12:44 12:44 12:45 12:45 12:45

CHAIRMAN: Yes. So even though we signed up to the CRPD, it means it has to be taken into account, not followed -- not necessarily followed.

12:45

MR. RUCK KEENE KC: Well, until and unless it becomes part of national law and national courts have -- if it was the equivalent of the Human Rights Act, then

national courts would have to apply it in the same way. It has certainly proven influential before national courts in terms of, for instance, interpreting the European Convention on Human Rights.

12:46

So Lady Hale in Cheshire West, one of the reasons why she said deprivation of liberty has to be applied in a nondiscriminatory fashion, you can't just say it applies differently because this person is not trying to leave, she says the right to liberty has to mean the same for everybody - see the CRPD. So it has been influential in that way. But it is on the kind of harder-edged points which lead to actually, we're going to have to abandon a concept which seems very foundational to English and Northern Irish law, and I analysed the idea of capacity, the UK Supreme Court has said "no, we're going to proceed".

12:46

12:46

I can give you, if you need it, Chair, via leading Counsel, I can certainly give -- there's a recent article I co-wrote which goes through that in some detail to explain how it works.

12:46

CHAIRMAN: Yeah. Thank you.

MR. RUCK KEENE KC: So I think probably what I might do, Chair, is, if I just walk you through this slide by way of overview and then I might draw stumps there for a bit.

12:47

CHAIRMAN: Sure. That's the one that we've on the screen at the moment..

MR. RUCK KEENE KC: So a long journey from Bamford. Yes. Just to give you the overview because I think -- and then I can drill down a little bit into some of the detail after lunch.

CHAIRMAN: Yeah. You're just over halfway through, I think, your slides in any event. 12:47

MR. RUCK KEENE KC: Yes. I mean I was going to say I think I'm roughly where --

CHAIRMAN: You're on track

MR. RUCK KEENE KC: Insofar as I had worked out where I wanted to be, I am on track. 12:47

CHAIRMAN: Despite many interruptions.

MR. RUCK KEENE KC: Well, Chair, if I may so, it is incredibly helpful having them, because otherwise I would just deliver this and then it may be -- actually if we had been -- fundamental misunderstanding from Slide 2. So it is much better if we can -- I'm sure that wasn't the case -- 12:47

CHAIRMAN: Well, it is quite possible.

MR. RUCK KEENE KC: It is much better if we can have clarification. Because some of this is, some of this is just, frankly just not straightforward, and some of it is based on it is very easy to fall into the trap of thinking everyone else understands this bit and actually it is not always -- 12:47 12:48

CHAIRMAN: Yeah. No, no.

MR. RUCK KEENE KC: So one of the things that changed between the 2007 Act or the 2007 Report and the very kind of strong Bamford drive, which was this was

supposed to be zero upwards, was the 2016 Act is 16-plus. As I said earlier, it does include -- it has introduced into the Mental Health Order some of the kind of safeguards and protections and thinking in relation to under 16s which now apply to over 16s, but it's - there's no -- it's not replacing the Mental Health Order for under 16s. That was in significant part because it gets very complicated very quickly thinking about younger people because you then start thinking about what exactly the components are of decision making and also what role those with parental responsibility legitimately have in their life in terms of decision making. 12:48 12:48

I think actually just one point just to flag there. It was extremely useful that it's 16-plus, because since that Act came in or since the Act was enacted, the UK Supreme Court has made clear in a case called Re D that once somebody hits 16 no one can consent on their behalf to confinement. There are limited circumstances pre-16 where someone acting with parental responsibility can authorise confinement, you definitely can't do it aged 16-plus. So they didn't know that when they passed that legislation, but it was extremely helpful from a deprivation of liberty perspective that they did, because there is a framework which applies 16-plus. 12:49 12:49

So it is intending ultimately in due course to be an

overarching framework for all acts of care and treatment. So you don't have to start asking: Is this person a mental health patient or is what's really going on a physical condition? You just say: Does this person need help? And it is capacity based, almost entirely, with the significant exception of the situation where somebody is being diverted in forensically where, insofar as possible, treatment decisions about them are capacity based but whether they're actually discharged is not purely capacity based. 12:50 12:50

Ultimately the call was taken society is not in a position -- does not feel comfortable -- or the Northern Ireland society doesn't feel comfortable moving to a thing where capacity is completely determinative where the public interest is sufficiently at stake. I mean that's my take on it. 12:50

So there are a number of overarching matters, and we'll talk about these in a little bit more detail after lunch. So the first is, unlike the Mental Health Order, there is a set of principles on the face of the 2016 legislation. A very important commitment to saying in order to understand how this legislation works you need to have a moral compass. We're going to put the moral compass on the face of the Act. 12:50 12:51

It's then capacity based. So a functional idea about capacity, we'll talk a little bit more about that after lunch, and then the idea of best interests. So best interests, in particular, thinking about the person's wishes and feeling, but it does also -- and we'll talk about this more -- take into account potentially the public interest. 12:51

Then sort of doing my best I can to give a helicopter overview, what it's got is a very -- the way it works, as I've called it there -- this is my language and not the language of the Act -- a series of graduated safeguards. The more serious the intervention, the higher or the more rigorous the set of safeguards needed. So a very in formal, a very low-level intervention, low-level act of care and treatment, when it is fully enforced doesn't require formality, you have to apply the principles, it doesn't require formality. The more serious the intervention the greater the safeguards. So admission into circumstances of confinement, various forms of medical treatment. 12:51 12:52

Then an important role for the nominated person. So, remember the 1986 Order, you're basically lumbered with your nearest relative unless you can make an application to get them displaced. Here you're meant to be choosing from the outset. So you can see this is all oriented around trying to reformulate it around the 12:52

person. A big role for advocacy, recognising that many people -- all sorts of people require advocacy in order to actually just make their rights effective. An ability to implement in a -- there are -- there's a limited scope for making Powers of Attorney under Northern Irish law at the moment in relation to property and affairs. This would provide ability for people to make greater provision for managing their money, but also appointing someone else to make decisions about their health and welfare in due course. This bit isn't yet in force. Only very limited. The only bits which are in force are the deprivation of liberty, money and research, at the moment.

CHAIRMAN: Right.

MR. RUCK KEENE KC: Sorry, Chair, I cut you off.

CHAIRMAN: No, no, no, I was going to say if you could make it clear as we go through which bit is actually in force and which isn't.

MR. RUCK KEENE KC: Yeah. Yeah. I was going to do that by reference to a slide a little bit a later on.

CHAIRMAN: Yeah, sure.

MR. RUCK KEENE KC: But, yes, essentially nothing is in force except for the deprivation of liberty bit and the bit which ties into that in relation to nominated persons and the ability to take challenges of that to the mental health and expanded Mental Health Review Tribunal. There are also provisions in relation to research and management of money and valuables where someone is in a care setting.

I mean research has, as it were, got nothing to do with it. It's a bit which I think it was considered it was possible to implement relevantly straightforwardly. The money and valuables kind of goes with if someone is confined in a care setting. So we are, we're in a slightly odd situation legislatively -- or Northern Ireland is in a slightly odd situation legislatively where you've got the arrangements to confine someone are set down in statute, but the arrangements to determine individual acts of care and treatment are still governed by common law. Because this person by definition isn't going to be under the Mental Health Order. 12:54

CHAIRMAN: No. 12:54

MR. RUCK KEENE KC: So then the Court has a place in some cases, but for DoLS, Deprivation of Liberty Safeguards, which is the bit which is in force at the moment, you're route of challenge -- I'll talk about this later -- is to the Mental Health Review Tribunal which now has an expanded remit. It is hearing both cases coming in under the Mental Health Order and cases coming in under the 2016 Act. 12:54

CHAIRMAN: So significant parts effectively of the Mental Health Orders are still highly relevant. 12:55

MR. RUCK KEENE KC: Yes.

CHAIRMAN: Until some of the later provisions -- some of the provisions of this later.

MR. RUCK KEENE KC: Yes. I mean it is -- well, I won't

ask to skip to the slide, but just so you're not left hanging, the Mental Health Order is still in force and the transition provisions which brought in -- or the commencement order rather, sorry, which brought in the DoLS provisions related to care and treatment say if the person can be detained under the 1986 Order, the 1986 Order has to be used. So -- and I should say I was very interested to know, because I thought it would be important in terms of me giving evidence or making this presentation to have any understanding of were or are any of the people at Muckamore Abbey Hospital subject to the 2016 Act, because if they're not then this is, as it were, fascinating but mildly academic. I understand that there are some who were there or have been during the currency of your -- the period of inquiry, I understand from enquiries having been made, I'm sure leading counsel will be able to assist on the precise details. I mean I don't -- it is not so much the numbers, it's the fact that there are some. So there are three cohorts of people. You've got entirely informal, you've got the 1986 Order, then you've got the 2016 Act. So for the 2016 Act people, their care and treatment has not been -- like the framework for care and treatment, the framework for treatment isn't the 1986 Order. 12:55 12:55 12:56 12:56 12:56

CHAIRMAN: Yeah. It is common law.

MR. RUCK KEENE KC: Yes. Because the Mental Capacity Act 2016 hasn't been brought into force to provide the treatment safeguards. So the only possible basis -- no

doubt the Trust will be able to assist you if they have a policy which is saying we're providing it on a different basis, but from a plain reading of the law the 2016 Act isn't in force, save and in so far as it relates to the deprivation of liberty provisions. The deprivation of liberty provisions provide authority to confine, they don't provide authority to treat. The specific treatment safeguards within the 2016 Act aren't yet in force. 12:57

CHAIRMAN: So why do you not then go back to the Order? 12:57

MR. RUCK KEENE KC: Well, because it is exclusive. The commencement order says if the patient is there under -- you either use the 19 --

CHAIRMAN: Ah! Sorry, I hadn't realised --

MR. RUCK KEENE KC: No, no, no. Sorry, no, it is probably my fault, Chair. And if I have misunderstood how Muckamore Abbey Hospital or the Trust has - 12:57

CHAIRMAN: Well we'll be hearing, I'm sure.

MR. RUCK KEENE KC: We'll undoubtedly be hearing. 12:57

DR. MAXWELL: So if somebody was admitted under the 2016 Act currently has no legal framework for DoLS or --

MR. RUCK KEENE KC: No, no, if they were admitted under the 2016 Act they've got a legal framework in place for their confinement. They've got the ability to challenge that confinement before the Tribunal. 12:57

DR. MAXWELL: But you said the parts relating to deprivation of liberties haven't been enacted yet.

MR. RUCK KEENE KC: So it was the part relating to treatment hasn't been enacted.
CHAIRMAN: So DOL has.
DR. MAXWELL: Deprivation has been enacted.
CHAIRMAN: Yeah. 12:58
MR. RUCK KEENE KC: Yeah, deprivation --
DR. MAXWELL: What about safeguarding?
MR. RUCK KEENE KC: So the -- well let's wheel it back.
DR. MAXWELL: Okay.
MR. RUCK KEENE KC: So if you imagine the 1986 Order 12:58
contains the framework for admission. So that provides authority to detain.
DR. MAXWELL: Yes. Yes.
MR. RUCK KEENE KC: It's got Part 4 which provides
authority to treat, which has got the safeguards, SOADs 12:58
and things like that.
DR. MAXWELL: Yeah.
MR. RUCK KEENE KC: The 2016 Act has DoLS, authority to detain, deprivation of liberty, that's been brought
into force. The treatment safeguards haven't. So 12:58
there isn't the equivalent of Part 4 Mental Health Order which has come into force yet.
DR. MAXWELL: So some patients at Muckamore have got treatment safeguards and some haven't under the law.
MR. RUCK KEENE KC: Well, the basis on which they are 12:59
being delivered -- I mean I think this -- I think this is going to be a bit where you're going to need to hear direct evidence from those who were in charge of the policies there. But --

DR. MAXWELL: I'm just asking about the law.
MR. RUCK KEENE KC: Yeah. No, of course, yeah.
DR. MAXWELL: Obviously the practice is different, and we'll ask about practice, but actually strictly in law there is a difference in the legal protections for people under the different legislative framework. 12:59
CHAIRMAN: They still have protections but they'll be protections under the common law, presumably.
MR. RUCK KEENE KC: Yes. The common law being -- effectively it is the doctrine of necessity. Do you -- lack of capacity, best interests. I mean if, if it's the case that the 2016 -- those people who are subject to the 2016 Act are having the treatment safeguards used, then I'm sure someone will correct me over the lunch adjournment, but I can't see how that can be the case because my understanding is that the treatment safeguards provisions haven't been brought into force yet. I don't know if it is appropriate to say, I was quite surprised when I learned that there were some people subject to the 2016 Act in this framework, because -- I just was quite surprised. 12:59 12:59 13:00
CHAIRMAN: Yes. Well --
MR. RUCK KEENE KC: But that's just -- I don't want to go any further because that would be me commenting inappropriately. 13:00
CHAIRMAN: No, I think you're right not to. As I say, we will be hearing from other experts and, indeed, from the Trust itself who will be able to give us more information.

MR. RUCK KEENE KC: Yes. Yes. As I say, I hope I didn't stray, but I just -- I think it's important to sort of see where --

CHAIRMAN: No, no, no. But I certainly hasn't realised - I may be the only one in the room - that they are effective mutually exclusive. 13:00

MR. RUCK KEENE KC: Yes. Yes. Because I mean, just to reiterate, the 1986 Order provides authority to treat somebody who is detained under the 1986 Order.

CHAIRMAN: Yes. Yes, yes. 13:00

MR. RUCK KEENE KC: So you couldn't use -- I've got someone here under the 2016 Act and I would like to use the safeguards contained in the 1986 Order -- I mean let's just run this for a second. You're a good clinician, I would like to make sure this person has got access to the protections under the 1986 Order, but they're here under the 2016 Act, you can't, as it were, borrow. What you can do is say I don't think this person -- I think this is a person who could be detained under the 1986 Order, or say I'm going to detain this person under the 1986 Order because then they've got access to treatment safeguards. So you could do that because then you could swap the person from the 2016 DOL provision to them being detained under the Mental Health Order if they met the criteria for detention. 13:01 13:01 13:01

DR. MAXWELL: So you can choose which one to detain somebody under?

MR. RUCK KEENE KC: The statutory language is,

Article 3 of the Commencement Order says:

"If a person can be detained under the 1986 Order, the 1986 framework must be applied."

13:01

The problem is -- I mean if I may be blunt -- the problem is this was not a problem which should ever have happened. Because the entire point of the 2016 legislation was it was supposed to replace everything.

CHAIRMAN: A comprehensive piece of legislation. 13:02

MR. RUCK KEENE KC: Yes. And if it -- and this is just factual. Had it come into force in the way it was intended, everybody would be there with the same set of safeguards, because it would either be the 2016 Act or nothing. Sorry. 13:02

DR. MAXWELL: I understand the point, and I understand that practice may be different, but if, if the current requirement is to use the '86 Act --

MR. RUCK KEENE KC: Order. Sorry, it is my fault. I think I said Act. Apologies. 13:02

DR. MAXWELL: Order. Order, if possible, who is it that it's not possible to use the '86 Act for and therefore you have to use the 2016?

MR. RUCK KEENE KC: Well, an example would be -- the thing is this is one of those areas where I think it's 13:02 going to be very helpful, if I may, for the Panel to hear evidence from clinicians about their understanding of the operation of the two pieces of legislation.

DR. MAXWELL: I understand that.

MR. RUCK KEENE KC: But an example would be, to go back to the question I was asked, you know, when we were thinking a bit about what I'd say is learning disability, abnormally aggressive seriously irresponsible conduct, say you have somebody who did not have a severe mental impairment accompanied by abnormally aggressive and seriously irresponsible behaviour -- abnormally -- sorry, it has been a long morning. Abnormally aggressive behaviour or seriously irresponsible conduct. So you've got somebody who it is considered needs to be in a place where they're receiving care and treatment, they need to be confined, you can't use the 1986 Order because they don't have -- you know, it is a mild learning disability or it's not accompanied by abnormally aggressive or seriously irresponsible conduct, so you couldn't use the 1986 Order because the person simply doesn't meet the entry criteria for the 1986 Order. That somebody who you couldn't use the 1986 Order for, if the person is being confined, there needs to be legal authority to confine, DoLS on its face applies to somebody who is confined, lacks capacity, so long as it is in their best interests and necessary and proportionate to the risk of harm may be had, but I just -- we --

13:03

13:03

13:03

13:04

PROF. MURPHY: I can't imagine a person --

13:04

MR. RUCK KEENE KC: Sorry?

PROF. MURPHY: I can't imagine a person that would fit those conditions.

MR. RUCK KEENE KC: I feel slightly edgy talking in too

much detail about this because I'm very aware that I'm partially transposing extensive experience from England and Wales when we spent an awful lot of time navigating --

CHAIRMAN: Yes. I think we have got to be careful. 13:04

MR. RUCK KEENE KC: And I don't think -- but all I can say is factually, as I understand it, there are some people who -- Muckamore Abbey Hospital -- who during the currency of the terms of reference of the inquiry are there under the 2016 Act, they're there under the 13:04 -- some under the 1986 Order, and then it is a question of if they're under the 2016 Act, DoLS undoubtedly is providing -- without commenting on the facts of their cases, DoLS authority to confine, not the authority to treat, the authority to treat can't come from the 1986 13:05 Order, it can't come from the treatment safeguards because the treatment safeguards aren't in force, so SOADs, for instance, under the 2016 Act don't exist because they're doing their job under the 1986 Order, which should soon -- is intended to go away. So then 13:05 there has to be the question of the basis of that treatment is either their capacitous consent, if they don't have capacity to consent, it must be the common law.

CHAIRMAN: Yes. 13:05

MR. RUCK KEENE KC: As I say, if I've misunderstood, which I don't think I have, but if I've misunderstood then no doubt that can be made clear to me over the luncheon adjournment and I can walk you through any

additional bit.

CHAIRMAN: All right. Well that might be a very good point to take a break. So, can I thank you very much indeed. Obviously, again, normal court rules don't apply. If you wish to speak to Mr. Doran or indeed anyone else, you're very welcome to. We'll try and sit again at ten past two. Thank you very much indeed. 13:05

13:06

THE INQUIRY ADJOURNED FOR LUNCH

THE INQUIRY RESUMED AFTER THE LUNCHEON ADJOURNMENT AS FOLLOWS:

CHAIRMAN: Thank you. Yes, I gather you wanted to clarify something.

MR. RUCK KEENE KC: Yes. Well, I just thought it might be helpful, just in light of the exchange before lunch -- and also I apologise to the stenographer. I think I got a bit carried away. I will try and speak more slowly this afternoon. 14:12

I just thought it might be helpful, just in terms of this business about who might be -- if you are subject to the 2016 Act, what's going on? So I went and had a look in the Statutory Code of Practice, which has been published to accompany the 2016 Act, so the deprivation of liberty provisions. So if I could get that document up on screen, please? 14:12

So that's -- this is talking about the jurisdiction of the Review Tribunal. So, as I said, the Review Tribunal is -- their remit has now -- jurisdiction has now been expanded to cover cases coming in under the Mental Health Order, cases coming in under DoLS, Deprivation of Liberty provisions. It is really paragraphs 15.2 and 15.3 -- 14:12 14:13

CHAIRMAN: What are we looking at? What is this document?

MR. RUCK KEENE KC: So this is the Statutory Code of

Practice.
CHAIRMAN: Right. Sorry. Thank you.
MR. RUCK KEENE KC: Sorry. Published November 2019. So this is accompanying the relevant bits of the deprivation of liberty provisions. So it is particularly paragraphs 15.2 and 15.3 seem to be just helpful, just so we've got it squarely before us. 14:13

So you can see: 14:13

"The Review Tribunal can only consider the care arrangements amounting to a deprivation of liberty. A decision to authorise deprivation of liberty relates only to the care arrangements in the place where the person who lacks capacity is." 14:13

It doesn't include where the person should live. Then:

"The treatment the person should receive or any other aspects of the care and treatment is not directly relating to deprivation of liberty." 14:13

So you can't go to Tribunal to say, for instance: "I don't like this treatment." 14:14

Then at 15.3:

"Department recognises other aspects of the care and treatment may be of great importance to the person.

However, during the first phase of commencements of the Metal Capacity Act only aspects relating to deprivation of liberty are included. These other aspects of the care and treatment..."

14:14

-- and this is in bold, as you can see, Panel:

"...are not within the remit of the Mental Capacity Act and are therefore not in the jurisdiction of the Tribunal."

14:14

There are, of course, other methods for the person and others to challenge decisions, including seeking declaratory orders from the High Court.

CHAIRMAN: Yes.

14:14

MR. RUCK KEENE KC: So that's -- I just thought -- I was trying to think what's the easiest place to find something which kind crystallises it, and that seemed to me potentially of some assistance.

CHAIRMAN: Just so that everybody understands, when we talk about declaratory orders from the High Court and, indeed, when we talk about the common law, we are referring to case law that has been built up, sometimes through quite a period of judgments from normally High Court judges or normally the Court of Appeal which, in general terms, medical practitioners would need to follow.

14:14

14:15

MR. RUCK KEENE KC: Yes. So there has been an extensive body over time developed which identifies

what it means to have lack of capacity to make a decision, and then if somebody lacks capacity, what medical professionals are allowed to do.

CHAIRMAN: Yeah.

MR. RUCK KEENE KC: Getting around the problem which otherwise arises, if you provide treatment to somebody who doesn't have capacity to consent, you might be committing an assault because you're touching someone without their consent. 14:15

CHAIRMAN: Unless it is -- 14:15

MR. RUCK KEENE KC: Unless -- and the judges have made the solution, have crafted the solution of the common law to say, essentially, the doctrine of necessity means you have to be able to do this because otherwise you'd have the appalling situation where the doctor says "I can't provide treatment to this person because they can't consent", and then they don't get the treatment that they need. 14:16

CHAIRMAN: Quite.

MR. RUCK KEENE KC: So. And one way of thinking about -- sorry, just to complete that thought, in relation to declaratory orders from the High Court, that would be somebody taking the case to the High Court for a declaration, for instance, that the person has or lacks capacity or that this particular treatment is or is not lawful or whatever else might be under challenge. 14:16

CHAIRMAN: Yes. And the problem, I suppose, about common law is it relies on somebody doing that,

sometimes in quite specific circumstances?
MR. RUCK KEENE KC: Well, that relates to taking the case to court. But the common law has undoubtedly covers, without needing to go to court, a doctor's ability to provide treatment to someone who can't consent. 14:16
CHAIRMAN: Oh, yes. Of course. Yeah.
MR. RUCK KEENE KC: Yes. I mean I think, if I may say so, the real problem is that the 2016 Act, one of its really important things it was doing was setting down in statute, so everybody could see, this is what it means to have capacity or lack capacity to make a decision, this is what it means to act in someone's best interests, and so people could then be held accountable. And then it also combined with that -- and, actually, do you mind if we go back to the slides now, if that's okay? It also combined with that a set of graduated safeguards. So there was -- there's very informal things going on. Somebody -- I mean to take the example, somebody with dementia in a care home who has lost the ability to consent to being touched for purposes, for instance, of changing their underwear. You know, someone needs to do that. That's, as it were, very important. There needs to be something. That's the sort of thing which the -- at the moment is covered by the common law. When the 2016 Act comes fully into force, that will be covered by the kind of lowest level of safeguards which is essentially application of the principles and the test "Do 14:17 14:17 14:17 14:18

you reasonably believe you're acting in the person's best interests?".

I think what we explored before lunch is the fact that there are treatment safeguards contained in the 2016 Act which look in some ways a bit like those in the 1986 Order. You know, for instance, second opinion and things like that. But those haven't been brought into force yet. So as I hope I managed to explain before lunch, if you've got somebody who is in a facility, deprived of their liberty under the 2016 Act, that's providing the lawful framework which is required at both common law and European Convention of Human Rights level, lawful framework for the authority to deprive the person of liberty, but it is not providing the authority for the individual act of care and treatment, those individual acts of care and treatment are either being provided on the basis that the person is consenting or that they can't consent and the doctrine of necessity is telling a doctor you're allowed to do it. 14:18 14:18 14:19 14:19

CHAIRMAN: But you're not allowed to go back to the order to get --

MR. RUCK KEENE KC: Well, because it's -- the two things sit side by side. 14:19

CHAIRMAN: Yeah. It's become irrelevant. Yes.

MR. RUCK KEENE KC: I mean I think it is important -- I mean I -- this is much more matters to be explored with Department of Trust, other people, not me. But one

thing I think I might just point out, or it is important to know contextually, is that the DoLS safeguards, so the Deprivation of Liberty Safeguards, are intended to apply -- are for the longer term framework, and I'll come on to this in a bit, but just to say this and I'll come back to it -- in a place where care and treatment is available. So that's including, for instance, care homes. 14:19

So if you think about it, DoLS is providing a framework of safeguards to authorise deprivation of liberty in a very wide range of settings. A mental health hospital is a distinct subset of that. And what the Department -- what happened upon commencement was, if you use the -- if you can use the 1986 Order, happy to use it, otherwise it could be DoLS. But all of these things are things which from a purely legal perspective should never have happened because this was all supposed to happen at once. I hope that's reasonably clear? 14:20 14:20

I hope that page -- as I said, that's from the Statutory Code of Practice and it seemed -- doing the best I could over lunch that was the clearest way in which to kind of disentangle the two bits. 14:20

CHAIRMAN: I just wonder if we need to understand why it didn't happen all at once? Is that too contentious and beyond your brief? 14:20

MR. RUCK KEENE KC: I think it -- I don't think it really would be appropriate for me to comment.

CHAIRMAN: No. All right.

MR. RUCK KEENE KC: The only observation I would make is at the same time in England and Wales, post the decision of the Supreme Court in Cheshire West, it became very, very obvious there were an awful lot of people who were to be identified as being deprived of their liberty who hadn't previously been thought of being in that position. Because the Supreme Court made clear both the concept applies anywhere but, also, it's not just where the person is banging on the door objecting saying "let me out", and I think it may well be in part because -- I mean that's a Supreme Court decision, it applies throughout the United Kingdom, including Northern Ireland, and that's a -- so there was a kind of shift in the external legal landscape. But I think it would be inappropriate of me to go any further. 14:21 14:21 14:21

CHAIRMAN: No, no, fine. I understand. Okay. We better move into your slides again.

MR. RUCK KEENE KC: So I think that was all I was proposing to say just on that slide. Just except the last bit. That's not in force yet, the forensic diversion. 14:22

CHAIRMAN: Diversion. Yes.

MR. RUCK KEENE KC: Again, just to reiterate, when that's fully in force that's never going to be entirely capacity based. It will be capacity based essentially as to treatment but not about detention. But that's, as it were, we're not there yet. 14:22

CHAIRMAN: Yeah.

MR. RUCK KEENE KC: If I could possibly get the next slide, please?

So the next slide just looks at the -- the next slide, the subheading is slightly misleading -- oh, sorry, no it isn't. The principles are in Section 1 of the 2016 Act, and so I don't think I need to read them out. What I wanted to do was make sure that you just had them on screen and then people had them for their reference later. So they're a set of principles to think through how to approach the question of does someone have capacity? And to me, the easiest way of thinking about this is a moral compass. This is a way of thinking. So it's not the test of capacity itself, it is how are you supposed to approach it? So the presumption of capacity. The idea that you can't determine incapacity just on the basis of someone's condition. I mean we know that happens the whole time. Or any other characteristic of the person which might lead people to make unjustified assumptions.

The next one is hugely important, and I should say that the 2016 Act is much better than it's equivalent in England and Wales here. It has much more concrete stuff about supporting people to take their own decisions.

Then the last one is designed -- so people talk about it is the unwise decision principle. The last one is

designed to stop what we've seen across time, which is:

"Person agrees with doctor, person has capacity. Person disagrees with doctor, person doesn't have capacity." 14:24

That's what it's there for.

And then the best interest principle at one level isn't very interesting in the sense of what it says is: 14:24

"Acts done or decisions made for or on behalf of the person must be done in their best interests."

It is not that it is not important it's just not 14:24
interesting in and of itself because it doesn't flesh out what does it mean to act in someone's best interests, and that's spelled out in more detail later.

So those are the principles. I think I just want -- 14:25
I don't mind reiterating this, because I think it is very important to understand. 1986 Order has no principles on the face of the Order. They're retrofitted in through a Code of Practice. The Bamford process is predicated on a set of principles, the 14:25
2016 Act is predicated on a set of principles, so that anyone coming to the legislation looks at it and goes "This is how we can start holding people accountable."

CHAIRMAN: Yeah. Are you going to deal in more detail

later with what best interests mean?
MR. RUCK KEENE KC: Yes, I am. Yes. Yes.
CHAIRMAN: Because that's quite a complex --
MR. RUCK KEENE KC: Yes. Yes.
CHAIRMAN: Particularly when a person is entitled to 14:25
make an unwise decision.
MR. RUCK KEENE KC: Just pausing on that. Yes. It is
important to read -- it is necessary to read that
principle. That's the direct language of the Act and
it is important to know what it says and what it 14:26
doesn't say. So what it's saying is you're not allowed
to treat someone as lacking capacity just because the
decision they want to make is unwise. What it is not
saying is, for instance, there is a right to make
unwise decisions. 14:26
CHAIRMAN: Right. Okay.
MR. RUCK KEENE KC: And the Supreme Court -- actually,
do you mind if we just get the next slide?
CHAIRMAN: Yeah. Please.
MR. RUCK KEENE KC: The Supreme Court in that case 14:26
there, A Local Authority -v- JB, you can see referred
to at the bottom, that was the first case where the UK
Supreme Court considered what mental capacity means
under, for these purposes, materially identical
provisions. And one of the things that the Supreme 14:26
Court said was if the person has got capacity, they
have a right to make an unwise decision. It may seem
like a very fine distinction, but it is quite an
important distinction, because we, at least in England

and Wales, have learnt since the R Act came in in 2007, there have been quite a few situations where people have been left in very dangerous situations because people think there's a right to make unwise decisions, there's a presumption of capacity, who are we to intervene? Or sometimes sort of hiding behind that. And that's one of the things the Supreme Court was clarifying is, if you've got capacity to make a decision, then you can frame it under the common law, you can frame it as an aspect of your right to autonomy, you've got a right to make unwise decisions. 14:27 14:27

The only other thing I'd say is the courts are now very clear, at least in England and Wales, if you make a decision which appears unwise, that should be a trigger for people thinking do you in fact have capacity to make it? That doesn't mean you move immediately to "this person lacks capacity", but it is a trigger to -- well, sometimes I train on the basis that it's a requirement to engage your brain or professional curiosity. So it is a very, very important right, that unwise decisions one, but it is a nuanced one. If that helps? 14:27 14:28

CHAIRMAN: Yes. Yes. Thank you.

MR. RUCK KEENE KC: So in terms of "capacity", what does it mean? It means can the person make their own decision, which means for statutory purposes can they understand the information? Can they retain the information? Can they use and weigh the information 14:28

and appreciate the information, and can they communicate their decision? It's only if they can't do that that you then go on to ask, why not?

I think it's important to flag that that's very, very clear from the jurisprudence of the UK Supreme Court in relation to the Mental Capacity Act. Your code of practice, the Statutory Deprivation of Liberty Code of Practice had it that way around as well. The only reason for saying that is in England and Wales people have proceeded for rather a long period of time on the basis you started with the so-called diagnostic element, so, in other words, you started with has this person got something wrong with them? If so, then think about their capacity, which is -- 14:28 14:29 14:29

CHAIRMAN: Much more of a medical sort of approach.

MR. RUCK KEENE KC: It is much more of a medical model. It also leads sometimes, or in practice has led sometimes to, as it were, diagnostic overshadowing. So, in other words, I'm going to think this person -- I've been told this person has an intellectual disability, therefore I'm likely to think they don't have capacity. Which is clearly contrary to all the presumptions we've just looked at -- the presumptions we've looked at. So helpfully your Code had it right, so the Northern Ireland Code of Practice had it right, and the Supreme Court has made very clear, applying law which in this regard is absolutely identical. So it doesn't mean -- I mean there are a range of 14:29 14:29

complexities, but that's the order.

One thing just to mention in relation to medical, actually, just while we're there, there's no requirement -- I mean capacity is not a medical thing. 14:30
So, in other words, it's -- it's not a medical condition of having or lacking capacity. So it is not something that only a doctor can diagnose, if that's the right expression.

14:30

When it comes to deprivation of liberty, so there's kind of a capacity across the piece. When it comes to deprivation of liberty, the way the legislation works is that the capacity evidence does have to be given by a doctor. But that's because it's doing two things. 14:31
One, it is showing the person doesn't have capacity, and the second is it's giving what the European Court of Human Rights have said is necessary, which is medical evidence that the person has a mental disorder.
So it's, as it were, ticking -- it's doing two things 14:31
at the same time. But that's not because capacity generally is a medical thing. It is just for deprivation of liberty purposes there needs to be medical evidence of mental disorder.

14:31

So that's capacity. I was going to move on to best interests, if that's...
CHAIRMAN: Yes.
MR. RUCK KEENE KC: So, as I said, the principle is not

very illuminating, but what you find illumination in is Section 7 of the 2016 Act, which has a statutory checklist of factors. I'm sorry, I haven't included the Act in the papers. But it's got a statutory checklist of essentially things to do, which includes consulting with people interested in the person's welfare and things like considering whether it is likely they're going to regain capacity. But the bit I wanted to single out was the fact that it requires special regard to be given to the person's past and present wishes, feelings, beliefs and values, and the other factors they'd be likely to consider if they were able to do so. 14:32 14:32

So you'll recall in the morning we had that exchange about the convention on the rights of persons with disabilities and how that tracked with, you know, the two things were sort of happening at the same time. This is one of the aspects which is said to make it clear that we do -- this legislation does comply with the CRPD because this isn't best interests which is sometimes said to be applied for instance in the children context, which is extremely paternalistic. Because that's really what the Committee on the Rights of Persons with Disabilities, and rightly, doesn't like, which is always do what the professionals want under the code of best interests. This is making it clear there has to be special regard. So if it is very clear that the person wouldn't want to be there, or 14:32 14:33

it's very clear, for instance, that the person wants to do something which everyone else regards as spectacularly unwise, and they don't have capacity to make that decision, it is something which still has to be taken into account. 14:33

So there's an enormous body of case law from England and Wales under the Mental Capacity Act 2005, including at Supreme Court level, which is, and I've said there, is likely to be applicable in Northern Ireland in 14:34
relation to best interests, and it is drawn upon -- if you read the statutory code of practice, the language there in relation to best interest is drawing very heavily upon the language from the English courts, in particular the Supreme Court decision of Aintree -v- James. 14:34

CHAIRMAN: Can you just explain the last bullet point? "Can include harm to others where it blows back on the person."

MR. RUCK KEENE KC: Yes. Can I get to that bit in a second, if I may? 14:34

CHAIRMAN: Sorry. Yes.

MR. RUCK KEENE KC: Sorry. Sorry. No, it's a fate of putting it down on paper because then one's eye is drawn to it. 14:34

CHAIRMAN: Yeah.

MR. RUCK KEENE KC: So just to be clear, in Aintree -v- James the Supreme Court makes clear best interests is thinking about matters from the person's point of view.

It said "patient" because Mr. James was a hospital patient, but otherwise it would be "person". So the approach taken in the Northern Ireland Code of Practice and then bolstered by the statutory special regard is very clearly in that zone. But there hasn't been -- there isn't post implementation case law coming out of Northern Ireland in relation to 2016 Act squarely on it. 14:35

So the best interests test, if one thinks about it from the perspective I've just been talking about, so in other words considers matters from the patient's point of view, normally you would think, "Well, wouldn't this person -- if you knew this person was going to want to do something which everybody else would consider unpleasant and put other people in danger, well if we are considering matters from their point of view and special regard, why don't we let them do it?". So case law in England and Wales, which undoubtedly applies here, and the DoLS code of practice itself proceeds on this basis, is that you can say it's in someone's best interests not to cause harm to somebody else, say, if there are going to be repercussions for the individual. So, to take an example, if you've got someone with paedophiliac tendencies and they go and do something in relation to a small child, they might be at risk of being attacked by a parent, or they might be at risk, or somebody else in another context, they might do something which would then get them within the remit of 14:35 14:35 14:36

the criminal justice system, and that might expose them to the risk of criminal prosecution, or potentially be diverted away from criminal justice system into psychiatric detention.

14:36

That's a very recent case, that DY case was decided at the tail end of last year, and that was a flat out challenge in the Courts of England and Wales as to the logic of that position. And the court goes, "No, it is actually about the risk of harm to the person. But you are allowed to take into account the public interest through that mechanism."

14:37

CHAIRMAN: One can understand it. It is a bit of a stretch, isn't it?

MR. RUCK KEENE KC: The honest answer is I find it extremely challenging. I've called it Orwellian in writing because -- but if one is in the position where if you think through Bamford, and this may be something you want to explore tomorrow in relation to Bamford, if you think a regime which is moving from Mental Health Order provides very squarely, very expressly for risk of harm to others. There's no pretense under the mental health world this is anything about best interests. This is risk to harm, risk to self. You can really easily accommodate risk to others. If everything societally is considered to be "this must be about best interests", and DoLS has prevention of serious harm as well -- I mean Northern Ireland DoLS -- then societally, legislatively, there has to be a way

14:37

14:37

14:38

in which to take into account public interest. This is the mechanism which has been adopted. It has been stress tested -- I mean obviously what the English courts one though will say is completely sort of irrelevant, but I just thought it was important that you knew that this proposition has been stress tested in the Courts of England and Wales, and indeed the JB case I talked about a minute ago, the one in the Supreme Court, in JB's case -- which I should declare an interest in -- I acted -- I was one of the team acting in the Supreme Court for the local authority -- but in JB's case the situation is that the expert evidence is that JB cannot, as a result of his cognitive impairments, understand that the person he wants to have sex with, any person, needs to be able to consent. So he is currently subject to a framework which regulates his contact, because he doesn't have capacity to make decisions about contact, where part of the reason for ensuring that he doesn't have unsupervised contact with somebody, which might give rise to that person being sexually assaulted, is that the expert evidence is that because of his particular impairment, if he was detained in a psychiatric hospital, he'd be at very high risk of self-harm, and so he is currently in a supported living placement under those provisions, which are in his best interests. 14:38 14:38 14:39 14:39 14:39

One gets into some very complicated ethical waters, but

that's -- the courts have thrashed it through and it is very clear that your, that the Northern Ireland DoLS regime expressly includes consideration of the public interest, it is just filtered through best interests and prevention of serious harm where the serious harm could be indirectly to other people.

CHAIRMAN: Sure. Yes.

MR. RUCK KEENE KC: If that makes sense?

CHAIRMAN: Yeah. Well you call it Orwellian and I call it a bit of a stretch, but I understand. 14:40

MR. RUCK KEENE KC: Well, yes. As I said, I mean I -- I'm just in writing as having said that because I personally feel it's -- it's a difficult message to give, from personal experience, 95% of the time to say best interest is do what the person would want, and 5% of the time actively don't, and you're trying to give the same message to the same people. 14:40

CHAIRMAN: No, I understand.

MR. RUCK KEENE KC: But that's -- the law is just clear, and the DoLS Code of Practice is very clear, and this bit is active, if you see what I mean, in relation to anybody who might be at Muckamore Abbey Hospital during the relevant time, this is -- this is what is being applied, and I've no idea, and it is not for me to comment on, whether the risk factors were said to be to other people or to themselves. But at all times it would have had to have been in their best interests and risk of harm to them, serious -- prevention of serious harm. If that makes sense? 14:40 14:41

CHAIRMAN: Yes.
MR. RUCK KEENE KC: Okay. So next slide, please.

So this is -- there's going to be a slide in a second about deprivation of liberty, but I wanted to sort of back -- we've already talked a bit about deprivation of liberty, but there will be a formal slide about deprivation of liberty in a minute. I just wanted to get there by reference to the nominated person. So this is just reminding us this morning the nearest relative under the Mental Health Order, you don't really get a choice, or you don't get a choice to start with. You have to actively take steps to try and get your statutory nearest relative displaced. Here, if you're 16-plus, you've got a choice and you've got capacity to do so. If you don't have capacity then there's a kind of set of default provisions working out how to get you the nearest relative or nominated person. They're going to play an increasingly important role as the 2016 Act rolls out across the piece. But at the moment they play -- you can see the two main roles that they play in relation to deprivation of liberty. So one is being consulted. So you can see, like the nearest relative has to be consulted before an application for admission. They have to be consulted. And then they can also bring applications to the Review Tribunal.

14:41 14:41 14:42 14:42 14:42

CHAIRMAN: So the comment "will have substantial role" relies on what, the rest of the legislation being

brought into effect?
MR. RUCK KEENE KC: Yes. Yes. Yes. I mean at the moment their role is being brought into effect as much as is necessary to enable the DoLS regime to work. In due course, for instance, in relation to treatment safeguards, the treatment safeguards, they are going to have a role in relation to consultation in relation to the treatment, say. Because, obviously, what's had to happen is the Departments have to go through and say, "Well, if we're going to enact this legislation only to deal with DoLS, what bits do we absolutely have to bring in?" So that's what's gone on there. 14:43 14:43
CHAIRMAN: Yes.
MR. RUCK KEENE KC: Yeah. So they don't have the equivalent role to the nearest relative under the 1986 Order to discharge. That's partly because the way in which DoLS works in a slightly different way to detention under the Mental Health Act. 14:43

So if we could get the next slide, please? 14:44

So -- actually, I've just noticed the very last bullet point there was in terms already saying what we then had the exchange about at lunchtime, just before lunchtime. 14:44

So you asked why did DoLS come into force in December 2019? I mean as I've said there, in answer to your question, Chair, that's really predominantly a

matter for the Department to answer, but as I said there, it is really a recognition that the deprivation of liberty is a phenomena which is more widely occurring than people might have thought and undoubtedly requires formality. 14:44

Then they made provision for money, valuables and research.

One thing to flag, Panel, is that there isn't a definition of deprivation of liberty. Just like the 1986 Order doesn't say these are precisely the cohort of people we're applying it to. The DoLS legislation doesn't say: If you satisfy X, Y and Z criteria your care, if you are subject to two-to-one interventions you fall within the scope, or if the door is locked you fall within the scope, it just says "If you are deprived of your liberty". Which is one of the reasons why the case law I looked at very, very first thing this morning with you and then have come back to, about the concept of deprivation of liberty is still extremely relevant. Because the decision was taken, effectively this, this concept is going to remain judicially determined. Because they could have said, and various other countries have said, "we will identify or set it down". 14:44 14:45 14:45 14:45

CHAIRMAN: Could have defined it.

MR. RUCK KEENE KC: Yes. It was a -- England and Wales didn't do that. Northern Ireland didn't do it.

What there is is, in the DoLS Code of Practice, the statutory code sort of thing I showed you an extract from, there's guidance as to what deprivation of liberty looks like which, unsurprisingly, follows the sort of case law I've been talking about. And, in particular, emphasises the concept that deprivation of liberty has to be applied in a nondiscriminatory fashion. And you need not to get confused by "we're doing this for a beneficial reason" to then think, "well, we're not the depriving this person of their liberty". Or to put it another way round, one person's act of care and support is another person's confinement. That's the point Lady Hale was really seeking to make in Cheshire West and has really been internalised and operationalised in the DoLS Code of Practice. 14:46 14:46 14:47

So a little bit like with the 1986 Order, there's twofold approach. One is there's either short-term detention or longer term detention. The most important thing to note is that longer term detention can take place not just in hospital, it's a place where appropriate care and treatment is available. So that can include, for instance, a care home, it can include someone's own home, say. And it requires an HSC Trust Panel authorisation, so a Panel of three people has to consider and determine whether the criteria are met. So you can see that's -- it has got the same thinking of there needs to be more than one set of eyes on this 14:47 14:47

and there needs to be more than one discipline involved, but actually it ramps up the protection significantly because there's a degree of formality by having to go to a group of people who are operationally independent, because they may well be employed by the same Trust which is actually seeking to detain the person, but they have to be operationally independent of the people making the decisions. 14:48

And that last bullet point is the one we -- I explored by reference to that passage from the Code of Practice. So the authorisation is only about the deprivation of liberty. So the arrangement giving rise to the deprivation of liberty. It's not about the individual act of care and treatment. 14:48

CHAIRMAN: At some stage it may be that we'll hear evidence about what -- how appointments to the HSE Trust Panel are made and of what they comprise.

MR. RUCK KEENE KC: Yes. I mean the statute provides a framework for how things are done. I think, Panel, Chair, it is going to be likely to be of most assistance that you, as it were, get the direct evidence from how that's done, whose on it, those sort of things, from someone other than me. 14:49

CHAIRMAN: Absolutely. Yes. 14:49

PROF. MURPHY: So can I just ask, short-term detention, it has to be in hospital, does it? It couldn't be in a care home.

MR. RUCK KEENE KC: Yes. No.

PROF. MURPHY: It seems a strange logic to me.
MR. RUCK KEENE KC: Well I think it -- well I think you might have to explore the underpinning rationale with say the Department of Health, but I think it is partly to do with -- there's -- it's a potential distinction between it's a short-term crisis where what we need to do is have the person somewhere where you can look at them intensely, decide what they need, and that probably may be more likely to be in hospital, versus a situation where we know roughly what the problem is and we're trying to work out how to address it, which could be taking place anywhere. 14:50 14:50
CHAIRMAN: So it is regarded really as an emergency provision in a sense.
DR. MAXWELL: Well it's assessment. 14:50
MR. RUCK KEENE KC: Yes. Yeah. Well it is assessment, but it could also be "I've got somebody in a physical health hospital, so not a mental health hospital. They are confined, they can't consent, their circumstances give rise to a deprivation of liberty, we need to have something lawful in place around them." 14:50
PROF. MURPHY: The problem is that if there's a crisis then you're forced to use a hospital, it seems to me.
MR. RUCK KEENE KC: Well, no, because you could -- no, no, no, because you could go immediately to seeking Trust Panel authorisation. It is not -- sorry, maybe I should have been clear. It's not that you do short term and then longer term. You could go "actually, this is going to be a situation which is not 14:50

going to be resolvable in the short term" or "we're trying to do something which isn't in hospital".
I think one of the things is its --
PROF. MURPHY: It is just that very often if there's a crisis in a person's care, what you need is a brief period somewhere else, but not necessarily in a hospital, it seems to me. This seems to be locking you in to a hospital. Maybe respite care, for example, would have resolved the matter.
MR. RUCK KEENE KC: So I think the two things I might -- that's a very good question. There are two things I might say. One is there's nothing to say that the application can't be got up and running to an HSE Trust Panel for what looks like it might be a longer term authorisation which actually ends up not being able to proceed because the respite has now been sorted out, or the respite has done what it is that people think is necessary, because then at that point the whole process stops, if you see what I mean? Because the Act provides -- it doesn't say "until you've got that authorisation in place in a genuine emergency you're not allowed to do anything". So that's one answer.

The other answer is its probably, I suspect -- well, it may be something you find of assistance to get evidence from the clinicians involved and from those involved in kind of thinking about how do we address crisis situations in the community at an operational level

rather than from me, as it were. Because there's the distinction between what the law says and then how people respond. And a lot of it, I think entirely neutrally, is down to what provision is actually available in the community to enable situations. 14:53

But, yes, sorry, just to be clear, it is not that you're only allowed to do -- to go to the longer term Trust Panel authorisation once you've been through the short term. So it is not like the -- so one of the 14:53 kind of mind shifts you need to make, if you're familiar with the 1986 Order, is very much you're only allowed to go to the treatment provisions once you're in hospital to deal with this on the assessment side. That's different. Because this is not just -- if you 14:53 think of all the situations this is covering, it is not just in-patient admission for assessment and treatment of mental disorder. This is people going into a care home, this is somebody being looked after in an adult foster care placement. This is someone being looked 14:53 after at home. So it is trying to cover a much, much bigger range of situations. But, yes, at a fundamental level though, if the only response available is a medical provision in hospital, that's a kind of very important issue, but that's not really being addressed 14:54 in terms by this legislation. If that makes sense?

Okay. So can I get the next slide, please?

Really, although there's a lot of text on here, I probably don't need to grind through it in horrible detail. This is just making clear there's a route of challenge to the Mental Health Tribunal which is now 14:54
doing two things. It's now hearing cases coming in under the 1986 Order and it's hearing cases coming in under DoLS. So, you can apply, your nominated person can apply, if you've got capacity to make the application, you have to agree to your nominated person 14:54
doing it. Then there are a series of -- sorry, chair.
CHAIRMAN: No, I read that. If you don't have capacity it doesn't prevent the nominated person from applying.
MR. RUCK KEENE KC: Yes. Yes. But if you do, it does because you effectively get one bite of the cherry per 14:55
period of detention.
CHAIRMAN: Right.
MR. RUCK KEENE KC: It would be extremely unfortunate if your nominated person made an application too early.
CHAIRMAN: At the wrong time. 14:55
MR. RUCK KEENE KC: At the wrong time, because actually what might be going on is things might be being ameliorated and then you've lost the opportunity.
CHAIRMAN: Yes. And it's normally six-month periods.
MR. RUCK KEENE KC: Yes. Six months, six months and a 14:55
year at a time. And the rest there are a series of safeguards to make sure that if you yourself or the nominated person hasn't got their act together to bring an application, somebody is going to make sure it gets

to court, to the Tribunal. I'm aware there have been a significant number of applications by the Attorney General discharging the very important function of making sure that people who are in situations where they're not able to speak up for themselves are having things done. And just bearing in mind again this is applying to just a far greater cohort and range of condition and sorts of people than the 1986 Order stereotypically applies to. 14:56

CHAIRMAN: Sorry, again, in what circumstances does the Attorney General get involved? 14:56

MR. RUCK KEENE KC: As you can see the third bullet point -- the second one very rarely -- I'm not sure actually happens. The third one is where it happens.

CHAIRMAN: Oh, I see. 14:56

MR. RUCK KEENE KC: So there's a DoLS authorisation in place. The person doesn't have capacity at the six-month point to say, 'I want to make an application.' So the person in HSB Trust has to tell the Attorney General, and then the Attorney General refers the matter to the Tribunal. So many of those -- and I think one of the things to flag there, many situations are likely to be ones -- may well be ones where the reality is there's no prospect of discharge, this is a person being cared for in a care home with dementia, actually there's no specific reason to think -- I mean they may not be happy but there's no specific reason to think the care is overly restrictive. There is, in reality, nowhere else they 14:57 14:57

could be cared for. So it's a very important aspect of Article 5(4), making sure there's regular review, but it's not as if this is going to be a highly contested argument. As I say, anyone who is familiar with the 1986 Order or with mental health legislation, I know 14:57
from experience and having worked helping here in Northern Ireland with getting people up to speed, it's quite a shift in mindset to the cohorts of people now coming before the Mental Health Review Tribunal compared to the cohorts of people who were previously. 14:58
Obviously they've now had, since December 2019, to have experience of doing these cases but it's been quite a change.

I was then going to move on to the next slide, unless 14:58
there were any other questions.

CHAIRMAN: The last bullet point, HSE Trust to refer where extended for a subsequent time, is that a direct referral or again a referral having nudged the AG --

MR. RUCK KEENE KC: No, it's direct referral. That's 14:58
really, really backstop. Nothing has happened and they --

CHAIRMAN: Yes.

MR. RUCK KEENE KC: We sort of covered this earlier but this is the bit I referred to a couple of times when we 14:58
were discussing things earlier. This is the thing which should never have happened in the minds of the legislature when they were enacting the 2016 Act, in the sense that when the 2016 Act came into force, it

was supposed to be one piece of legislation applying across the piece age 16 plus, and there wouldn't have been a need to kind of navigate the interface between the Mental Health Order and the Mental Capacity Act.

DR. MAXWELL: Why didn't that happen? 14:59

MR. RUCK KEENE KC: I think you'd have to ask the Department of Health.

DR. MAXWELL: Okay.

MR. RUCK KEENE KC: I can't comment --

DR. MAXWELL: As a non-lawyer, it seems to me if 14:59
there's legislation, there's legislation. But you're saying it's discretionary and the Department of Health have a discretion about which parts to implement, is that correct?

MR. RUCK KEENE KC: It's not just the Department of 15:00
Health, it's up the Parliament to decide, the Northern Ireland Assembly to say which bits are -- it has been enacted, which bits come into force. And it is partly a question of the resources required and to enact the entirety of the Mental Capacity Act would require, 15:00
undoubtedly, significantly more resources in terms of having to resource treatment safeguards in a lot of situations, to resource advocacy in a lot of situations which don't currently exist. So the decision -- in a way it's not really for me to answer but the decision 15:00
must have been taken and there may well be explanatory material.

DR. MAXWELL: We can ask other people but there are decisions made about how to enact, or how to implement

the act. We need to ask somebody else who made those decisions and how.

MR. RUCK KEENE KC: I should say, it is not unknown, and in England and Wales as well, for a decision to be taken that things are brought into force in a sequential fashion or a staggered fashion. So you could do one bit first, then you do a bit, then you do it a bit, then you do another bit. So, I shouldn't really comment further on why. But what I would -- it's a very fair question. What I would comment on is it has led to a situation which should never have happened, which is people are having to decide is this a person who could be detained under the 1986 Order if they are, use the 1986 Order. If they are not a person who could be detained, do you use the 2016 legislation? And the exchange we had before lunch about, well, who could be in a hospital, a mental health hospital subject to the 2016 Act? It just shouldn't -- either everybody should have -- I mean when the legislation was passed either everyone would be there on the basis -- well, when the 2016 Act was passed, the intention at that point would have been everybody would either be there on the basis of their capacitous consent or under the provisions of the 2016 Act with the one, I suppose, important exception, if they were under 16 because the 1986 Order was always going to remain in place for under 16s. But that wasn't in relation to adults. Then you do get to that situation where you will have somebody in the bed or the room

15:01 15:01 15:01 15:02 15:02

next door who is under -- they're under two different bits of legislation.

So one of the things I anticipate you might be wanting to think about is the reasoning underpinning in relation to individual people why that choice was a made. But that would be entirely inappropriate. I won't comment on that because I think I shouldn't. 15:02

CHAIRMAN: This wouldn't, as it were, be exceptional in terms of a large piece of legislation in a relatively small piece of which has been actually brought into force? 15:03

MR. RUCK KEENE KC: Not at all.

CHAIRMAN: It happens across the board, fortunately or unfortunately. 15:03

MR. RUCK KEENE KC: I think it's very important to get that really, as it were, on the record.

Just to give one analogy: England and Wales are thinking at the moment about updating their mental Health Act and it's going to be very clear, if you read the underpinning documentation, certain bits will come on stream at one point, certain other bits can only come on stream when there's enough resources to provide for a greater pool of advocates, if you see what I mean? Because you cannot bring legislation into force unless you know you have got the resources to deal with it, otherwise you've almost got the worst of both worlds, which is you're then creating entirely 15:03 15:03

false expectations.

Chair, I was then going to stop in relation to -- not stop all together, but I was then going to stop in relation to the 2016 Act. Then I've got bits on -- 15:04

CHAIRMAN: How much longer do you think you have to go? 30 minutes?

MR. RUCK KEENE KC: I would have thought so, something like that.

CHAIRMAN: Shall we take a short break just to refresh everybody's brain. We'll try and make it ten minutes. 15:04

MR. RUCK KEENE KC: I wouldn't mind a small break, actually, if that's okay.

CHAIRMAN: We'll just take a 10-minute break.

15:04

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

MR. RUCK KEENE KC: If I could get the next slide, please.

15:18

So, the very last bit I was asked to cover was essentially the law everywhere else. So, I want to just take you through England and Wales, Scotland, the Republic of Ireland and then a couple of final points on wider international development. 15:18

So, in England and Wales there's the Mental Health Act 1983 which, as I say, has got a strong resemblance to the 1986 Order because it really comes from the same

vintage, mid-20th century regulation of coercion. It's got some differences, for instance, it's got a less restricted definition of mental disorder. Northern Ireland Mental Order, you can't detain on the basis of personality disorder; Mental Health Act 1983, it is possible to detain. You then get into all these questions about what's appropriate treatment, say. It has got a question mark less restrictive criteria for admission. I mean, these are really kind of technicalities so I don't propose to grind through them in detail but these are just some of the main differences. 15:19 15:19

The 1983 Act allows immediate detention to treatment as opposed to the 1986 Order where you detain to assess and then make a decision to think about treatment, detention later. A big difference is the fact that there are Community Treatment Orders. So, in other words, somebody could come into hospital and then be placed on a framework outside hospital to enable treatment support within the community. There's also what the 1986 Order doesn't have, the 1983 Act has got specific aftercare provision. Section 117, if you've been detained on the longer term treatment, not just the assessment, the longer term treatment, you have a right to free aftercare, effectively to minimise the chances you might be readmitted. It was last amended in 2007. There was a process under way to consider amending. Again, as I said, I was the legal adviser to 15:19 15:20 15:20

the review which reported in 2018. There's a draft Mental Health Bill which was put before Parliament for scrutiny last year, the Government are now thinking what will they do? Just to say there, there's no suggestion of following the Northern Ireland lead, so fusing mental capacity and mental health legislation, but very much the idea of Northern Ireland as a testbed for fusion. So if at any point I sounded personally frustrated that Northern Ireland has not fused, it's in part because it's making life in England and Wales more complicated because we would like there to be fusion so we can see how it works. That's not the only reason, but that's a reason. 15:21 15:21

Then there's the Mental Capacity Act 2005 which looks very, very similar in lots of ways to bits of the Mental Capacity Act 2016 we looked at. So it's got very strong resemblance in terms of the idea of the capacity, the idea of best interest. There's a less well-developed -- or put it the or way round. The 2016 Act has a much more carefully graduated series of safeguards in principle. We have seen they aren't in force yet but they are a much more carefully calibrated set of safeguards for serious intervention -- 15:21 15:22

CHAIRMAN: Just so I understand, by comparison, how much of English version is in force?

MR. RUCK KEENE KC: It's completely in force. It entered entirely into force on 1st October 2007. In

2009 there was -- what was introduced was, as I say there, a framework for the administrative organisation of deprivation of liberty. So that was to sit alongside the Mental Health Act, admission to care home or physical health hospital or possibly mental health 15:22
hospital, basically a care home or hospital to provide care and treatment where the person can't consent of their admission. We created, in England and Wales, a system where we had an interface, we still do have an interface. You have to decide is this person a mental 15:23
health patient? Are they a physical health patient, if you're in hospital. And if they're a mental health patient are they an objective mental health patient? In which case you have to use the Mental Health Act. Are they not objecting, in which case you have a 15:23
choice. And, Chair, you are not alone, everyone finds it horrendously complicated. It's unfeasibly complicated and you are also having to decide some very peculiar things. Somebody with schizophrenia and gangrene; are they a mental health patient, are they a 15:23
physical health patient? Well, no, the reality is they are a person who needs help. But the law in England and Wales requires you to classify, and unfortunately the law in Northern Ireland requires you to classify as well. 15:24

CHAIRMAN: Luckily, we may not have to go into great detail on this, but even though the Mental Capacity Act in England came into full force, there are still parts of the Mental Health Act that apply.

MR. RUCK KEENE KC: Yes.
CHAIRMAN: So you've still got two regimes, as it were, running?
MR. RUCK KEENE KC: Yes. There's no appetite in England and Wales to fuse, to abandon, to get rid of the Mental Health Act. We are stuck with, and Government has said, we're going to maintain -- I mean it particularly relates to in-patient admission where somebody can't consent. It was, I have to say, I think one of the factors leading to thinking that the 2016 Act in Northern Ireland was a good idea was that the experience of trying to operate this interface was so horrible that one of the actual kind of actual advantages of getting rid of it is you then don't have to make these decisions, it's just does this person have capacity or not? Which at the risk of sounding like a stuck record is why it's so important that you are -- currently professionals and families are people involved are having to grapple with an interface which legislatively was never meant to exist. 15:24 15:24 15:24 15:25

I would say that the framework in England and Wales for authorisation of deprivation of liberty, so-called DoLS - we use the same acronym, is widely recognised not to be working. There is an intention to replace it, to give another go round. It's, as I say there, in limbo. So we don't know what's happening with the replacement of the DoLS regime. 15:25
CHAIRMAN: And would the '16 Act face the same problem?

I mean you may not have done this comparison, but would the '16 Act in Northern Ireland face the same problems if it were fully brought into force?

MR. RUCK KEENE KC: The big advantage from -- well, a huge advantage of the 2016 Act over the English and Welsh legislation is it's not place-specific. The 2016 Act in Northern Ireland is a place where appropriate care and treatment can be provided, which could be in someone's own home; it could be in a supported living placement. So there's the framework for thinking it through, checks and balances, done. England and Wales was always focused on -- and it's just reflecting of the changing international environment. In 2009, people only ever thought of detention as an institutional thing. Supreme Court comes along in 2014, points out, no, this is happening everywhere. And so the English and Welsh legislation only provides the ability for an administrative check and balance if it's hospital or care home 18 plus, hundreds of thousands of people not in that zone, the liberty protection safeguards which is what is supposed to come into force to replace it, much bigger scale.

15:26

15:26

15:26

15:26

Going back to the question from the Panel member about resources and implementation, it's people quailing at the amount of resources required to bring in an administrative detention framework covering essentially every single person with complex care needs in England and Wales over the age of 16 is, I think, what's

15:27

causing the issue. I won't go on about that more because the focus of this Inquiry is obviously not on the issue of --

CHAIRMAN: No. Quite. Okay.

MR. RUCK KEENE KC: So that's the Mental Capacity Act in England and Wales. So in Scotland, by 2003 the Mental Health (Care and Treatment) Act, that was very firmly principles-based. And that was really one of the things that I think Bamford and those working on the Bamford Review were looking across to Scotland and saying isn't it important they've got principles-based mental health legislation? 15:27 15:27

There, the big distinction between Scotland and the other jurisdictions is the Tribunal is really involved from the outset as opposed to detain first, then challenge. Here, in general, especially for anything longer term, the Mental Health Tribunal is doing the authorising as opposed to detain, then challenge. 15:28

CHAIRMAN: So, the psychiatrist, presumably unless it's an emergency? 15:28

MR. RUCK KEENE KC: Yes, they're short-term things. But if it's anything longer term, the intention is you go to the Tribunal, the Tribunal then authorises a Compulsory Treatment Order, which could be in the hospital, it could be in the community. And the Scottish legislation has got a capacity element in it. So their mental health legislation, you've got to have significantly impaired decision making and mental 15:28

disorder.

Then the 2000 Act - slightly predating it - is the Scottish equivalent of the Mental Capacity Act. In fact, as a matter of interest, it was the very first piece of legislation passed by the devolved administration when they got legislation-making powers in the Scottish Parliament. That's based on capacity. It's not technically based on best interests, it's based on benefit. But one ends up in a similar sort of place, focus on the person's wishes and feelings. 15:29 15:29

The Scottish legislation is much more based on the idea of somebody needing to have formal authority. So the Mental Capacity Act in England and Wales and in due course when the legislation is fully enacted here, the 2016 Act, is you don't always need formal authority to do things if it's a lower level intervention. The Scottish legislation is much more heavily based on someone having to be appointed to do something as a guardian, or sometimes doctors authorising treatment in hospital. It's just a function of the fact -- I think it's largely a function of the fact that it's reflecting a very different legal tradition in Scotland. And they don't have any equivalent to Deprivation of Liberty Safeguards at all. Either the Northern Irish version or the English version. They have been grappling with -- I remember meeting the Scottish Law Commission team at the back of the court 15:29 15:30 15:30

in the Supreme Court decision in the case of Cheshire West, they came down to see what the law was looking like it was going to be and they've been working since 2014 to try and implement some kind of framework. They haven't yet.

They've separately got something which neither Northern Ireland nor England and Wales has, which is a standalone piece of legislation, the Adult Support and Protection Act where an adult is at risk. So that's not capacity based. That's, for instance, someone who appears to be subject to coercion in their own home, there are a range of things that could be done.

CHAIRMAN: Sorry, so under which of these Acts does deprivation of liberty or the equivalent of --

MR. RUCK KEENE KC: The 2003 Act has got a framework to detain in hospital. Deprivation of liberty other than in hospital is currently there is no legislative framework. Where people are taking appropriate steps it is going to the sheriff court in Scotland and getting judicial sanction, quite often by appointing a guardian with power to do something.

I think it's fair to say it's widely realised, in particular, by, for instance, the Law Society in Scotland, which I sit on, but I know that they have been extremely concerned about very large-scale unlawful deprivation of liberty in Scotland for people with dementia, people with learning disability, because

there isn't the administrative framework that there is in Northern Ireland, there isn't the administrative framework, clunky as it is in England and Wales. That's the current position.

15:32

I was going to move on to the next slide. This is a bit of a whistle-stop-tour.

CHAIRMAN: I think it can be.

MR. RUCK KEENE KC: One thing about Scotland, it merits two slides, because I've just given you the current position, this is where they're going. John Scott, now Lord Scott, now the equivalent of a High Court Judge in Scotland, was commissioned to undertake a review of all mental health, mental capacity and adult support and protection legislation in Scotland, so the Scott review of Scottish legislation reported in the summer of last year. Their report looks like a much longer version of the Bamford report in the sense that it's not legislating, it's setting a direction of travel. It's really in some ways significantly different to what the Mental Capacity Act 2016 look like. It's much more focused on the idea of positive rights. So, in other words, the rights for people to get support within the community, the rights for people to get medical treatment as opposed to the regulation of what happens if someone doesn't have capacity or we need to detain. So, it's actually very strongly influenced by the CRPD.

15:32 15:32 15:33 15:33

If Bamford was kind of 21st century thinking, this is

kind of mid or middler 21st century thinking. And there's a real suggestion of also trying to move away from the idea of capacity to autonomous decision making, which captures things like you may technically pass the test for being able to understand, retain and use the information but actually you're under someone's influence. They're trying to think that through. 15:34

I should say it's a very detailed report. A lot of what they're suggesting legislatively is very much direction of travel. The Scottish Government are currently working out how to respond. One thing they didn't really do was say let us go down the fusion route in Scotland in the same way that Northern Ireland has done. But it's very radical, very challenging proposals. Challenging in terms of how services are currently constituted. 15:34

So that's Scotland.

The next slide, please. Republic of Ireland. That's the term I'm using. I hope that's appropriate. 15:35

So there, similar to here, at the moment there is separate mental health legislation and mental capacity legislation. So, the mental health legislation in Northern Ireland feels a little bit similar to here and the 1986 Order in the sense that it's got mental disorder but it then is more focused on the idea of 15:35

impaired judgment and then best interests. And they have a rather stronger idea of immediate early access to a Mental Health Tribunal. So it sort of sits halfway between Northern Ireland and Scotland. They are in a process of - and it's been quite a long process, but in process of thinking about ways to reform their mental health legislation. I mean it's a running theme, all of these things take up quite a long time. 15:35

Separately, there's the Assisted Decision Making (Capacity) Act, which was passed in 2015 and within the last month it's been announced it's coming into force in April 2003. So, in other words, the end of this month. 15:36

CHAIRMAN: It's taken eight years.

MR. RUCK KEENE KC: Yes. Actually, just to give an example of a piece of legislation which was enacted in stages, that is one, because part of the 2015 Act came into force early on to allow the Decision Support Service to be set up, which is going to be very important as part of the legislation in due course, the rest hadn't. People really were beginning to wonder what's happening, but it is coming into force next month. There, there's a very strong emphasis on supporting decision making and co-decision making. So, in other words, if someone has got a condition which they might be able to make decisions with someone to assist them, they can formally appoint someone to make 15:36 15:36

decisions alongside them, rather than moving towards actually they don't have capacity, let someone else make that decision. They have a similar functional idea of capacity to that which exists here. What they don't have is any requirement that the inability to make the decision is because of an impairment or disturbance in the functioning of the mind or brain, which they are going to be grappling with. So, in other words, all - "all" - you have to establish is that the person, for instance, can't use the relevant information. You don't have to say "and that is because the impact of the intellectual disability means they can't use away." They took a decision they wanted to have a purely, purely functional test. We will have to see, I mean again I'm a purely interested bystander, we will have to see how that tracks out. They don't use best interests --

15:37

15:37

15:37

CHAIRMAN: I was going to ask you that.

MR. RUCK KEENE KC: -- because, in very significant part, because they wanted to -- the Irish legislature were very, very keen to make sure or very keen to try and to comply with the CRPD and the language of the CRPD is respect for rights, will and preferences. So, the 2015 Act in the Republic of Ireland is firmly based on will and preference. So, the language of best interest just doesn't apply. But I'm duty bound to say the distinction between a will and preferences approach and an approach which says put yourself in the shoes of the person actually collapses down quite significantly.

15:38

15:38

CHAIRMAN: What do you mean it collapses down? It comes to similar --

MR. RUCK KEENE KC: Exactly. The CRPD Committee's view is that best interest is inherently paternalistic and inherently will give too much weight to the view of the professional. If you have an approach which says start with what the person wants, you probably end up quite often in a relatively similar place. Obviously, they are going to have to grapple with what happens where the person's will and preference is to do something which harms other people. They don't have any equivalent to DoLS so there is no statutory framework for what happens to all the people in care homes, say, who don't have capacity to consent and are confined. They are working on - again this sounds like a running theme - they have been working for a while on some form of administrative framework akin to DoLS here. 15:39 15:39 15:39

Chair, members of the Panel, by way of sort of aide-memoir, one of the documents, the very first document I referred you to this morning is a kind of bullet-point framework of all of them. It's pretty bullet pointed but it's occasionally helpful, I find, to be able to look, kind of visually compare across the piece just to see where people are thinking and what they're doing. 15:39 15:40

That was all I was going to say about the Republic.

Can I just finish off on one last slide on kind of much more on where do we go? Not much where do we go, but if I started this morning with everything has to be seen in the changing international context, if I can come back to that now. So, as I say, there is this continuing debate whether compliance with the CRPD requires abolition, or even capacity-based legislation providing for involuntary care and treatment. So, in other words, if you're going to comply with the CRPD as a state, are you going to have legislation, such as the 1986 Order which allows for detention on the basis of mention disorder and, even if you abolish that and you had full introduction of the 2016 Act, are you allowed to have that because that's still allowing for involuntary care and treatment, it's just limiting the cohort to those people who don't have capacity to decide on admission. And the CRPD Committee, as I said, have got very clear and very strong views that they don't consider that the concept of mental capacity has validity as a concept. 15:40 15:40 15:41 15:41

CHAIRMAN: Out of interest, do you know of any country in the world that has really adopted the CRPD and gone with it legislatively?

MR. RUCK KEENE KC: So, the short answer is yes, but the longer answer is you can only understand what they've done by understanding the entire legislative picture in the country and then, when you understand that, you realise the answer is not really what people think. Can I just unpack that, because it's far too 15:41

late in the day to be cryptic.

For instance, the CRPD Committee routinely points to countries in Latin America as CRPD-compliant because several countries, for instance Peru, have abolished the idea of incapacitation within their constitutions. So, previously you could be legally incapacitated, so you could be declared to be non-person, effectively. So they've abolished that so it makes it sound like everybody is always seen has having legal capacity. What you then realise, if you actually go and look, is that, for instance, you will have a law called something like an emergency health law which says, in an emergency you can be admitted and detained. At which point you think, well there's very -- I'm not downplaying the symbolism but you do start realising, actually that feels rather different to the picture that, actually, we're in a place where all treatment and all care is always on the basis purely of the person's consent. 15:42 15:42 15:42 15:43

I mean it's definitely right to say that the CRPD has hugely influenced law reform since it came fully into effect. I mean it already had the impact in Northern Ireland you saw with the 2016 legislation of let us make sure that we give special regard. I mean that's something which probably wouldn't have happened but for the CRPD. I've just given you a couple of examples there. 15:43

Norway has really moved to a much more capacity-based mental health legislation. Northern Ireland, as it were -- as far as anyone knows, Northern Ireland was the first to legislate for purely capacity-based legalisation difficulties, it wasn't fully brought into force. Norway did and has. Then people are tracking through, with some considerable interest, seeing whether the rates of detention go up or down. Then it's certainly provoking lots of interest in law reform in different places. So, for instance, Scotland, they really are, or the review was really trying to internalise what does CRPD compliance mean? But even the Scott review took the perspective that actually there are going to be circumstances under which it would be, well I'm going toe use an editorial term "unethical" to say actually we're not going to proceed here because actually if this person is really not in a position where they can say yes or no, we need to do something. That's been the approach of courts, which have really grappled with the CRPD, for instance the German Federal Constitutional Court in a decision a couple of years ago, said what do the CRPD Committee want us to do? In a situation where somebody doesn't have capacity, applying any form of understanding of that, just does not seem to be able to understand, they need life sustaining treatment, they're not seriously suggesting we don't treat. No, they aren't, we must provide authority to treat. But it's definitely right

15:43 15:44 15:44 15:44

that it's provoked a lot of discussion and a lot of news.

The last point, and I really would want to emphasise this if I may, I said this morning and then again, increasing recognition of all the non-legislative tools which can be used to reduce coercion. So, in other words, it's not what's on the letter of the law, it's all of the things which sit around which are professional codes of conduct, it's professional ethics, it's are there evidence-based interventions which actually encourage people to realise, you know, we don't need to automatically default to this, and all of those sorts of things. One of the things that the CRPD has really provoked, and I've given you the reference to that literature review, there's an increasing body of empirical evidence of interventions which actually mean you don't have to get to the point of thinking about the hard-edged stuff. That wouldn't have happened, as it were, but for the CRPD and that's a kind of continuing international trend. 15:45 15:45 15:45 15:45

I think, Chair, that was it.

CHAIRMAN: You've done it in brilliant time as well. 15:46

I don't know if counsel to the Inquiry has any questions he wanted to ask?

MR. DORAN KC: No questions at this stage, Chair, but I did want to say something about the process of asking

questions or raising questions in relation to what the speaker has said today.

CHAIRMAN: Yes.

MR. DORAN KC: Obviously, we covered a lot of ground thanks to our speaker. I suspect the same observation will apply tomorrow morning when we'll be hearing from Prof. Roy McConkey on the first three topics in Module 1. I mentioned earlier that all Core Participants will have an opportunity, at a later stage, to put forward questions or issues arising from the first two presentations in Module 1. This should be done, obviously, through Inquiry counsel and we will then relay the questions and issues, as appropriate, to the speakers. 15:46 15:46

Now, we may at a later stage have a further oral session involving the two Module 1 presenters or we may conduct the exercise in writing. We can make a judgement call on that at a later stage. 15:47

CHAIRMAN: We'll do it remotely or however we can do it. 15:47

MR. DORAN KC: Yes, indeed. But I think, Chair, what we propose to do is to send round a note after tomorrow's session to all the Core Participants just outlining how we intend to proceed. I should say that my remarks are confined to the two Module 1 presentations, obviously as regards all of the other witnesses who will be giving sworn evidence over the next period of weeks, the normal procedure applies for 15:47

the furnishing in advance of questions to Inquiry counsel.

CHAIRMAN: Sure. So we're not, as it were, encouraging direct contact with Prof. Ruck Keene, everything should be done through Inquiry if it is Inquiry related. 15:48

MR. DORAN KC: Yes, indeed, Chair.

CHAIRMAN: All right. Thank you.

Can I say, I think your students are very lucky because you turned something which could have been extremely 15:48 dry and, frankly, incomprehensible into something that was fascinating. So thank you very much indeed for your time and for your presentation.

MR. RUCK KEENE KC: Thank you.

CHAIRMAN: I think you can now go with the Secretary to 15:48 the Inquiry. Thank you very much indeed.

Tomorrow at ten o'clock and it will be by video.

MR. DORAN KC: Yes.

CHAIRMAN: Thank you very much, everyone. 15:48

THE INQUIRY ADJOURNED UNTIL TUESDAY, 21ST MARCH 2023 AT 10:00 A.M.