Mental Capacity Law Newsletter August 2014: Issue 49

Compendium Issue

Welcome to the August issue of the Mental Capacity Law Newsletter family. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Newsletter: a very important medical treatment about life-sustaining treatment and MCS, a difficult case about capacity and pregnancy/contraception, deprivation of liberty in children's homes and the Law Commission's project on deprivation of liberty;

(2) In the Property and Affairs Newsletter: cases on revocation of EPAs, capacity and tenancy agreements, and the Law Commission's project on wills;

(3) In the Practice and Procedure Newsletter: an important case on when to hold a fact-finding hearing, a challenging case on the inherent jurisdiction and care management, the end (for now) of the *Redbridge* saga, and news of an important appeal on nominal damages for unlawful detention;

(4) In the Capacity outside the COP newsletter: an update on the work being done to assess the compatibility of the MCA with the CRPD, news of the consultation on the draft MHA Code of Practice, news of the Northern Irish Mental Capacity Bill

(5) In the Scotland Newsletter: an update on the legal consequences of delaying reporting by MHOs in welfare guardianship applications, news of the MWC's most recent investigation, and an important case on capacity to consent to sexual relations.

We are now taking a break and will return in early October, although will send out newsflashes where necessary (including as regards the post-*Cheshire West* cases). Enjoy your summer!

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Hyperlinks are included to judgments; if inactive, the judgment is likely to appear soon at www.mentalhealthlaw.co.uk.

Contents

At the outer edges of risk

The Mental Health Trust/The Acute Trust & The Council v DD and BC (Number 1 and Number 2) [2014] EWCOP 11 & [2014] EWCOP 13 (Cobb J)

Medical treatment – deprivation of liberty

Summary

Both these cases concern DD, a 36 year old woman with a mild to borderline learning disability and autism spectrum disorder. At the time of the hearings she was at an advanced stage of pregnancy. She had what the judge described as "*an extraordinary and complex obstetric history*" and was expecting her sixth baby. DD's five children were all cared for by permanent substitute carers and four of the children had been adopted.

The first case – DD (No.1)

The Applicants sought declarations and orders in relation to the care and health of DD during the final stage of her pregnancy, and in the safe delivery of the unborn baby. Specifically, the Applicants sought:

1. a declaration as to the lawfulness in arranging for DD's baby to be delivered by planned caesarean section;

2. a further order authorising the conduct of an assessment of DD's capacity to make decisions around contraception, following the birth.

The judge made clear that "*the rulings in this case challenge the most precious and valued human rights and freedoms. Authorisation for the deprivation of DD's liberty and for the use of restraint (even for a short time) is sought, as is permission to intrude, by force if necessary, into the privacy and sanctity of her home. Steps to promote her physical health and well-being, it is argued, require a physically invasive medical procedure, to be conducted under general anaesthetic*". The judge concluded that he was "*acutely aware of the unusually onerous responsibility which* [fell] *upon* [him] *sitting as a Judge of the Court of Protection in determining this application*".

The judge considered that it would be right to authorise and render lawful the course proposed by the Applicants in relation to the planned caesarean. He considered that it was in DD's best interests to authorise the caesarean and associated actions (which included forced entry into her home, restraint and sedation) even though he was conscious that to do so would inevitably have profoundly distressing consequences for DD. He did not authorise the one day assessment of DD's capacity to make decisions about contraception and refused that part of the application.

The judge recorded that the Applicants (the body which provided DD with mental health services, the body that would provide medical obstetric treatment and the relevant local authority) had worked closely and collaboratively in seeking to resolve the exquisitely difficult issues in the case. He noted that they had prepared the application with "*considerably effort and conspicuous care*" and referred to "*ample evidence*" that since February 2014 they had sought to engage DD in their discussions and plans but that at almost every turn their efforts had been frustrated. The court had been provided with a 'balance sheet' analysis of the risks and benefits of the competing options on all issues.

DD was not present at the hearing but was represented by the Official Solicitor as her litigation friend. By the conclusion of the hearing and "*having tested thoroughly the evidence*" the Official Solicitor accepted on DD's behalf that: (i) she lacked capacity to litigate the application in so far as it relates to the delivery of her baby; and that (ii) she lacked the capacity to make a decision about the mode of delivery of her unborn baby.

DD's partner, BC, was neither present nor represented at the hearing. He had significant learning difficulties and was said to have a lower IQ than DD. The judge was satisfied that BC had notice of the hearing. The judge regarded it as of considerable importance that BC should take part in the proceedings and that he be

encouraged to do so. The judge acknowledged that as he had not heard from BC and BC was not represented there was an interference with his Article 6 rights. However the judge noted that the relief sought required urgent adjudication and it was not appropriate or proportionate to delay the decision.

The judge heard evidence over the course of 2 days from (i) Dr F (Community Consultant Psychiatrist for adults with learning disabilities); (ii) Mr A (Consultant Gynaecologist and Obstetrician), the consultant who, it was proposed, would be in charge of DD on the labour suite; (iii) Mrs C (safeguarding midwife); (iv) Mr D (social worker and AMHP); (v) Dr Richard Latham, Consultant Forensic Psychiatrist, instructed on behalf of DD by the Official Solicitor.

DD's obstetric history was set out in detail and was "*extraordinary and complex*" as indicated by the judge. The summary of the acute complications of pregnancy/child birth for DD was set out in the judgment in the following way:

1. the need for an emergency caesarean (Child 1) due to foetal distress;

2. baby in breech position requiring caesarean (Child 2);

3. DD displaying signs of a delusional disorder immediately following the birth of Child 2;

4. delusional disorder following the birth of Child 3;

5. seriously distended bladder with required catheterisation (Child 3);

6. intracerebral embolism causing fitting (status epilepticus), probably brought about by the pregnancy (Child 4); refusal to take prophylactic injections to prevent further blood clots;

7. significant post-partum haemorrhage (Child 4).

The summary does not reflect some of the more extraordinary elements of the case, which included a complete failure by DD and BC to engage with the authorities, BC helping to deliver Child 3 at home, an inability to care for the new born babies and complications which impacted on the new born children.

The judgment contains a lengthy background of DD's current pregnancy and ante-natal care which was characterised by the social care team attempting to engage DD and BC and being "*frustrated at every turn*".

The judge considered the evidence on whether DD had capacity to litigate the proceedings and whether she had capacity to decide on the mode and timing of the delivery of the baby.

It was the clear opinion of Dr F that DD lacked capacity to litigate the proceedings and the Official Solicitor conceded that she lacked capacity to litigate.

The evidence in relation to DD's capacity to decide on the mode and timing of the delivery of her baby was more mixed. Dr F's clear view was that she lacked capacity in that respect. Dr Latham (instructed by the Official Solicitor on DD's behalf) felt that the conclusion on capacity was finely balanced. He considered that she was able to understand, retain and communicate information but he accepted that she lacked capacity to use or weigh information. He concluded that her lack of capacity was 'marginal'.

The judge considered that the difference between Dr F and Dr Latham lay in describing where on the autistic spectrum DD fell to be considered, and whether her lack of capacity was to be regarded as 'marginal'. The judge preferred the evidence of Dr F because (i) he had greater experience in assessing woman with autism and (ii) he had the benefit of meeting with DD in order to perform the assessment. The judge also noted that "*a conclusion on incapacity is not necessarily a 'marginal' one simply because P demonstrates an inability in relation to only one of the functionality criteria in section 3(1) of the MCA 2005. I felt that Dr Latham's evidence, taken as a whole, tended to reflect that thinking, whereas Dr F was clearer, and his reasoning more cogent, in his analysis of the discussion about DD's inability to 'use or weigh' the information*".

The judge considered that there was sufficient evidence for an interim declaration that DD lacked capacity to decide whether she should submit to an assessment of her capacity to make decisions relevant to the issue of contraception.

When considering best interests, the judge adopted the approach distilled by Hayden J in *Sheffield Teaching Hospital NHS Foundation Trust v TH and Another* [2014] EWCOP 4 which quoted from the speech of Baroness Hale in the *Aintree* case in respect of the need to understand P's wishes and feelings.

There were 4 different proposals in this case for the mode and delivery of DD's baby:

1. VBAC ("Vaginal Birth After Caesarean") in hospital – spontaneous

2. VBAC in hospital – induced

3. VBAC at home

4. Caesarean section

The judge set out 3 "*general important points*" when resolving the issue of mode of delivery in DD's best interests:

1. That 'best interests' are not limited to best *medical* interests, but the wider best interests of DD. It must be in the best interests of any woman carrying a full-term child whom she wants to be born alive and healthy that such a result should if possible be achieved;

2. Whatever the ethical arguments engaged, he did not have the jurisdiction to take the interests of the unborn baby into account;

3. That he must have regard to the statutory principle of least restriction.

And the following specific points, relevant to the case:

4. That it was plainly in DD's best interests (both physically and mentally) that her child be born alive, healthy and safely;

5. DD and BC's wishes were for a home birth without social or health care assistance;

6. A vaginal delivery most accorded with DD's wishes, and would interfere least with her rights;

7. The Trust's antenatal guideline for risk assessment categorised DD's pregnancy as 'high risk' because: (i) she had had a previous pre-term baby (ii) she had had more than four pregnancies (iii) she had had three previous caesarean sections; and (iv) she had had previous thrombo-embolic disease.

The judgment then considers the various options in the form of a balance sheet exercise as well as DD's ascertainable views and those of BC.

The judgment also considers the use of reasonable force and deprivation of liberty which would be necessary to give effect to any decision that attendance at hospital was required. Whilst the judge authorised the necessary steps, he did so subject to a number of restrictions (see paragraph 131 of the judgment).

On the issue of mode and delivery of DD's baby, the judge concluded:

> *"In this judgment I have sought to highlight some of the key features of the relevant evidence on risk and benefit of each option. I have weighed these, and the additional competing considerations which were rehearsed in the evidence, with considerable care.*
>
> *As indicated at the outset of this judgment, my decision impacts on many of the most precious and valued human rights and freedoms enjoyed by any citizen, and I am acutely conscious of the fear and confusion, the possible outrage (even if short-lived) and upset, which DD is likely to experience in having to deal with these overwhelming and distressing events.*
>
> *While giving due weight to her wishes, and her fundamental rights, and those of BC, I have nonetheless come to the clear conclusion that it would be in her best interests that she should be delivered of her baby by caesarean section, and grant the Applicants the ancillary authorities they seek in order to achieve this".*

The judge further held that DD and BC should be given only partial information in respect of the delivery plan, namely that they should be told that the Applicants' were going to arrange for a caesarean section but not when the intervention was to take place. The interference with their Article 8 rights was justified in this instance.

As stated above, the judge concluded that it would not be in DD's best interests to authorise an assessment of her capacity to decide about future contraception at this stage.

The second case – DD (No.2)

This case was to consider:

1. whether it was in DD's best interests that the Applicants should be authorised:

    a. To provide DD with education in relation to contraception, and then

    b. To assess her capacity to make decisions in relation to contraception.

    this followed from the judge's finding in DD (No. 1) that there was reason to believe that DD lacked the capacity to consent to an assessment of her capacity to make decisions in relation to contraception.

2. Whether the judge should authorise the Applicants to take such necessary and proportionate steps to give effect to the best interests declaration in (i) above, to include forced entry into her home, and to use such restraint as it deemed necessary to convey her to an appropriate place to provide the opportunity for such education and assessment;

3. Whether there was reason to believe (section 48 MCA 2005) that DD currently lacked the capacity to take decisions in relation to contraception;

4. If there was reason to believe that she currently lacked capacity (in relation to (iii) above), whether it was in DD's best interests that a short-term contraception be administered by way of injection (and to authorise the Applicants' staff to do so).

As in DD (No.1) the judge noted that he remained acutely aware of the extraordinary interference with DD's private and family life, her freedoms and her liberty which flow from the steps which I earlier authorised. "*In determining this application, I recognise that additional significant interference into her life is contemplated; this application, as the last, engages vividly DD's rights under article 3, article 5, and article 8 of the ECHR.*"

The judge concluded that:

1. It was in DD's best interests that he should authorise the Applicants:

    a. To provide DD with education on contraception, and then

    b. To assess her capacity to make decisions in relation to contraception.

2. It was in DD's best interests that he should authorise the Applicants to take such necessary and proportionate steps to give effect to the best interests declaration in (i) above, to include, if necessary, forced entry into her home in order to convey her to a community health service resource, and if necessary use restraint.

3. There was reason to believe that DD currently lacked the capacity to make decisions in relation to contraception.

4. It was in DD's best interests to be administered a Depo-Provera contraceptive injection at the time of the caesarean section and the Applicants' staff were authorised to do so.

Recent events showed that the Applicants had made a number of attempts to engage DD and BC in a discussion about contraception but such attempts had proved fruitless.

The judge set out that he intended this judgment to be read with DD (No.1).

There had been no specific current assessment of DD's capacity to make decisions in relation to contraception. The judge was therefore being asked to determine whether there was sufficient evidence for an interim declaration to be made.

The judgment set out in detail that during her childhood and adult life she had periodically received advice about contraception and that she had been prescribed and had used different forms of contraception. Notably, the history showed that DD had been administered the Depo-Provera injection in the past but was unwilling to use it again after 2 injections because of heavy bleeding. The history suggested that DD had been able to make capacitous decisions about contraception in the past.

Dr F (see DD No.1) gave evidence on the question of DD's capacity in relation to contraception. He considered that there was reason to believe that DD lacked capacity to make decisions on contraception. He referred to the extreme rigidity of her thinking and understanding, and difficulty in cognitive flexibility as features of her autistic spectrum disorder. Dr F considered that "she is unable to 'weigh in the balance information regarding the risks of her current pregnancy' and therefore opines that it is likely 'when making a choice regarding contraception, she will be unable to weight up information regarding risks of future pregnancy'; this stems from (or is 'because of': section 2(1) her autistic spectrum disorder".

The judge held that there was reason to believe that DD lacked capacity currently to take decisions about contraception.

The Applicants wished to assess DD's capacity to make a decision about contraception. The Applicants recognised that 'all practicable steps' must be taken 'in order to help [her]' to make the decision. The court's intervention can only be justified if those steps have been unsuccessful.

An education plan had been prepared by the Applicants in 3 parts. At the end of Part 3, a capacity assessment would be attempted. All capacity assessments would be conducted by Dr F.

DD's wishes were reasonably clear: she did not want any involvement from the statutory services and wanted to be left alone. It was also apparent that in the past, DD had actively sought contraception when she did not wish to bear another child.

DD's wishes and feelings were a significant factor but on the facts of this case it was difficult to ascribe particular weight to them given that DD had not engaged at all in relation to these issues. It could be reasonably predicted that DD would have fixed and firm views that no assessment should be undertaken, particularly against her will. It was equally predictable (although not inevitable) that she would wish to choose not to have contraception at this time. BC's views could be presumed to be the same.

It was clearly in DD's best interests to be assessed for her capacity to make contraception decisions. No party was suggesting that DD should be compelled to co-operate with the assessment or compelled to answer questions. The Applicants accepted that threats or attempts to force DD to agree to an assessment would not be acceptable. The Applicants would take all reasonable steps to encourage DD to participate willingly in the assessment.

The judge authorised the Applicants to take steps necessary to give effect to the education assessment plan. This included removing DD forcibly from her home. The judge authorised such steps as were necessary subject to the requirements which were set out at paragraph 131 of DD (No.1) which were intended to minimise distress to DD and maintain her dignity.

In answering the question as to whether it was in DD's best interests to be administered short term contraception at this stage, the judge noted that neither irreversible nor long acting reversible contraceptive methods were under consideration. However, pending assessment of DD's capacity to make a decision in relation to contraception and given the risks associated with her conceiving before the court can consider the evidence, it was the judge's decision that it was in DD's best interests to be provided with a short term contraception. It was possible that following education on contraception and assessment DD might demonstrate that she had capacity to take the decision for herself but for the time being it was the least restrictive option and one which met her needs.

Two forms of temporary contraception were under consideration and both had caused DD some adverse side effects in the past. Two of the experts favoured the administration of a Depo-Provera injection. The judge agreed with the experts.

A further hearing would be scheduled before Cobb J to take decisions about long term contraception if the proposed assessment of capacity concluded that DD is unable to make such decisions for herself.

Comment

These cases have been covered in some detail in order to illustrate the care and scrutiny that the court must exercise when proposing to authorise action which interferes so fundamentally with a person's Article 3, 5 and 8 rights. It will rightly only be in the most extreme cases that the court will intervene in a woman's

right to decide how she should give birth to her child (even where that woman is judged to lack capacity). The facts in this case were stark and the preponderance of evidence suggested that DD's health and welfare would be at considerable risk if she were left to deliver her child at home as she and her partner wished. Nonetheless, the judgments still make for uncomfortable reading. The notion that a woman should be forcibly removed from her home to undergo education in relation to contraception is on the face of it difficult to reconcile with her best interests. However, the judgment carefully sets out the detailed plan to engage DD with education in relation to contraception and given her "extraordinary and complex obstetric history" it was clearly in her best interests to be enabled (if possible) to take a capacitous decision about contraception.

A further – wider – importance of this case is as regards the question it poses as to how (if at all) an approach compliant with the CRPD would differ. The CRPD (at least as interpreted by the Committee on the Right of Persons with Disabilities) is strongly predicated upon a model in which, with suitable support, all persons can be enabled to exercise legal capacity, such that substitute decisions need never be taken on their behalf. As a fallback position, the CRPD requires that, if decisions are to be taken for an individual, they must be taken so as to respect their rights, will and preferences. This case poses a particular challenge to that model given that the primary difficulties here stemmed (in broad caricature) not from over-zealous and over-hasty state involvement, but rather than from a refusal by DD and her partner to engage with support offered by the state. The risks posed by DD both to herself and her child were very significant indeed – but protecting her against those risks inevitably involved a very significant departure from her 'will and preferences.' This is therefore very much an example of the 'hard case' that those championing the strong version of the CPRD must provide practical answers to in order to persuade front-line professionals of the need to change.

A melancholy milestone?

United Lincolnshire Hospitals NHS Trust v N [2014] EWCOP 16 (Pauffley J)

Best interests – Medical treatment

Summary

History was made in a very dignified and quiet way on 15 July when Pauffley J made a declaration that it would be lawful and in the best interests of a woman for a treating NHS Trust not to make further efforts to establish and maintain a method of providing her with artificial nutrition. The declaration, for which the reasons were given in a judgment handed down on 21 July, is momentous because the woman was at the time in a Minimally Conscious State ('MCS') and it is arguable that Pauffley J has gone further than any Court of Protection judge has previously been willing to go in relation to such a case.

Background facts

The background facts can be shortly summarised, although the shortness of the summary is not in any way intended to detract from the significance of the decision for N and her family.

N was a woman in her early fifties. In June 2013, she suffered a sub-arachnoid haemorrhage. She was in consequence thereafter in a MCS and lacked capacity to make decisions as to her medical treatment.

In mid June 2014, N was admitted to hospital from the care home where she had been living because the PEG tube through which she was fed was no longer in place. Since then, N had been physically resistant to all efforts to re-establish a method of providing her with nutrition, and had pulled out a naso-gastric tube and several cannulae.

As a result of these difficulties, N had not been receiving any nutrition from 14 June 2014; an urgent application was made by the treating Trust on 8 July, and (inter alia) independent expert gastroenterology evidence was obtained in advance of a final hearing on 15 July.

The evidence

Pauffley J carefully set out the evidence of the views of N's adult daughter, D, and N's former husband, both of whom were clear that N was a very private person, would prefer the dignity of not having the PEG *"forced on her*," and that N had no quality of life and could not interact with her environment or other people. Importantly, D gave evidence to the Court of a conversation that she was told her mother had prior to her brain injury with a friend as to their wishes if they had been incapacitated in a road accident. Apparently, both said that they would not like to continue life in a reduced capacity. D stated that, although this was different, she believed it summarised what her mother's views would have been.

The independent expert, Dr Barry Jones (whose evidence was specifically praised by Pauffley J), whilst ultimately confirming in oral evidence that he agreed that N was in an MCS, noted that N appeared to be sentient and was able to remove a nasogastric tube and bridle which required a degree of dexterity, effort and determination. He stated that "*it is possible that despite her severe cognitive impairment as part of her* [MCS], *she is able to express her refusal of these treatments*". He was clear that continuing attempts to reintroduce feeding would be "*a perpetuation of a state in which none of us would wish to find ourselves and one which N would not have wished to experience*."

The Law

In her analysis of the legal framework, Pauffley J noted thus (in passages that we set out in full as a very clear statement of the law):

> *"52. There is a strong presumption in favour of the preservation of life, see e.g. In re M (Adult patient) (Minimally conscious state: withdrawal of treatment) [2012] 1 WLR 1653, paras 7, 220, 222. This does not displace the patient's best interests as the paramount consideration for the court.*

53. The court will not order medical treatment to be provided if the clinicians are not willing to offer that treatment on the basis of their clinical judgment (see AVS and a NHS Foundation Trust [2011] EWCA Civ 7, per Lord Justice Ward at para. 35, and Aintree University Hospitals NHS Foundation Trust v David James and others [2013] 3 WLR 1299 para. 18) but the power under s15(1)(c) of the Act to make declarations as to "the lawfulness or otherwise of any act done, or yet to be done, in relation to [the] person" enables the court to rule on the lawfulness of the proposed withholding of life-sustaining treatment, in this case further attempts at provision of a method of providing artificial nutrition.

54. Lady Hale, giving the judgment of the Court in Aintree, said [para19-22]:

> *'However, any treatment which the doctors do decide to give must be lawful. As Lord Browne-Wilkinson put it in Airedale NHS Trust v Bland [1993] AC 789, which concerned the withdrawal of artificial hydration and nutrition from a man in a persistent vegetative state, "… the correct answer to the present case depends upon the extent of the right to continue lawfully to invade the bodily integrity of Anthony Bland without his consent. If in the circumstances they have no right to continue artificial feeding, they cannot be in breach of any duty by ceasing to provide such feeding" (p883). Generally, it is the patient's consent which makes invasive treatment lawful. …*
>
> *20. … the fundamental question is whether it is lawful to give the treatment, not whether it is lawful to withhold it.*
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> *21. In Bland, Lord Goff (with whose judgment Lord Keith and Lord Lowry expressly agreed) pointed out that "the question is not whether it is in the best interests of the patient that he should die. The question is whether it is in the best interests of the patient that his life should be prolonged by the continuance of this form of treatment" (p868). To the same effect was Lord Browne-Wilkinson, at p884:*
>
> > *"… the critical decision to be made is whether it is in the best interests of Anthony Bland to continue the invasive medical care involved in artificial feeding. The question is not the same as, 'Is it in Anthony Bland's best interests that he should die?' The latter question assumes that it is lawful to perpetuate life: but such perpetuation of life can only be achieved if it is lawful to continue to invade the bodily integrity of the patient by invasive medical care."*
>
> *22. Hence the focus is on whether it is in the patient's best interests to give the treatment, rather than on whether it is in his best interests to withhold or withdraw it. If the treatment is not in his best interests, the court will not be able to give its consent on his behalf and it will follow that it will be lawful to withhold or withdraw it. Indeed, it will follow that it will not be lawful to give it."'*

55. The test to be applied by the court is whether the treatment would be in the patient's best interests. Whilst –

> *'the starting point is a strong presumption that it is in a person's best interests to stay alive … this is not absolute. There are cases where it will not be in a patient's best interests to receive life-sustaining treatment'. [para 35]*
>
> *'The most that can be said, therefore is that in considering the best interests of this particular patient at this particular time, decision- makers must look at his welfare in the widest sense, not just medical but social and psychological; they must consider the nature of the medical treatment in question, what it*

> *involves and its prospects of success; they must consider what the outcome of that treatment for the patient is likely to be; they must try to put themselves in the place of the individual patient and ask what his attitude is or would be likely to be; and they must consult others who are looking after him or interested in his welfare, in particular for their view of what his attitude would be.' [para39]*

> *56. In so doing the Court must consider whether the treatment in issue would be futile in the sense of being ineffective or being of no benefit to the patient. The treatment does not have to be likely to cure or palliate the underlying condition or return the patient to full or reasonable health, rather it should be capable of allowing the resumption of a quality of life which the patient would regard as worthwhile. The Court must weigh the burdens of the treatment against the benefits of continued existence and give appropriate weight to N's family life [para 40].*"

The balance sheet

Pauffley J, following Baker J in *W v M*, applied the balance sheet approach, identifying five advantages of attempting to re-insert a PEG, and seven in favour of not so attempting. Importantly, and in a passage that is in some ways strikingly at odds with that of Baker J in *W v M* (a point to which we return below), Pauffley J noted that there was:

> *"60… no evidence that N has made any advance refusal of treatment directly applicable to the circumstances in which she now finds herself, namely in a minimally conscious state facing the prospect of no further provision of nutrition. However, what the views of the patient might be, and what the views of the family are, are highly material factors when considering best interests, although not determinative: An NHS Trust v (1) A and (2) SA [2006] LS Law Medical 29, per Waller LJ at para 59."*

Pauffley J found herself in no doubt as to (1) N's continuing and irreversible lack of capacity; and (2) where N's best interests lay:

> *"65. I also find that it is not in N's best interests that a further attempt be made to insert a PEG or to secure other means of providing her with artificial nutrition. I am entirely satisfied that the entire range of treatment options has been carefully and diligently considered by the team of clinicians at the local hospital as well as by Dr Jones. I have considered and weighed all factors in the best interests' checklist as well as the available information about N's views in relation to life sustaining treatment. Similarly, I have taken account of the wishes and feelings of N's close family members.*
>
> *66. The critical decision is whether it is in N's best interests to continue invasive, risk laden, medical care as would be involved in a further attempt at artificial feeding. I am utterly convinced that it would not. Accordingly, I declare that it is lawful and in her best interests for the clinicians (a) not to make any further attempt to secure a means of providing artificial nutrition; (b) to withdraw the provision of intravenous fluids and dextrose; and (c) to provide such palliative care and related treatment (including pain relief) as considered appropriate to ensure she suffers the least distress and retains the greatest dignity until such time as her life comes to an end.*"

Comment

In *W v M*, Baker J held (contrary to the submissions of the Official Solicitor) that the 'conventional' balance sheet applied to determining where a patient's best interests lay in continuing life sustaining treatment whilst they were in an MCS. In that case, Baker J:

> "230… *accep*[ted] *without qualification that [*the family *members*] *B and S are accurately relaying the various statements made by M in the past. I accept, therefore, that when her grandmother and father were in declining health and moved to live in nursing homes, M said on more than one occasion words to the effect that she would not wish to live like that, that she would not wish to be dependent on others, and that she "wanted to go quickly". I also accept the evidence that, when reports about Tony Bland appeared on television, M expressed views to the effect that it would be better to allow him to die."*

However,

> "*230… , as conceded on behalf of the Applicant, there is no evidence that M ever specifically considered the question of withdrawal of ANH, or ever considered the question whether she would wish such treatment to be withdrawn if in a minimally conscious state. Furthermore, even if M did specifically consider those questions, there is no way of knowing her current views, having lived in that state for over eight years. Given the importance of the sanctity of life, and the fatal consequences of withdrawing treatment, and the absence of an advance decision that complied with the requirements previously specified by the common law and now under statute, it would be in my judgment be wrong to attach significant weight to those statements made prior to her collapse."*

Baker J also accepted that S and B believed that M would want ANH to be stopped, and that they believed the withdrawal of the treatment is in her best interests and would therefore wish that to happen. He took their evidence into account but did not think it carried decisive weight (see paragraph 250). Rather, he expressly held that the importance of preserving life was of determinative weight (see paragraph 249).

N's case might be distinguishable on the facts; in particular, M's case was about withdrawal of ANH rather than sanctioning the decision not to keep offering ANH. It seems to us, though, that the logic of Pauffley J's analysis did not turn on 'standard' distinctions between omission and commission but (rightly) rather on the fundamental question of whether continued PEG feeding was in N's best interests. Moreover, she did not just sanction a decision not to seek to restart PEG feeding but also the withdrawal of intravenous fluids and dextrose.

It is undoubtedly correct that M did not manifest the same resistance (however that is to be characterised, and expressive of whatever level of 'sentience') to the provision of ANH. However, legally, both were held to be in the same position of minimal consciousness and Pauffley J did not, as she could have done, seek to ascribe to N wishes and feelings based on her actions, but rather focused on her earlier expression.

In this regard it seems to us that there is something rather different about the approach adopted by the two judges to the wishes and feelings expressed by and on behalf of the individual by those closest to them. On a proper analysis, it would seem that N's comments as to what she would wish in the event of a road traffic accident were of a similar level of generality to those expressed by M in relation to Tony Bland's case, and the views expressed by the families of the two women as to what they would have

wished were materially identical. But it seems that in N's case they were given very significant weight, but in M's case they were not.

There are undoubtedly grounds upon which to question whether all the neurological issues were addressed in full (see, for a discussion of this point, the comment upon Alex's post on this case here). On balance, however, Pauffley J's analysis seems both compelling and humane. It will be very interesting to see whether Hayden J follows a similar approach if and when the case of *Sheffield Teaching Hospitals NHS Trust v TH* returns to Court, as this is another case where it would appear, on its face, entirely clear that we know what P would have wanted – and that it is not to live in the way that medical science now allows.

Support and the capacity assessment

LBX v K, L, M [2013] EWHC 3230 (Fam) and [2013] EWHC 4170 (Fam) (Theis J)

Mental capacity – assessing capacity

Summary

These long-running proceedings began nearly six years ago, the previous judgments being [2010] EWHC 2422, [2011] EWHC 2419, [2012] EWCA Civ 79, [2012] EWHC 439. L was born in 1983 and had learning disabilities with an IQ of 59. His incapacity to decide on residence, care and contact was not previously in dispute but was considered to be borderline. In the first judgment, reported at [2013] EWHC 3230 (Fam) (but only recently made publicly available), Theis J concluded that a further assessment of L's capacity was required. Five months later, in the second judgment, reported at [2013] EWHC 4170 (Fam), L was found to have capacity but the inherent jurisdiction was invoked to protect him.

In the first judgment, the capacity assessment of a social worker was preferred to that of a doctor. The court highlighted the need for evidencing a clear rationale; guarding against imposing too high a test of capacity; the importance of using tangible resources, like drawings and pictures, to assess and improve the person's level of understanding; and clearly articulating the information relevant to the decision. MCA s.3(4) refers to "reasonably foreseeable consequences" only and such information will of course differ according to the decision. But it may assist capacity assessors to know what information was and was not relevant when assessing L's capacity to make the following decisions.

Capacity to decide as to residence:

Relevant:

1. what the two options are, including information about what they are, what sort of property they are and what sort of facilities they have;

2. in broad terms, what sort of area the properties are in (and any specific known risks beyond the usual risks faced by people living in an area if any such specific risks exist);

3. the difference between living somewhere and visiting it;

4. what activities L would be able to do if he lived in each place;

5. whether and how he would be able to see his family and friends if he lived in each place;

6. in relation to the proposed placement, that he would need to pay money to live there, which would be dealt with by his appointee, that he would need to pay bills, which would be dealt with by his appointee, and that there is an agreement that he has to comply with the relevant lists of "do"s and "don't"s, otherwise he will not be able to remain living at the placement;

7. who he would be living with at each placement;

8. what sort of care he would receive in each placement in broad terms, in other words, that he would receive similar support in the proposed placement to the support he currently receives, and any differences if he were to live at home; and

9. the risk that his father might not want to see him if L chooses to live in the new placement.

Not relevant:

1. the cost of the placements;

2. the value of money;

3. the legal nature of the tenancy agreement or licence;

4. what L's relationship with his father might be in 10 or 20 years' time if he chose to live independently now were not relevant.

Capacity to decide as to contact with others:

Relevant:

1. who they are and in broad terms the nature of his relationship with them;
2. what sort of contact he could have with each of them, including different locations, differing durations and differing arrangements regarding the presence of a support worker;

3. the positive and negative aspects of having contact with each person. This will necessarily and inevitably be influenced by L's evaluations. His evaluations will only be irrelevant if they are based on demonstrably false beliefs. For example, if he believed that a person had assaulted him when they had not. But L's present evaluation of the positive and negative aspects of contact will not be the only

relevant information. His past pleasant experience of contact with his father will also be relevant and he may need to be reminded of them as part of the assessment of capacity.

Not relevant:

1. abstract notions like the nature of friendship and the importance of family ties;

2. the long-term possible effects of contact decisions;

3. risks which are not in issue, such as the risk of financial abuse.

Capacity to decide on care:

Relevant:

1. what areas he needs support with;

2. what sort of support he needs;

3. who will be providing him with support;

4. what would happen if he did not have any support or he refused it;

5. that carers might not always treat him properly and that he can complain if he is not happy about his care.

Not relevant:

1. how his care will be funded

2. how the overarching arrangements for monitoring and appointing care staff work.

The judge accordingly required capacity to be investigated further before the court could finally determine the application. By the time of the second judgment, five months later, L was judged to have capacity to decide on residence, care and contact, although it was still borderline. Theis J observed that L remained vulnerable to overwhelming emotional issues which could compromise his capacity. Emotional safety would best promote his retention of capacity. And this required "*a proportionate structure in place that enables him to be able to maintain his capacity in a relatively calm environment, and free from the emotional maelstrom, as I have described it, resulting from the relationship that he has with his father in particular, and the relationship the father has with those who support L in the care that he has*." Accordingly, invoking the inherent jurisdiction, her Ladyship made orders which restricted L's father from having contact with him and his care team.

Comment

These KLM decisions are very useful in terms of breaking down the core components of relevant and irrelevant information to three classes of decision. Insofar as they relate to residence, the first decision can usefully be read with the decision in *LB Islington v QC* noted in this month's Property and Affairs Newsletter. They also highlight the importance of the second statutory principle, to take all practicable steps to help the person decide. The assumption of, and being required to max-out the prospects of, having capacity are key to the promotion of autonomy. They illustrate that, with proper care and attention, someone of borderline capacity may regain and thereafter retain the ability to decide for themselves. Moreover, it is important for capacity assessors to identify the salient details of the relevant decision. And the first judgment provides a very helpful illustration for practitioners. Crucially, the bar must not be set too high. We must not expect more from those with mental impairments than we do from those without. Otherwise Article 8 –embodying as it does many aspects of our free society – will not be universal.

The second, inherent jurisdiction, decision exemplifies how the great safety net can be invoked to set out the parameters to enable people to be unencumbered by others' influences so as to decide for themselves. This is – we suggest – precisely how the inherent jurisdiction is intended to operate (and is therefore to be contrasted with the *PB* decision discussed in this month's Practice and Procedure Newsletter).

Deprivation of liberty – some fog clears about children's homes

Liverpool City Council v SG & Ors [2014] EWCOP 10 (Holman J)

Article 5 ECHR – Deprivation of Liberty – Children and Young Persons

Summary

In a judgment that assists in resolving one issue that has been exercising practitioners (of all hues) since the judgment in *Cheshire West*, Holman J has confirmed that the Court of Protection has the power to make an order which authorises that a person who is not a child (ie who has attained the age of 18) may be deprived of his liberty in premises which are a children's home as defined in section 1(2) of the Care Standards Act 2000 and are subject to the Children's Homes Regulations 2001 (as amended).

The facts of the case are irrelevant to the point in issue, save that the individual in question, SG, was aged 19, and, whilst arrangements were made to move her into supported living, continued to be resident in the same children's home as she was in prior to the age of 18, subject to a regime that indisputably amounted to a deprivation of her liberty. She lacked capacity to decide as to her residence and care arrangements.

The problem identified by the parties arose from the fact that the Children's Homes Regulations 2001 provide at regulation 17A (Restraint) that:

> *"(1) Subject to paragraph (2) a measure of restraint may only be used on a child accommodated in a children's home for the purpose of-*

(a) preventing injury to any person (including the child who is being restrained);
(b) preventing serious damage to the property of any person (including the child who is being restrained); and
(c) in the case of a child accommodated in a children's home which is a secure children's home, preventing the child from absconding from the home,

and then only where no alternative method of preventing the event specified in sub-paragraphs (a) to (c) is available."

In Guidance issued jointly by the President and OFSTED on 12 February 2014 entitled "Deprivation of Liberty – Guidance for Providers of Children's Homes and Residential Special Schools," guidance that (as Holman J) had caused "uncertainty" on the part of lawyers and providers as to the powers of the Court of Protection in this area – the following appeared at paragraph 3:

"3. The Court of Protection should be reminded by the parties of the regulations that apply to children's homes and residential special schools. The Court of Protection does not have the jurisdiction to require any home or school to act in breach of such regulations or to authorise any such breach. Accordingly, the Court of Protection should not make an order authorising a plan for the care and supervision involving the detention of a person, where to do so would involve the children's home or a residential special school breaching the regulations that apply to it. If compliance with an order of the Court of Protection would involve such a breach of the relevant Regulations it cannot be relied on to justify breach of the Regulations or enforced in a manner that would involve such a breach."

Holman J noted (at paragraph 41) that the paragraph contained no more than a legal truism. "*Regulations have the force of law, and no court, frankly, in any circumstances that I can readily think of, can authorise a person or body to act in a way that contravenes a regulation, or still less a statute, so as to be in breach of the regulation or statute. On a careful reading of that paragraph of the guidance, it ultimately says no more than that. The question, therefore, in any case is whether what the Court of Protection is otherwise being asked to authorise would amount to a "breach" of some regulation.*"

Holman J was more circumspect about the accuracy of the subsequent paragraph in the Guidance, which provides as follows

"4. All children's homes must meet the Children's Homes Regulations (2001). In this instance, the relevant regulations are:

Regulation 11 (Promotion of Welfare),

Regulation 17 (Behaviour, management and discipline) and

Regulation 17A (Restraint).

As restraint can only be used to prevent a child from leaving a secure children's home, there is no purpose to be served in seeking an order of the Court of Protection authorising such restraint by a non-secure children's home because the Court of Protection has no jurisdiction to order or authorise a breach of these regulations."

Holman J noted that *"it is possible (I put it no higher than that) that the accuracy of that part of the guidance is more debatable. It may beg the question of whether paragraph 17A(1)(c) of the regulations is a platform or a ceiling. But that is territory into which I simply should not and do not venture in the present case because paragraph 4 of the guidance is directed to "a child" and, as I have stressed, the patient in this case is not a child*."

"*The essential point and difficulty* that has been raised by this case, and maybe a large number of other cases," Holman J identified at paragraph 46, "*is that readers of the guidance have understood it to be preclude any resort to the Court of Protection at all, in any circumstances in which the premises in which a person (whether a child or an adult) is residing or detained happen to be premises which are a children's home as defined in section 1(2) of the Care Standards Act 2000. It is, however, necessary to stress and emphasise yet again that the point that has been made in both paragraphs 3 and 4 of the guidance is that the Court of Protection cannot authorise an act which would involve or represent a breach of the regulations. That simply does not arise and is not in point in any case in which the person concerned has attained the age of 18*."

Rather:

> "*48. The short and simple point is that the relevant parts of the Children's Homes Regulations 2001 simply do not apply at all in the case of a person who is no longer a child. It may often happen, as it has happened in this case, that the premises in which a person, now adult, resides or is detained happen also to be a children's home. But it frankly makes no difference whether the premises themselves are a children's home or are some dedicated premises that have been provided in the community under the kind of "supported living model" contemplated for this very patient in this very case.*
>
> *49. In my view, the Court of Protection has undoubted power in the present case to make, if appropriate, an order authorising the deprivation of liberty. Further, it is the duty of the person or body, in this case the local authority, who is or are depriving the patient of his liberty, to apply to the court for an authorisation; and, indeed, the duty of the court to make such authorisation as in its discretion and on the fact and in the circumstances of the case it considers appropriate*."

It should, finally, be noted that the judgment represented the judicial endorsement of an agreed position. At paragraph 4 of his judgment, Holman J was at pains to note that he had not heard any arguments to the contrary such that "[i]*f, in some other case, on a future date, some party wishes to argue to the contrary, then of course that limitation or reservation upon the value of this ex tempore judgment as a precedent may be noted*."

Comment

It is fair to say that the Guidance (which, as we noted at the time, was not issued as the result of a specific case) has caused a considerable degree of concern amongst lawyers and providers. This judgment provides very helpful clarification in relation to one category of those who appeared to be caught by it – i.e. those over 18 who continue (for whatever reason) to be placed in a children's home subject to the 2001

Regulations. It is unfortunate – but perhaps not all surprising given the facts of the case before him – that Holman J did not venture on to hold as to the Court of Protection's powers in relation to those below 18.

It appears, however, likely that the issue will be determined in relatively short order given the terms of an email from the Treasury Solicitor before Holman J in which the case-holder indicated that he was "*instructed on behalf of the Secretary of State for Education in a number of cases which raise the issue as to whether children who are resident in non-secure children's homes or residential special schools are being deprived of their liberty in such settings following the decision of the Supreme Court in Cheshire West & Chester Council v P.*" As the email continues:

> *"\If they are being deprived of their liberty, that in turn raises further issues as to how any such deprivation of liberty is to be authorised. This involves a careful consideration of the terms of the Children's Homes Regulations 2001, the Education (Non-Maintained Special Schools) (England) Regulations 2011, and the National Minimum Standards for Children's Homes and Residential Special Schools. For children over the age of 16, it may also raise issues as to the terms of the joint guidance published by OFSTED and the President of the Court of Protection in February 2014.*
>
> *These issues potentially affect a large number of children and young people who lack capacity but who currently reside in non-secure children's homes or residential special schools. By way of example only, as at 31st March 2014, there were more than 6,500 over 16 year olds residing in care homes, children's homes or residential special schools. The Secretary of State has not yet been able to determine the proportion of those 6,500 odd young people who may lack capacity."*

Yet again, therefore, as the ramifications of the *Cheshire West* decision continue to unfold, it is a question of watching this space.

Short Note: Medical Treatment at the end of life

In *County Durham & Darlington NHS Foundation Trust v PP & Ors* [2014] EWCOP 9, declarations were made that it was not in P's best interests to receive artificial nutrition or for attempts to be made at resuscitation in the event of cardiac or respiratory arrest as part of an end of life care package. P was an 85 year old woman who was '*in a terminal phase of her life'* and was only expected to live up to another 4 weeks. The court accepted the medical consensus that she was in a state of diminished consciousness, and that any escalation of treatment would not be in P's best interests as it would be unlikely to be successful in assisting her either to regain capacity or to have a meaningful quality of life, and would be accompanied by significant physical burdens.

Short Note: Another case that wasn't

In a frustrating echo of the decision in *TA v AA and Knowsley Metropolitan Borough Council* [2013] EWCA Civ 1661, a procedural requirement relating to appeals prevented Baker J in *GW v A Local Authority and B Ltd* [2014] EWCOP 20 from considering "[potentially] *fundamental questions concerning the interpretation of section 48 – namely whether the practice of the Court of Protection in continuing or instigating a deprivation of liberty under section 48 is lawful under the statutory scheme set out in the 2005 Act and the*

Deprivation of Liberty Safeguards ("DOLS") in Schedule A1 to the Act and/or is compliant with Article 5 of the European Convention for the Protection of Human Rights and Fundamental Freedoms." The appeal instead revolved around the question of whether the trial judge had erred in their assessment of GW's capacity to leave and return to her residence unescorted and to make decisions concerning her care and residence. Over and above the confirmation that a trial judge should not adopt a 'review' approach to the assessment of capacity by relying solely on the view of the experts, but should instead carry out their own evaluation (as Baker J found that HHJ Marston had properly done), it is perhaps of – some limited – wider interest for its suggestion that, where possible, Circuit Judges should consider circulating drafts of judgments to assist in the identification of typographical errors. Founding a ground of appeal on the basis of excessive numbers of typos is not, however, a sensible ground, as Baker J made painfully clear.

Law Commission project on deprivation of liberty

As part of its 12th Law Reform Programme, the Law Commission will be starting work on a project on mental capacity and detention. We reproduce below the announcement on the Law Commission's website, and hope to be able to bring you further details of this vitally important work in due course.

"Mental capacity and detention

Status: We are starting work on this project in summer 2014 and expect to publish our report, with recommendations for reform and a draft Bill, in summer 2017

The Mental Capacity Act 2005 provides the framework for assessing whether people have the necessary capacity to make certain decisions, and where they do not, for others to make those decisions in their best interests. In 2004, a case before the European Court of Human Rights established that it was possible for decisions taken in a person's best interests about the provision of residential and social services were capable of amounting to a deprivation of liberty under Article 5 of the European Convention on Human Rights. The UK was found to be in breach of the Article, because in such circumstances the law in England and Wales did not provide for an adequate system of authorisation and review of the deprivation of liberty.

In 2007, in reaction to the finding, the deprivation of liberty safeguards (DOLS) were introduced into the Mental Capacity Act 2005 by the Mental Health Act 2007. They were introduced in order to plug the gap identified in the case, and to ensure that such situations are properly regulated in line with the person's human rights. DOLS applies only to deprivations of liberty that take place in hospitals and care homes. If a person's right to liberty is compromised in other settings, his or her deprivation of liberty has to be authorised and supervised by the Court of Protection.

The DOLS provisions have been criticised since they were introduced for being overly complex and excessively bureaucratic. It is said that staff often do not understand them and that there is confusion over the differences between the powers of the Mental Health Act 1983 and DOLS.

In March 2014 a House of Lords select committee conducting a post-legislative scrutiny of the Mental Capacity Act found that DOLS were not "fit for purpose" and called for them to be replaced. The committee also recommended that the new system should extend to cover people in supported living arrangements, not

just hospitals and care homes. Shortly afterwards, the Supreme Court found that a person will be deprived of their liberty in more situations than had previously been thought to be the case.

The Department of Health has accepted that there are difficulties with DOLS and has announced various measures designed to improve the way the safeguards operate.

Our project considers how deprivation of liberty should be authorised and supervised in settings other than hospitals and care homes, where it is possible that Article 5 rights would otherwise be infringed. In addition to considering these settings, the project will also assess the implications of this work for DOLS to ensure that any learning which may be relevant is shared."

For further details, please contact Tim-Spencer-Lane at the Law Commission. We also hope to carry a more detailed update on the project in our October newsletter.

The Test for Revocation of an EPA

Re AB (Revocation of an enduring power of attorney) [2014] EWCOP 12 (SJ Lush)

Enduring Powers of Attorney – Revocation

Summary

In *Re AB (Revocation of an enduring power of attorney)*, Senior Judge Lush was again confronted with delinquent attorneys, this time on an application made by the Public Guardian for revocation of an EPA.

The attorneys had dissipated P's assets by gifts and loans to their family in substantial sums, unexplained expenditure and failed to pay nursing home fees leaving P with few assets and considerable debts. The gifts, loans and unexplained expenditure totalled about £98,000.

Senior Judge Lush had no difficulty in deciding to revoke the EPA. He directed himself to the court's power under paragraphs 16(4)(g) and 16(5) of Schedule 4 to the Mental Capacity Act 2005, which state as follows:

> "*16(4) The court must direct the Public Guardian to cancel the registration of an instrument registered under paragraph 13 in any of the following circumstances -*
>
> > *(a) – (f) ….*
> > *(g) on being satisfied that, having regard to all the circumstances and in particular the attorney's relationship to or connection with the donor, the attorney is unsuitable to be the donor's attorney.*
>
> *16(5) If the court directs the Public Guardian to cancel the registration of an instrument on being satisfied of the matters specified in sub-paragraph (4)(f) or (g) it must by order revoke the power created by the instrument."*

Senior Judge Lush referred to what the Law Commission said about the power in its report, *The Incapacitated Principal*, which was published in 1983 and led to the enactment of the Enduring Powers of Attorney Act in 1985. It said:

> *"This* [the expression 'unsuitable to be the donor's attorney] *needs some explanation. It would amount in effect to a criticism of the donor's choice of attorney. But we would not wish this ground to be sustained merely because the attorney was not the sort of person that a particular relative would have chosen. It is our wish that the donor's choice of attorney should carry considerable weight. Thus, for example, a mother might be content to appoint her son as her EPA attorney despite being aware of a conviction for theft. We would not want her choice of attorney to be upset simply because a particular relative would not want the son to be his attorney. The question should be whether the particular attorney is suitable to act as attorney for the particular donor. In short, the court should examine carefully all the circumstances, particularly the relationship between the donor and the attorney."*

Senior Judge Lush referred to the authorities on the subject, in particular the statement of Mr Justice Patten (as he then was) in *Re F*, [2004] 3 All ER 277, at page 284f:

> *"It seems to me that to remove a chosen attorney because of hostility from a sibling or other relative, in the absence of any effective challenge to his competence or integrity, should require clear evidence either that the continuing hostility will impede the proper administration of the estate or will cause significant distress to the donor which would be avoided by the appointment of a receiver. Neither of these conditions is satisfied by the evidence in this case."*

Finally at paragraphs 28 and 29 he said;

> "28. *The criteria for revoking a Lasting Power of Attorney (LPA) are different from those for revoking an EPA. Subsections (3) and (4) of section 22 of the Mental Capacity Act 2005 provide that the court may revoke an LPA if (a) the donor lacks the capacity to revoke the LPA, and (b) the attorney has behaved or is behaving in a way that contravenes his authority or is not in the donor's best interest, or proposes to behave in such a way.*
>
> *29. Generally speaking, any attorney acting under an EPA who has behaved, or is behaving, or proposes to behave, in a way that contravenes his authority or is not in the donor's best interests is likely to be unsuitable to be the donor's attorney, but the converse is not necessarily true. An attorney may be unsuitable to be the donor's attorney because the attorney has fallen out with them and no longer wishes them to act, even though their conduct as attorney has been exemplary.*

Comment

The facts of the case are of concern because they show yet again that often attorneys have little concept of their duties. It is also helpful as it sets out the law and practice regarding revocation of an EPA and the different test that applies compared to that applied to revocation of an LPA.

Capacity and tenancy agreements

LB Islington v QR Case No 12177934 (District Judge Batten)

Mental capacity – Tenancy Agreements

Summary

We make note of this case because it is one of the very few publically available judgments in which the elements of the capacity to enter into a tenancy agreement are considered, and we are aware that this is an issue that crops up very regularly on the ground.

The application – as finally constituted – was for an order that QR's current tenancy of a property owned by the London Borough of Islington ('the LBI') be terminated, QR lacking the capacity to make the decision for herself, and it being in her best interests. It arose in circumstances which are, again, not unique.

QR was subject to a CTO, which contained, inter alia, a requirement that she reside at a location, ABC. Her RC and Islington's Assertive Outreach Team ('IAOT') considered that she no longer required the structure and restrictions of the regime at ABC, and that she was ready to move into a more independent living arrangement. However they did not agree that she should return to her flat because, in light of her previous history, it was too dangerous for QR to live on her own. They considered that she must live in accommodation which provided 24 hour support and monitoring, so that QR would continue to be compliant with her medication and avoid the risk of a possibly fatal relapse. As District Judge Batten noted, "This conclusion by the treatment team determines the terms of the CTO."

Sheltered accommodation was available and can be provided by LBI. However because QR would need to sign a tenancy agreement in order to move into a supported living flat, she would have first surrender the tenancy of her flat. As it was considered that she lacked the capacity to make this decision, the application was brought (initially by the treating Foundation Trust).

QR objected to the application. She contended that she had capacity to decide whether to surrender the tenancy of her current flat and to sign a tenancy agreement for supported living accommodation. She did not wish to surrender the secure tenancy of her council flat which was important to her and she did not wish to move to any of the proposed supported living options which have been proposed by LBI.

The issues before District Judge Batten were therefore QR's capacity to decide where she should live, to surrender the tenancy of her flat and to sign a new tenancy agreement are the issues as to capacity in this case. They were to be decided within the context of the terms of the CTO made under the Mental Health Act 1983 which the Court of Protection had no jurisdiction to alter.

As District Judge Batten identified:

> *"33. The choices in front of QR at this point, if she has capacity, are as follows:*
>
> *i) to surrender the tenancy of her flat, sign a tenancy agreement for supported living accommodation and move to it under the terms of a revised CTO*
>
> *ii) to refuse to surrender the tenancy of her flat and remain living at ABC under the terms of the current CTO*

34. While the current CTO remains on foot, QR does not have a choice to return to live in her flat.

District Judge Batten noted that both QR's RC and the expert instructed on her behalf were in agreement that she had "capacity to understand the obligations of a tenancy agreement with regard to the payment of rent and other standard obligations of a tenant, and the landlord's responsibilities" (paragraph 93), but they disagreed as to the matters in issue in the application.

As finally analysed by District Judge Batten, the decisions in question were the decisions of whether QR should change her residence from ABC to a supported living flat, which would involve giving up the secure tenancy of her flat and taking on the tenancy of accommodation on terms that 24 hour support would be provided to her. As Distric Judge Batten emphasised, they were linked decisions rather than decisions which should be viewed independently of each other.

Helpfully, District Judge Batten was at pains to identify the information relevant to each decision:

"*97. In relation to the move from ABC to supported living, in my judgment the relevant information that QR needs to understand, use and weigh is*

i) She will have to give up the tenancy of her flat.
ii) The terms of the CTO will determine where she lives
iii) IAOT will not at this stage allow her to live in her flat or in any other accommodation which does not provide on site 24 hour support
iv) The move to supported accommodation will offer her greater independence and control over her life than are currently available at ABC
v) She will have self contained accommodation
vi) She is at risk of falling ill again, with life threatening consequences, if she does not take her medication

[…]

99. In relation to the decision to give up her secure council tenancy, in my judgement the relevant information that QR needs to understand use and weigh is

i) By surrendering her tenancy she loses the right to live or return there, and thus the opportunity to exchange that tenancy for another secure council tenancy
ii) She cannot move to a less restrictive environment than ABC unless she gives up her tenancy
iii) For the foreseeable future the terms of the CTO will not permit her to live in her flat
iv) She needs 24 hour support in her accommodation in order to remain well
v) Giving up her tenancy does not preclude the grant of a council tenancy by LBI in the future if she is well enough to live completely independently"

[…]

101. In relation to the decision to sign a tenancy agreement for supported living accommodation, in my judgment the relevant information that QR needs to understand use and weigh is

i) Her obligations as tenant to pay rent, occupy and maintain the flat
ii) The landlord's obligations to her under the contract
iii) The risk of eviction if she does not comply with her obligations

iv) *The purpose of and terms of the tenancy which is to provide her with 24 hour support so that she takes her medication and can maintain her mental health*

v) *The landlord/support staff's right to enter her flat without her permission in an emergency if there is serious physical danger or risk to her*

vi) *If she moves to supported living accommodation the CTO will be changed to require her to live there."*

For reasons that need not detain us here (but repay study as a model of careful analysis), District Judge Batten held that QR lacked the capacity to take the decisions in issue.

Finally, it should be noted that District Judge Batten found this to be one of those unusual cases identified by Munby J (as he then was) in Sheffield City Council v E [2005] 2 WLR 953 in which a person could lack subject matter capacity whilst still having litigation capacity. It is worth, perhaps, reproducing the relevant paragraphs in full because they are so clear an example of an approach that allows the maximum participation by P.

> "*115. Is this one of those very rare cases where a person may not have subject-matter capacity but has litigation capacity? I have been the judge giving directions and conducting hearings in this case since October 2013. I have been told by QR's solicitor that she has no concerns about QR's capacity to litigate and her ability to get instructions from her. The case has not involved disputes as to the facts. I have noted what Dr Kingett had to say about QR's understanding of the legal process and her relationship with her solicitor (see paragraph 49 above). Dr Akenzua, QR's expert witness, provided evidence which was directed to the issues in the case and was of assistance to me. Her case was most ably presented by counsel at the final hearing. It would fly in the face of my own experience of dealing with the case to find that QR lacks capacity to litigate.*
>
> *116. I have described above the matters in which QR has understanding and an ability to use and weigh information. She is in a stable state as regards her mental illness and recognises many of the realities of her situation. Her delusional illness affects her core understanding so as to make decisions for herself about the issues in this case, but does not prevent her from being able to manage her life and make most of her decisions for herself. She is able to understand the court process. Removing a person's capacity to litigate is a significant interference. I am not satisfied on a balance of probabilities that QR lacks the capacity to litigate.*"

Comment

The analysis of the information relevant to each of the – linked – decisions in the case is particularly helpful, especially that relating to the information relevant to the decision to enter into a supported living tenancy as (with the exception of the last element) this applies outside the context of this specific case and the information is in our experience frequently not properly understood. The decision can also usefully be read with the first decision in *LBX v K, L and M* discussed in this month's Health, Welfare and Deprivation of Liberty Newsletter.

Law Commission project on wills

As part of its 12th Law Reform Programme, the Law Commission will be starting work in early 2015 on a project on wills, publishing its report, with final recommendations and a draft Bill, early in 2018. The announcement on the Law Commission's website provides thus:

"It is estimated that 40% or more of the adult population does not have a will, and where they do, the state of the law means it will often be found to be invalid. Where there is no will or a will is invalid, the intestacy rules will apply; they are a blunt instrument that cannot replace the expression of a person's own wishes. Certain individuals and bodies cannot benefit under the rules, including cohabitants and charities. It is therefore important that people make wills and that the law supports this.
The primary wills statute, the Wills Act 1837, dates from the Victorian era. The law governing testamentary capacity, the mental capacity to make a will, derives from a case from 1870. There is concern that the current law discourages some people from making wills, that it is out of step with social and medical developments, and that it may not work in such a way as to give best effect to a person's intentions on death. It has been criticised for being difficult to understand and apply, and for sometimes being unworkable in practice. In the case of mental capacity, this presents a growing problem, since conditions that affect capacity are becoming more common as people live longer.

This project will review the law of wills, focusing on four key areas that have been identified as potentially needing reform: testamentary capacity, the formalities for a valid will, the rectification of wills, and mutual wills. It will consider whether the law could be reformed to encourage and facilitate will-making in the 21st century: for example, whether it should be updated to take account of developments in technology and medicine. It will also aim to reduce the likelihood of wills being challenged after death, and the incidence of litigation. Such litigation is expensive, can divide families and is a cause of great stress for the bereaved."

A true tangle – capacity, influence and the inherent jurisdiction

NCC v PB and TB [2014] EWCOP 14 (Parker J)

Court of Protection jurisdiction and powers – assessing capacity

Summary

This decision of Parker J was handed down in March, but only appeared on Bailii in the second week of July 2014. It contains an important analysis of the 'causative nexus,' some controversial obiter comments as to the scope of the inherent jurisdiction, and a robust discussion of case management before the CoP.

The issues before the court were whether PB had capacity to decide whether to live with her husband, TB, what contact to have with him, where and under what care arrangements she should live, and whether any deprivation of her liberty resulting from a placement in local authority care should be authorised by the court. They were complicated by the fact that TB also lacked the capacity to litigate, and was also represented by the Official Solicitor.

Background facts

The background facts are detailed and complex; they repay careful reading because they are –sadly – resonant of too many cases where self-neglect interacts with complex and unsatisfactory personal relationships. For present purposes, however, and to summarise wildly, the case concerns a married couple, both of whom had psychiatric conditions, and whose living circumstances (together and, on occasion separately), caused increasing concern to Norfolk County Council. The local authority ultimately brought proceedings in the Court of Protection in relation to the wife, PB (although, on the facts set out by Parker J, it is perhaps not immediately obvious that this was not, actually, a 'two P' situation).

The proceedings

The proceedings took a somewhat convoluted course, especially as regards the obtaining of expert evidence, and Parker J had some pithy comments about the management of the case that we set out in full below.

By the time of the final hearing, both PB and TB submitted that PB had capacity; TB played a full part in proceedings through Counsel and the cross-examination of experts. However:

> *"39. No concrete proposals were put forward as to where PB and TB were to live together. In my view the issue was not just whether PB was able to take a decision that she wants to be with her husband, but as to where she should live, in what circumstances, and with what care package.*
>
> *40. This case is a prime example of the need in Court of Protection cases to have regard to the factual matrix and evidence, and the actual rather than theoretical decisions to be made: both by the protected party, and by the Court*."

Parker J was profoundly unhappy with the state of the expert evidence as to capacity. At the hearing, she had three reports from an independent psychiatrist, Dr Barker, and two from Dr Khalifa, neither of who had given a clear view of capacity. Although they had made and produced a schedule of agreement, their overall view on capacity was still unclear. Dr Barker's final position in evidence was that the issue of PB's capacity was finely balanced and should be decided by the court. He "lean[ed] *to the conclusion that she has capacity to make decisions about residence, care and contact in optimal conditions*." He wavered somewhat as to whether he thought that PB lacked capacity when not with TB, and eventually concluded that he thought that she might do. Dr Khalifa's consistent position in oral evidence was that PB's mental illness, anxiety and influence from TB all contributed to her inability to weigh information, but that TB lacked capacity at all times, sometimes at a greater level than at others.

Parker J was asked (before, and at the hearing) to see PB and TB. She expressed the need for care to be taken as to how such a meeting should be treated; as she noted:

> *"The protected party does not give an sworn/affirmed account, and in particular if the meeting takes place only in the presence of the judge, with no opportunity to test the evidence, then in my view no factual conclusions save those which relate to the meeting itself should be drawn, in particular with regard to capacity (see YLA v PM and Another* [2013] EWHC 4020 (COP) *at [35]."*

Both PB and TB spoke to Parker J in the courtroom with representatives present. Parker J considered PB to be "*likeable, highly intelligent, sophisticated and articulate, well-read and knowledgeable*," and that "*it* [was] *obvious to me from all that I have read and heard as well as from the meeting that PB's intellectual understanding is at a high level. She stated 'I understand that this Act only came in in 2005. I wonder whether it's working out as it should be.'*" TB was also likeable, articulate and sincere. Parker J accepted that, whatever their respective problems, the couple had a long standing and committed relationship and that they loved one another dearly. There was no issue as to their capacity to marry, and Parker J accepted that the relevant public bodies were trying to preserve the quality of their relationship as a couple, while promoting PB's physical and mental wellbeing.

Capacity

The core issue of law that Parker J had to decide was whether TB's incapacity (which it was common ground could only relate to her difficulties with using and weighing the relevant information) was caused by a material impairment or disturbance of the mind or brain, or whether it stemmed from the influence exercised over her by her husband.

Having heard submissions upon the proper meaning of "because of" in s.2 MCA 2005, Parker J concluded (at paragraph 86) that:

> *"the true question is whether the impairment/disturbance of mind is an effective, material or operative cause. Does it cause the incapacity, even if other factors come into play? This is a purposive construction*."

Parker J also rejected the submission advanced on behalf of both PB and TB that McFarlane LJ in *PC v City of York* [2013] EWCA Civ 478 stated that the 'diagnostic' and 'functional' questions should be asked in the reverse order to that set out in the Code of Practice, holding that:

> *"In my view MacFarlane LJ did not purport to lay down a different test: nor did he take the questions in the reverse order, but simply stressed that there must be a causative nexus between the impairment and the incapacity."*

At paragraph 92, Parker J held that PB's condition was the cause of her inability to use and weigh. "*Her inability to challenge TB may at one time have stemmed from a belief in the ties of marriage: I do not know. But now she is unable to use and weigh the information because of the compromise in her executive functioning and her anxiety*."

Parker J, addressing specific submissions about the importance of the principle contained in s.1(4) MCA 2005 that a person is not to be treated as unable to make a decision merely because he makes an unwise decision, held that:

> "*98. This decision* [i.e. where to live] *requires PB to factor in immediate and serious consequences. The principle of autonomy must have limits, or there would be no intervention under the MCA 2005.*
>
> *99. Where a decision has consequences of a serious impairment of health or welfare, the court is not considering a decision which is merely unwise. Ms Street submits that the foreseeable consequences must be proximate and not remote. The foreseeable consequences here are all too proximate, and have been repeatedly demonstrated. PB is unable to use this information to take into account foreseeable proximate consequences*."

In a section of the judgment entitled 'Influence/overbearing of the will,' Parker J returned to the question of whether the impairment or disturbance must be the sole cause of the inability to make a decision. Rejecting the submission made on behalf of PB (relying on dicta in *R v Cooper* [2009] UKHL 42, [2009] 1 WLR 1786) that the impairment or disturbance must be the sole cause of the inability, she held that "*inability to exert the will against influence because of the impairment or disturbance is relevant*"

(paragraph 101). However, it should be noted that this conclusion (and the discussion of pre- and post-MCA 2005 case-law) was obiter because:

> *"*107 *… by reason of her condition alone, even without the influence of TB, in my view PB lacks capacity to use and weigh. The history over March and April 2013 in particular demonstrates that PB was not able in reality to make any decision at all which related to TB, or to her care needs. And what she has said during the course of these proceedings demonstrates the same process. Her impairment /disturbance is the effective cause, the primary cause of her inability to make a decision" (emphasis in original)*

Inherent jurisdiction

In a section of her judgment that is also obiter, Parker J went on to discuss whether – if PB had the capacity to decide where to live – she could impose a 'residence requirement' upon her under the inherent jurisdiction. In brief terms, she held that she could, because:

> "*113… The inherent jurisdiction exists to protect, liberate and enhance personal autonomy, but any orders must be both necessary and proportionate. Miss Burnham submits that what is proposed is protective and necessary and proportionate and is not a coercive restricting regime. I am inclined to the view that a regime could be imposed on PB if that is the only way in which her interests can be safeguarded. To be maintained in optimum health, safe, warm, free from physical indignity and cared for is in itself an enhancement of autonomy.*
>
> *114. I see no indication that the inherent jurisdiction is limited to injunctive relief. Each case depends on the degree of protection required and the risks involved. And the court must always consider Article 8 rights and best interests when making a substantive order.*"

Parker J further held that Article 5 ECHR would be complied with because:

1. Any order would be in accordance with a procedure prescribed by law because any order would be "imposed by a court of law through a legal process of which notice had been given and it would be perfectly possible for a person of sufficient capacity to understand its effect. That fulfils the "Purdy" criteria [i.e. those set down in *R (Purdy) v DPP* [2010] 1 AC 345];

2. PB's diagnosed psychiatric condition would satisfy the requirement of "unsoundness of mind" in Article 5(1)(e) even if it had not sufficed to establish a lack of capacity. As Parker J noted, incapacity is not co-terminous with unsoundness of mind.

The conclusion on best interests

Parker J held that it was in PB's best interests to remain at the care home where she had been placed by the Council, and that that it was lawful and proportionate for PB to be deprived of her liberty by the court with controlled contact to TB until a statutory authorisation can be obtained.

Case management

Parker J concluded with some robust comments upon case management which we reproduce in full because it is clear that they were intended for wide dissemination.

> *"126. I stress that I do not wish to criticise the advocates in this case. But I take this opportunity to offer some general guidance derived from my experience in Court of Protection cases from the point of view of the decision maker. This is not a new stance: I have raised the same points in other cases. But over the years some effective steps have been taken to control and manage family cases from which lessons have been learnt. Even more progress is being made under the impetus of the family justice reforms.*
>
> *127. Adoption of a practical approach does not detract from intellectual analysis and rigour. Lord Wilson of Culworth as a puisne judge described himself as "family lawyer of practical disposition". The reality and practicality of the subject matter of the decision can in my experience sometimes get lost in Court of Protection cases. So can the focus on effective administration of justice. The quest to address arguments of increasing subtlety can, as in this case, paralyse effective decision making by a Local Authority and hamper the ability of the court to deliver a decision. All those who practice in the Court of Protection must appreciate that those who represent the vulnerable who cannot give them capacitous instructions have a particular responsibility to ensure that the arguments addressed are proportionate and relevant to the issues, to the actual facts with which they are dealing rather than the theory, and to have regard to the public purse, court resources, and other court users. I do not accept that (i) every possible point must be put (ii) the belief of a protected party is relevant to the issue of capacity. As Lord Judge reminded the profession in R v Farooqi and Others [2013] EWCA Crim 1649, it is for counsel to decide what question to ask and not the client. The fact that a client may lack capacity is not a green light for unmeritorious or unrealistic arguments to be put forward.*
>
> *128. Everything comes at a price. And every penny spent on litigation is in reality (because it all comes out of the public budget) a penny taken away from provision for care. There were many court hearings whether attended or not, at most of which almost nothing of any materiality was achieved. One of the problems may have been lack of judicial continuity. It took many months for a fact finding hearing to take place. The Court is still not in a position to determine best interests. I had to read and reread reams of material and law reports after my return from leave to conclude this judgement.*
>
> *129. I recognise the importance of this field of litigation. I recognise the need to promote the Convention rights of as well as to protect the vulnerable and the incapacitated. But in cases under the Children Act 1989 equally important human, Convention and protective issues arise. As in the Court of Protection, the court has to have regard to the overriding objective. Experts are not routine and have to be "necessary", and the necessary expertise may come from the social worker.*
>
> *130. Baker J in CKK and KK [2012] EWHC 2136 (COP) and Butler-Sloss J in Ms BS v An NHS Hospital Trust [2002] EWHC 429 (Fam) [2002] 2 All ER 449 reminded clinicians that a close professional relationship with P might lead them to be drawn to a supportive or emotional rather than analytical approach to capacity.*

I do not read these comments as supporting the appointment of an "independent" expert as the first line approach before the treating clinician has even set out the reasons behind the certificate of incapacity. Second opinions must be justified: and not just ordered as a matter of routine until there is no reason to doubt the first.

131. I am told Moor J queried the need for further evidence and the time estimate but was assured by the Official Solicitor that this was "reasonable" in order to ensure that the matter could be "properly resolved" by the Court. I cannot imagine that Moor J envisaged that there would be five reports in all, a "schedule of agreement" which was in fact not truly agreed, all of which led to considerable confusion, muddle, and prolongation of the court process. It certainly led to a prolonged examination of the witnesses, as fine distinctions in use of language and formulation of ideas were pursued and analysed.

132. The social care evidence has been crucial. The assessment of capacity is in the end for the Judge on the basis of all the facts (see in particular Baker J in CC & KK & STCC [2012] EWHC 2136 (COP)) echoed by me in YLA & PM MZ COP 1225464. After all a single expert can be challenged by the process of cross-examination.

133. Attempts have been made to encourage if not direct Court of Protection practitioners to comply with basic sensible rules of case management in order to assist the judge. Moor J's attempt to bring some order to the proceedings failed. The most basic of requirements, to provide a witness time estimate template, was ignored. Thus at the commencement of the hearing I was met with an assertion that there was insufficient time available: particularly for lengthy cross-examination. I had to take counsel in detail through the list of potential witnesses, and the issues which they were to address, in order to create a plan for the hearing of the case. This took up time. All this should have been done beforehand and a late return was no excuse. Specialist counsel had been on board throughout. Ms Street submitted that Dr Barker's evidence was still so unclear as to require two hours cross-examination by her alone. I managed to shorten this a little. Even so the case proceeded much more slowly than was necessary. In my view this should have been a two day case at most.

134. Before seeking a four day listing the advocates should have provided for Moor J a precise broken down time estimate of what time was required for each witness, submissions and judgment, focused on the actual issues, or likely issues. I insist on this at directions hearings, and I find that I can usually shorten the individual times required, and the overall time estimate, very considerably in the process. Time estimates must be adhered to.

135. A judge cannot easily understand the issues, or give an effective ex tempore judgment, without a chronology of essential dates. I asked for one at the outset. It was produced part of the way though the hearing, obviously in a hurry, and a number of important dates, particular court hearings, were not included. I had to trawl though the applications and orders in the bundle and the many lengthy statements in order to produce the analysis of the history above which I have found so essential here.

136. Fact finding schedules should be produced in a way which makes it easy for the Judge to utilise them as a tool for delivery of judgment. The contents of the document produced were in fact useful, but difficult to use. I hope it is not churlish to complain that it was created in landscape rather than portrait, that when answered the page references were omitted, and there was no space for the judge's comments. It would have been even more useful if there had been a chronology.

137. The evidence could have been addressed much more shortly. The actual issues raised were:

i) The psychiatric evaluation of PB

ii) The extent to which TB's influence or pressure affected capacity: the legal issue arising from that was a matter for the judge.

iii) The extent to which PB's beliefs may have been causative of her decision making: the interpretation of the words "because of" was for the judge and not the witnesses.

iv) Whether any potential decisions were simply unwise: again as Dr Barker recognised this was really a matter for judicial evaluation.

138. The joint statement should have addressed starkly:

i) Is there impairment or disturbance, if so what is it and what is its effect?

ii) What is the decision to be made?

iii) What is the information necessary to make that decision?

iv) Is the person able to retain, use or weigh, that information and/or communicate that decision?
v) Is there a lack of capacity and if so why?

139. And if the experts do not agree, they must make it clear. If they have not made it clear, they must be asked to do so. If their disagreement does not affect the outcome that is one thing. If they disagree on the fundamental issue, they must say so. The experts are not a jury considering whether they can give a unanimous verdict. There is no duty to "harmonise" views if in reality the experts do not agree. It simply makes the task of the judge more difficult.

140. Practitioners need to ask themselves:

i) What do I really need to challenge?

ii) What does the judge need to know?

iii) What is actually arguable and what is not?

141. Effective steps must be taken to reduce evidence to the essential. In Farooqi Lord Judge emphasised the requirement that cross-examination should proceed by short, focussed question rather than by comment, opinion and assertion. I also note that in The Law Commission lecture given last year Lord Judge stated (as I was taught) that in principle no question should be longer than one line of transcript. In any event, the judge is interested in the answer, not the question.

142. Advocates need to be able to control the witness by the form and structure of their questions and not permit discursive replies or to allow the witness to ramble (particularly if the witness has the tendency to be prolix). There is no necessity for a long introduction: apart from anything else it may distract and confuse the witness and the judge.

143. Examination must not proceed by way of "exploration" of the evidence: i.e. a debate, or by putting theory or speculation, rather than by properly directed questions which require an answer.

144. This is all the advocates' responsibility. However hard a judge tries to speed the process, this takes up time and interrupts the flow, and often leads to a debate with the advocate. Also it can give the wrong impression to the lay client about the judge's view of them or their case.

145. Where two parties have the same case to put, the same points must not be repeated.

146. Finally the advocate needs, if facts are challenged, to put the client's case.

147. I note and am glad to see that in IM v LM the Court of Appeal approved Peter Jackson J's decision to determine the issues in a 2 hour hearing. The second opinion psychiatrist was not cross–examined. I am sure that in that case it helped that there had been judicial continuity throughout.

148. I am certainly not suggesting that this case should not have been litigated. It may have been necessary to have two experts. I really cannot tell, because of the way their instruction progressed, which may have led to their lack of precision on paper. But more focus on case management and case progression is essential."

Comment

It is unfortunate in some ways that the Official Solicitor did not seek permission to appeal this decision (on behalf of either PB or TB), because we have considerable concerns about two aspects of the judgment.

That having been said, the comments made in relation to case-management are ones that practitioners would do very well to heed because they are reflective of an increasingly robust approach to case management which is likely to be adopted by ever judges and (in due course) potentially to be reflected in amendments to the Court of Protection Rules and/or Practice Directions so as to align them with the position in respect of family proceedings.

Capacity

With the greatest of respect to Parker J, her reasoning on this question is somewhat obscure. It is possible to read paragraph 86 as suggesting that the impairment or disturbance need be no more than a material cause of a person's inability to decide; if so, this is plainly incorrect, and inconsistent with the decision of the Court of Appeal in *PC*.

If, however, as seems more likely from paragraph 107, Parker J was holding that s.2(1) MCA 2005 requires that the court identify whether the impairment/disturbance identified by the evidence was the material/effective/primary cause of the inability, then we would respectfully agree. It would appear, indeed, that this was, in fact, her conclusion because at paragraph 107 she was at pains to emphasise that she concluded that PB's impairment/disturbance was the effective/primary cause of her inability to take a decision.

We are, though, troubled by Parker J's (obiter) discussion of the role of influence. This is a very difficult area, not least because of the fact that two of the most important authorities (*Re G (an adult) (Mental capacity: Court's Jurisdiction)* [2004] EWHC 222 (Fam) and a *Local Authority v SA and others* [2005] EWHC 2942 (Fam) pre-dated the coming into force of the MCA 2005 and the sharp distinction that fell to be drawn thereafter between those lacking capacity and those who were 'merely' vulnerable. Further, a decision upon which Parker J placed particular reliance, *Re A (Capacity: Refusal of Contraception)* [2011] Fam 61, was a decision that pre-dated that in *PC* and, we would suggest would be approached rather differently in light of the emphasis in *PC* upon the causative nexus (for our part, *Re A* looks a lot more like – as was submitted on PB's behalf – an inherent jurisdiction case, rather than an MCA 2005 case).

It seems to us that there is a clear (and principled) distinction to be drawn between:

1. A person who because of their impairment/disturbance is unable to resist the influence of another; and

2. A person who is in some way vulnerable and is also subject to influence.

For a discussion of this difference which appears not to have been put before Parker J (it post-dated the hearing before her, but pre-dated her judgment) which makes the point very clearly indeed, see the judgment of Russell J in *LB Redbridge v G, C and F* [2014] EWCOP 485 (COP).

For our part, therefore, we would counsel considerable caution in placing reliance upon these paragraphs in Parker J's judgment and would reiterate that they are obiter because she was ultimately at pains to hold that the material cause of PB's inability to decide as to residence was the impairment/disturbance from which she suffered.

Inherent jurisdiction

We are even more troubled by Parker J's observations as to the scope of the inherent jurisdiction; we presume that the reason that the Official Solicitor chose not to seek to appeal the decision (as was intimated might be the case at paragraph 109) was because they were obiter.

We are, for a start, troubled by the soundness of the observations as a matter of law. In particular, it is difficult to reconcile her decision with that of Macur J in *LBL v RYJ and VJ* [2010] EWHC 2665 (COP), In that case, Macur J expressly rejected (at paragraph 62):

> *"the initial contention of this local authority that the inherent jurisdiction of the court may be used in the case of a capacitous adult to impose a decision upon him/her whether as to welfare or finance. I adopt the arguments made on behalf of RYJ and VJ that the relevant case law establishes the ability of the court, via its inherent jurisdiction, to facilitate the process of unencumbered decision-making by those who they have determined have capacity free of external pressure or physical restraint in making those decisions"* (emphasis added)

In this regard, recall also that the Court of Appeal in *Re DL* expressly endorsed the approach adopted by Macur J (at paragraph 67, per McFarlane LJ):

> "*Further, in terms of the manner in which the jurisdiction should be exercised, I would expressly commend the approach described by Macur J in LBL v RYJ and VJ* [2010] EWHC 2665 (COP)*, paragraph 62, which I have set out at paragraph 33 above. The facilitative, rather than dictatorial, approach of the court that is described there would seem to me to be entirely on all fours with the re-establishment of the individual's autonomy of decision making in a manner which enhances, rather than breaches, their ECHR Article 8 rights*."

On a proper analysis, it seems to us that Parker J's approach allows for decisions to be imposed upon a capacitous adult. Not only is this difficult to square with the two decisions set out above, but – more fundamentally – how is such an approach to be distinguished from taking a decision on behalf of such an adult? Or – where the decision that is dictatorially imposed upon the adult is different to that which they purported to wish to take – how is that to be distinguished from overriding their capacitous decision? And, if it cannot, what purpose does the MCA 2005 actually serve in identifying a distinction between two classes of individuals in circumstances where (as Parker J had herself previously recognised in *XCC*) "*The Court of Appeal in DL stressed that in contrast to incapacitated adults, the decisions of adults with capacity cannot be overridden on the best interests test or welfare grounds*"?

Further, whilst Parker J was at pains to identify the approach that she was suggesting as being supportive of PB's autonomy, it is perhaps not impertinent to suggest that it is very unlikely (given the description of PB's relationship with TB) that PB would regard this as being the case. There is a distinct flavour here of forcing an individual to be free.

That the balance may come down in an appropriate case under the MCA 2005 in favour of protection over autonomy may well be inevitable, but the MCA 2005 provides a framework within which this decision will be taken and principles against which it can be tested. There is no equivalent framework for the exercise of the inherent jurisdiction beyond the need to do what is necessary, proportionate and not incompatible with the ECHR. It is also worth recalling here that Parker J in *XCC* expressly held that when she was considering exercising the inherent jurisdiction that she was not bound by the provisions of s.4 MCA 2005 and could take into account – for instance – public policy considerations that the CoP could not. Her comments in *XCC* might be distinguished because she was concerned there with granting relief in respect of an incapacitated adult where the relief sought was outside the scope of s.15 MCA 2005, rather than granting relief in respect of an adult outside the scope of the MCA 2005. However, the decision in *XCC* is (perhaps inadvertently) revealing of some of the pitfalls that may lie ahead if judges go down the path identified in this more recent case.

Finally, and with specific regard to Article 5(1) ECHR, it is far from obvious that the making of an order under the inherent jurisdiction in relation to a person who may have the capacity to decide where to reside but (as may well be the case) not have the capacity to litigate would satisfy the *Purdy* requirements. And it is also worth noting, perhaps, that very much greater safeguards are enshrined in the powers contained in

the Adult Support and Protection (Scotland) Act 2007 to order the temporary removal of a capacitous but vulnerable adult from their own home: see this discussion paper here.

A substantial irony here is that the approach suggested by Parker J which is, at heart, predicated upon risk, irrespective of the capacity of the individual concerned, could be seen to be less discriminatory than that contained in the MCA 2005 and therefore, arguably, more compatible with the CRPD. But it is an approach that – with respect – flies in the face of the clearly established current threshold for intervention set down in the MCA 2005. It is also an approach which, for our part, we would wish to be considered very carefully – and, ideally – addressed in statute, rather than developing incrementally.

Meeting P

One final, very small point, it is perhaps worth noting that it is not instantly obvious that merely because PB and TB were P and a protected party respectively they could not give evidence (as Parker J appear to have held at paragraph 42). It may well have been that this section of Parker J's judgment was compressed in its reasoning, but it should be recalled that (where evidence is to be given on oath or after an affirmation) the test for competence to give such evidence is distinct from the test for whether P has capacity to conduct the litigation. The test is whether the witness is capable of understanding the nature of an oath and of giving rational testimony.

To fact-find or not to fact-find?

LBX v TT and others [2014] EWCOP 24 (Cobb J)

Practice and procedure – Fact-finding

Summary

TT was a 19 year old woman with moderate learning disabilities and global developmental delay. In November 2012, she alleged that her stepfather had sexually assaulted her and forced her to watch pornographic videos. She was placed in adult foster care and her stepfather was awaiting trial in the Crown Court. As a result of significant concessions by the parents, rather than a three-day hearing to conduct a full enquiry into the allegations, Cobb J was able to proceed to a more limited factual enquiry, principally directed to the issue of contact between TT and her mother ('MJ').

One issue was whether, in light of the concessions, the court could make orders upon an agreed basis of facts without having to make factual findings. Or, given that TT's mother's stance on contact would be likely to change following her husband's trial, whether a fact-finding hearing should proceed. Cobb J reiterated the principle that he who asserts must prove on the balance of probabilities, as described by Lord Hoffman in *Re B (Care Proceedings: Standard of Proof)* [2008] UKHL 35 at §2:

> *"If a legal rule requires a fact to be proved (a 'fact in issue'), a judge or jury must decide whether or not it happened. There is no room for a finding that it might have happened. The law operates a binary system in which the only values are 0 and 1. The fact either happened or it did not. If the tribunal is left in doubt, the*

doubt is resolved by a rule that one party or the other carries the burden of proof. If the party who bears the burden of proof fails to discharge it, a value of 0 is returned and the fact is treated as not having happened. If he does discharge it, a value of 1 is returned and the fact is treated as having happened".

In determining what factors should influence the exercise of the court's discretion in deciding whether these should be a finding of fact hearing at the interim or final hearing, his Lordship drew upon some analogous jurisprudence from the family courts:

"46. I have had the relative luxury of three days of court time set aside to determine these issues; the court will however often be constrained by sheer practicalities of time and opportunity for an oral hearing. In each situation, the Judge surely has to make a determination – often under pressure of time – as to how far he or she can go to test the material. By analogy with the position in family law, the judge would in my judgment be well-served to consider the guidance of Butler-Sloss LJ in the family appeal of Re B (Minors)(Contact) [1994] 2 FLR 1 in which she said as follows:

> '*There is a spectrum of procedure for family cases from the ex parte application on minimal evidence to the full and detailed investigations on oral evidence which may be prolonged. Where on that spectrum a judge decides a particular application should be placed is a matter for his discretion. Applications for residence orders or for committal to the care of a local authority or revocation of a care order are likely to be decided on full oral evidence, but not invariably. Such is not the case on contact applications which may be and are heard sometimes with and sometimes without oral evidence or with a limited amount of oral evidence*.'

It is acknowledged that the 'spectrum' may now be narrower than that described in 1994 following the revisions to rule 22.7 of the Family Procedure Rules 2010, but the principle nonetheless remains, in my judgment, good.

47. Butler–Sloss LJ went on to define the questions which may have a bearing on how the court should proceed with such an application (adapted for relevance to the Court of Protection):

i. Whether there is sufficient evidence upon which to make the relevant decision;

ii. Whether the proposed evidence (which should be available at least in outline) which the applicant for a full trial wishes to adduce is likely to affect the outcome of the proceedings;

iii. Whether the opportunity to cross-examine the witnesses for the professional care or other agency, in particular in this case the expert witnesses, is likely to affect the outcome of the proceedings;

iv. The welfare of P and the effect of further litigation – whether the delay in itself will be so detrimental to P's well-being that exceptionally there should not be a full hearing. This may be because of the urgent need to reach a decision in relation to P;

v. The prospects of success of the applicant for a full trial;

vi. Does the justice of the case require a full investigation with oral evidence?

48. In deciding whether to conduct a fact-finding hearing at all, I consider it useful to consider the check-list of considerations discussed by McFarlane J in the case of A County Council v DP, RS, BS (By their Children's Guardian) [2005] EWHC 1593 (Fam) 2005 2 FLR 1031 at [24]. Following a review of case-law relevant to the issue he stated that:

"… amongst other factors, the following are likely to be relevant and need to be borne in mind before deciding whether or not to conduct a particular fact finding exercise:
(a) the interests of the child (which are relevant but not paramount
(b) the time that the investigation will take;
(c) the likely cost to public funds;
(d) the evidential result;
(e) the necessity or otherwise of the investigation;
(f) the relevance of the potential result of the investigation to the future care plans for the child;
(g) the impact of any fact finding process upon the other parties;
(h) the prospects of a fair trial on the issue;
(i) the justice of the case."

49. There is some (but not universal) acknowledgement at the Bar in this case that this list (with modifications as to (a) to refer to the best interests of 'P' rather than 'the child') provides a useful framework of issues to consider in relation to the necessity of fact finding in the jurisdiction of the Court of Protection."

According, Cobb J decided to conduct a limited fact-finding exercise and made resulting declarations and decisions. This included an authorisation to deprive TT of her liberty in the foster home.

Comment

When to hold fact-finding hearings in the Court of Protection is an issue in respect of which – unlike in relation to children – there is no guidance and a paucity of reported cases. The topic is discussed in some detail in the new Court of Protection Handbook (see further below) in which Alex expressed the view that a useful analogy could be drawn with the pre-MCA case of *Re S (adult's lack of capacity: carer and residence)* [2003] EWHC 1909 (Fam), [2003] 2 FLR 1235). However, this decision of Cobb J is by far the most comprehensive to date in terms of its analysis. Until and unless a Practice Direction or Practice Guidance is produced setting out a framework, it is suggested that the model set out by Cobb J is one that will be of considerable assistance to practitioners and judges in determining whether a fact-finding hearing is required and the need for oral evidence. It should, though, be recalled, that the tenor of recent judgments from the Family Division/Court of Appeal is that very considerable caution should be exercised before a separate fact-finding hearing is listed (see, for instance, *Re S, Cambridgeshire County Council v PS and others* [2014] EWCA Civ 25).

Short Note – the power to evict/duress and revocation of LPAs

The unedifying saga of the *Redbridge v G* case that we have been reporting on in recent newsletters has come to an end for now at least, in the form of the judgment of Russell J in *LB Redbridge v G (No 4)* [2014] EWCOP 17. For the full background, see our comment on the first judgment here.

In short terms Russell J has concluded that it is not in G's best interests for her carer C and C's husband F to continue to live in her house, or for her to have any contact with C or F. The judgment is, in our respectful submission, compelling for its detail and sympathetic engagement with G as an individual: it is, of particular note, that Russell J's balance of the current (and inconsistent) wishes and feelings expressed by G – caught in the middle of the 'spider's web' – with her previous past consistent wishes and feelings.

The judgment is of wider interest for two reasons.

The first is the clear holding by Russell J that she had the power to require C and F to leave G's house:

> *"93. Whether or not it is in G's best interests for C and F to continue to live with G is "a matter concerning P's personal welfare"; s17(1) (c) expressly provides that the court can prohibit a named person from having contact with P. I intend to make an order regarding contact between C and F and G. I consider that I have powers under s 17 to make the order I have that C and F vacate G's home, as I am making the decision on G's behalf in relation to a matter concerning her personal welfare as provided for in s 16(1) (a) and s 16(2) (a) and s 47 (1). The latter provides that the court has in connection with its jurisdiction the same powers, rights, privileges and authority as the High Court. I have considered the Court of Appeal case of DL v A Local Authority & Others [2012] EWCA Civ 253 and could under the inherent jurisdiction of the High Court, exercise the power under the inherent jurisdiction to make a mandatory injunction requiring C and F to leave the property. However I do not consider that to be necessary as the powers under the MCA are sufficient."*

The second is the approach adopted by Russell J to the revocation of a health and welfare LPA purportedly granted by G in favour of C. Russell J did not have before her sufficient evidence that G had lacked the requisite capacity at the material time, so could not revoke the LPA on the basis that such capacity is required by s.9(2) MCA 2005. However,

> *"95. The local authority submits that the LPA should be revoked, and I agree. The argument is put forward that the court can revoke the instrument based on the provisions of s.22(3) (a) (i) and (ii) and/or (b)(i) and revoke by virtue of s22 (4) (b). The need for a further hearing on this matter given the findings I have made in respect of C would seem to be disproportionate. On the findings I have made the provisions of s 22 (3) (a) (i) and/or (ii) are met; as it is more likely than not that C used undue pressure. It offends against logic to suggest that s22 (b) (i) can only refer to the behaviour of a donee when purporting to act under the authority of the instrument when the court has found that a donee has behaved in a way that is not in P's best interests, particularly when the behaviour relates directly to the specific LPA; in this case health and welfare. In view of my decision regarding the evidence of ML (which I accepted) that he discussed drawing one up granting her brother that power instead, very shortly before the existing LPA was drawn, therefore I revoke the LPA pursuant to s 22(4) (b)."*

The approach adopted by Russell J should is consistent with and should perhaps be read alongside the decision of HHJ Marshall QC in *Re J* (which appears not to have been brought to Russell J's attention). In that case, HHJ Marshall QC rejected a submission that s.22 embodied a broad concept of

unsuitability; she also rejected a that the only conduct that the Court could take into account for purposes of s.22(3)(b) was that of the donee in his capacity as donee. Rather

> *"11. In my judgment, the key to giving proper effect to the distinction between an attorney's behaviour as attorney and his behaviour in any other capacity lies in considering the matter in stages. First, one must identify the allegedly offending behaviour or prospective behaviour. Second, one looks at all the circumstances and context and decides whether, taking everything into account, it really does amount to behaviour which is not in P's best interests, or can fairly be characterised as such. Finally, one must decide whether, taking everything into account including the fact that it is behaviour in some other capacity, it also gives good reason to take the very serious step of revoking the LPA.*
>
> […]
>
> *13… noting the court's powers with regard to directing an attorney under s 23 of the Act... on a proper construction of s 22(3), the Court can consider any past behaviour or apparent prospective behaviour by the attorney, but that, depending on the circumstances and apparent gravity of any offending behaviour found, it can then take whatever steps it regards as appropriate in P's best interests (this only arises if P lacks capacity), to deal with the situation, whether by revoking the power or by taking some other course."*

Short Note – the costs of non-compliance

The case of *LB of Bexley v V, W and D* [2014] EWHC 2187 (Fam) contains a stark reminder of the need to comply with court directions concerning the filing of evidence. The local authority in this case failed to file its evidence in accordance with deadlines which had already been extended, and despite the court stating that if any party was going to be unable to comply with the extended deadlines, it should apply to the judge's clerk for an extension. It was said on the local authority's behalf that no application was made as the local authority did not know when it would be able to produce its evidence. Unsurprisingly, the court was not impressed, but fortunately it was possible for amended directions to be given which enabled all parties to file their evidence without jeopardising the final hearing in the proceedings. The local authority was criticised and required to pay the costs of the hearing: "*I understand that social work professionals and lawyers, whether engaged by public authorities or in private practice, are under enormous great strain in the current circumstances and economic climate, particularly given changes to public funding, but that does not relieve them of the obligation to comply with orders made by the court. The failures by the London Borough of Bexley in this matter are stark. This hearing would not have been required if they had complied with their orders and, in my judgment, it was right that this matter was listed at the earliest opportunity to address those failings and to enable the other parties to make submissions as to when they could comply with their obligations to file documents. Accordingly, I am in no doubt that it is right that the local authority should be ordered to pay the costs of this hearing*."

Similar approaches may well be taken by judges in the Court of Protection, particularly where failures to meet court deadlines delay the substantive determination of an application. And we would note the case of *Re W (Children)* [2014] EWFC 22 as a further example of the very robust approach that is being taken in

family cases – in the context of much tighter rules in the FPR; we anticipate that it is only a matter of time before the COPR includes similar provisions and a similar approach is taken in CoP cases.

Short Note – the Court of Appeal to examine nominal damages in the mental health context

Summary

The question of whether the principles relating to the assessment of damages set down in the Supreme Court decision of *Lumba* should be applied in the mental health context is to be reviewed by the Court of Appeal, permission having been granted on 1 July 2014 to the claimant to appeal the decision of HHJ Hand QC in *Bostridge v Oxleas NHS Foundation Trust*.

The appeal is of wider significance, because it is likely that it will also dictate the approach that would be taken to claims for damages for false imprisonment and/or unlawful deprivation of liberty arising out of deprivations of liberty under the MCA 2005.

The facts of Mr Bostridge's case are, insofar as relevant for present purposes, these. He was discharged from detention by the FTT (Mental Health) in April 2009, his discharge being deferred so a Community Treatment Order could be put in place. However, for technical reasons that need not detain us here, what was then purported to be put in place as CTO was not, in fact, a CTO such that, when his condition deteriorated in August 2009 and he was recalled to hospital and detained thereafter (with six days of leave) until November 2010, his detention was at all stages – and was admitted by the Defendant Trust – to be unlawful. The Defendant admitted that the period of 442 days amounted to false imprisonment and/or unlawful deprivation of liberty for purposes of Article 5 ECHR. His case was reviewed twice by a Tribunal during his detention (with no one realising the fact that the detention was unlawful), on both occasions the Tribunal finding that his condition warranted continued detention. The Claimant never realised that his detention was unlawful, nor did anyone involved in his care. A jointly instructed psychiatrist who reported in the subsequent claim brought on his behalf after it was realised that he had been unlawfully detained indicated that his re-admission to hospital in August 2009 was necessary as at that point, that there was no evidence that he had suffered damage during the period of unlawful detention due to his being unlawfully detained, and that he would have suffered the same unhappiness and distress had been lawfully detained.

Against that backdrop of agreed facts, HHJ Hand QC had to assess the quantum of damages that fell to be awarded the Claimant for both false imprisonment and unlawful deprivation of liberty. The Defendant relied heavily on the cases of *Lumba and Mighty v Secretary of State for the Home Department* [2011] UKSC12 and *Kambadzi v Secretary of State for the Home Department* [2011] UKSC 23 (discussed in more detail in Alex's article, co-written with Catherine Dobson, "*At what price liberty? The Supreme Court decision in Lumba and compensation for false imprisonment*" [2012] *Public Law* 628)

HHJ Hand QC held that *Lumba* and *Kambadzi* were authority for three propositions (of application beyond the immigration detention context):

1. the tort of false imprisonment is established even where the detention has caused no loss because it would have been inevitable if the detainer had acted lawfully;

2. there is no principle in the law of England and Wales of "vindicatory" damages;

3. where there is no loss suffered as a consequence of unlawful detention, damages for false imprisonment will be nominal.

It being accepted that there was no loss: the Claimant would have been detained had his illness been correctly addressed via s.3 MHA 1983, as it should have been on 19 August 2009, and thereafter he would have received precisely the same treatment and he would have been discharged in September 2011. HHJ Hand QC therefore held that he was entitled to judgment and to nominal damages.

Mr Bostridge applied for permission to appeal. The transcript of the permission hearing before Kitchin LJ ([2014] EWCA Civ 1005) contains the following material passages:

> *"7 Mr Drabble submits that in approaching the matter as he did the judge fell into error because the decisions of the Supreme Court in Lumba and Kambadzi do not establish that only nominal damages follow where there was a complete absence of statutory authority for a detention. To the contrary, Mr Drabble argues, there is a distinction between an unlawful detention where there was no threshold power to detain and detention which is unlawful on other grounds despite there having been lawful authority to detain in the first place. Moreover, Mr Drabble continues, the Act reflects the particular importance of compliance with the procedural requirements for lawful detention and it is simply no answer to the appellant's claim to say that he could have been detained had the appropriate procedures been followed. What is more, says Mr Drabble, the appellant has lost the protection of the rights and procedures which Parliament has provided in the Act for vulnerable persons such as him. That, he says, is a real not a nominal loss.*
>
> *8 I have been persuaded that these are points which merit consideration by this court, both because an appeal would have a reasonable prospect of success and because the appeal raises a point of principle, namely the approach to be adopted where a person responsible for an unlawful detention was not in a position lawfully to detain the subject without ensuring that an important condition precedent had been fulfilled, the condition precedent being compliance with the safeguards contained in section 3 of the Act. Further, in the circumstances of this case, compliance with those safeguards was not a matter which lay wholly within the power of the respondent.*

Comment

Whilst the "*Lumba* principles" are well-established in the context of immigration detention, precisely how they apply in the mental health – and mental capacity – context is less obvious. As Alex and Catherine Dobson noted in their article in *Public Law* – in arguments echoed on behalf of Mr Bostridge:

> *"Policy arguments could, for example, be made that the causation approach should not apply to the power to authorise the detention of individuals under the Mental Health Act 1983 or the Mental Capacity Act 2005. Both statutory schemes already protect certain categories of decision-maker from damages claims where the relevant decisions are taken in good faith and with reasonable care. This might give rise to the inference that Parliament intended procedural errors falling outwith the statutory exceptions to sound in substantive damages. There are good reasons why this would be so. Procedural requirements for the detention of individuals with mental disorders under the Mental Health Act 1983 or the Mental Capacity Act 2005 provide a crucial framework for overseeing the decisions taken by a care professional or medical practitioner in the exercise of their judgment in respect of particularly vulnerable individuals. It might properly be thought to be particularly important that they not be devalued by the award of nominal damages."*

We also hope that the appeal will consider the question of whether the principles set down in *Lumba* and *Kambadzi* apply solely to the domestic tort of false imprisonment (which was the only cause of action run in those cases) or also extend to actions brought under the Human Rights Act 1998 for a breach of Article 5 ECHR. The tort of false imprisonment is not co-existent with a deprivation of liberty (see, very recently, *Walker v Cmr of Police for the Metropolis* [2014] EWCA Civ 897), and it may be said that the principles that apply to the award of damages should be those derived from the ECHR and ECtHR (in principle those of just satisfaction) rather than those from the context of domestic torts. The decision in *R (KB & Ors) v MHRT* [2003] EWHC 193 (Admin) suggests that the need for a claimant to establish their loss also applies in the context of (at least) Article 5(4) ECHR, but there remains some unhelpful ambiguity in this area which we hope that the Court of Appeal will address in due course.

It goes without saying that local authorities and CCGs will be likely to looking to the appeal with some interest given that – if (in broad terms) HHJ Hand QC's approach is correct – this will have a significant impact upon the quantum of any damages that those whom the decision of the Supreme Court in *Cheshire West* have shown are unlawfully deprived of their liberty might be able to recover.

Court of Protection Handbook

By way of a shameless plug, Legal Action Group has just published the *Court of Protection Handbook: A User's Guide* edited by Alex, and co-written by him with Professor Anselm Eldergill, Kate Edwards and Sophy Niles. The book is accompanied by a new website which contains links to relevant statutory materials and other guidance that space precluded the team from including in the appendices, precedent orders covering most of the most common situations that arise before the Court, useful (free) web resources, and updates on practice and procedure before the Court of Protection. These updates take the form of posts on the site's blog, and also (where relevant) updates cross-referenced to the relevant paragraphs in the book. The book is available from the LAG Bookshop for £48. It is also available in Kindle format. Rest assured, incidentally, that the website will stand alongside this newsletter and the resources on our site (and Alex's site) as an addition rather than a competitor!

Is the MCA compliant with the CRPD? An update on the work of the Essex Autonomy Project Consultation

We are very grateful to Professor Wayne Martin, the director of the Essex Autonomy Project, for this detailed update on the work that the Project has been carrying out for the Ministry of Justice assessing (with the aid, inter alia, of Alex and Neil) whether the MCA is compatible with the CRPD.

Draft MHA Code of Practice Consultation

The Department of Health is consulting until 12 September 2014 on a revised Mental Health Act Code of Practice.

The new draft Code includes:

- five new guiding principles;
- significantly updated chapters on how to support children and young people, on the use of restraint and seclusion and the use of police powers and places of safety; and
- new chapters on care planning, equality and human rights, the interface between the MHA and the MCA (with specific reference to deprivation of liberty), and support for victims.

Details of the consultation are available here:

Ways to respond:

- Online
- Email

- In writing: Mental Health Act Code of Practice Review, Social Care, Local Government and Care Partnerships Directorate, Room 313 Richmond House, 79 Whitehall, London, SW1A 2NS

To contact the DH team:
Email: mentalhealthcode@dh.gsi.gov.uk
Phone: 0207 210 5420
Twitter: @MHCodeDH and follow #MHCodeDH #StrongerCodeBetterCode

Throwing down the gauntlet – the mental capacity revolution in Northern Ireland

Introduction

The civil provisions of a draft Mental Capacity Bill for Northern Ireland that has been published jointly by the Department of Health, Social Services and Public Safety ('DHSSPS') and the Department of Justice, and which is out for consultation until 2 September 2014, along with the proposals for those subject to the criminal justice system. We want here to flag up a few of its most radical features and a few of the features from which we can learn in England and Wales.

Background

The Bill has been long in gestation, and should be seen against a backdrop of a (current) landscape framework where questions relating to decision-making on behalf of those without capacity are predominantly determined under the common law, and questions relating to the treatment of mental disorder are determined by reference to the now distinctly venerable Mental Health Order 1986 (NI). A review commissioned by the DHSSPS into the delivery of mental health and learning disability services – known as the Bamford Review after its original chair, David Bamford (who tragically died before it was completed) – recommended in a report published in 2007 that there should be a single comprehensive legislative framework for the reform of mental health legislation and for the introduction of capacity legislation in Northern Ireland. This was seen as vital to reduce the stigma associated with having separate mental health legislation and provide an opportunity to enhance protections for persons who lack capacity and are unable to make a specific decision in relation to their health (mental or physical), welfare or finances for themselves, including those subject to the criminal justice system.

The Bill and its key features

After a very long gestation period, that central recommendation is now one step closer to being implemented in the form of Mental Capacity Bill, the civil provisions of which have now been published in draft. The civil provisions in the draft Bill – which applies those over 16 – and which will be accompanied in

due course by further measures relating to the criminal justice system – appears at first blush superficially similar to the MCA 2005. Terms such as capacity and best interests appear, and the tests for the assessment of both mirror (with variations to which we will return) the tests set down in the Mental Capacity Act. But this superficial similarity hides its truly radical nature:

- There will – if the Bill is passed during the current Assembly's mandate – be no replacement for the Mental Health Order 1986 (NI) in respect of those aged 16 and over (it will survive in respect of those aged 15 and below pending further consideration of how their position is best to be approached).

- There will therefore be no provision for the compulsory detention and treatment of those with mental disorder who have capacity to take the material decisions but refuse;

- The admission and treatment of those with mental disorder will, if they lack capacity to take the relevant decisions, be on precisely the same best interests basis as all other forms of decision-making for those without capacity.

If the civil provisions are enacted in substantially the same form as those issued for consultation – and if they are accompanied by a proper implementation programme – they will represent a truly ground-breaking shift in the approach to the care and treatment of those with mental disorder in Northern Ireland who will – in essence – disappear as a separate class of individual. We suggest that we will need to watch very carefully from this side of the Irish Sea to see how the consultation and legislative process unfolds – and in particular to see how the flesh begins to be put upon the bones of the draft primary legislation.

Like but not alike – some key comparisons between the civil provisions of the Bill and the MCA 2005

The civil provisions of the Bill also make particularly interesting reading for those steeped in the MCA 2005, because they appear both familiar and unfamiliar. In particular:

- There is far greater emphasis placed upon the provision of supporting individuals to make decisions, with an entire clause (4) devoted to fleshing out the principle in clause 1(3) that a person is not to be regarded as lacking capacity unless all practicable steps to enable them to make a decision without success. Those steps include such ones as ensuring that persons "whose involvement is likely to help the person to make a decision are involved in helping and supporting the person" (clause 4(2)(c)). Importantly, where a formal assessment of capacity is required (for 'serious interventions' – to which we return) – the statement of incapacity completed by the assessor must specifying what help and support has been given without success to enable P to make a decision in relation to the matter (clause 12(4)(d)). In these regards, the Bill is far more obviously CRPD-compliant than the MCA 2005, which (as many have noted) falls entirely silent as regards support after the reference in s.1(3); nonetheless, as with the MCA, there remains a question mark as to whether the very presence of a capacity test is itself discriminatory (note, in this regard, that the Assisted Decision-Making (Capacity) Bill in the Republic of Ireland – that has bent over backwards to comply with the CRPD – does not contain such a test);

- Whilst the 'functional' test in clause 3 appears similar to the functional test in s.3 MCA 2005, it includes in relation to the 'use and weigh' limb an additional element of not being able to appreciate the relevance of the information and to use and weigh it as part of making the decision in question. The inclusion of 'appreciation' would on its face go some way to assist with situations where the question is less one of cognition and more one of impairments in executive functions – a particular problem in relation to those with Acquired Brain Injuries;

- The 'best interests' test in clause 6 is – deliberately – framed using the same term as in the English legislation so that benefit can be drawn from the body of case-law building up in England and Wales under the MCA 2005. In light of the current debate as to whether best interests decision-making is forbidden by virtue of Article 12 of the CRPD, those taking the Bill forward might consider that it would be prudent to think of a less loaded term. However, whatever the language used, the reality is that this Bill is, ultimately founded upon a model of substituted decision-making where the wishes and feelings (or – in CRPD terms – the will and preferences) of the individual will not in all circumstances be determinative; as such, it seems prudent to proceed on the basis that it will not find favour with the Committee on the Rights of Persons with Disabilities. Whether that necessarily means that it can be implemented without infringing the terms of the CPRD itself is a topic for another day, and no doubt something that those charged with taking the Bill forward will be considering very carefully;

- The familiar protection against liability that finds its place in ss.5-6 MCA 2005 is, in the draft Bill, developed substantially into an entire Part. In particular, the draft Bill contains a fundamental distinction between general acts done in connection with the care, treatment or personal welfare of P, to which a mirror of s.5 MCA 2005 applies, and those acts to which additional safeguards apply before reliance can be placed upon the protection. Such acts include:

    - Acts of restraint;

    - The formal assessment of capacity and the consultation of a nominated person (who, if not nominated by P, is chosen by reference to a statutorily defined list) in the case of serious interventions (which has a statutory definition including but going beyond major medical interventions);

    - Certain treatments for which a second opinion is required;

    - Where authorisation is required for serious treatment where there is objection from P's nominated person or compulsion);

    - Where authorisation is required for an attendance or community residence requirement, both new concepts within the Bill;

    - Where authorisation is required for deprivation of liberty;

    - Certain serious interventions requiring the involvement of an independent advocate;

- Unlike under the MCA, the procedure for authorising deprivations of liberty is not to be found in a Schedule, but rather in the main body of the Act. In very broad terms, the following deprivations of liberty can be authorised (initially for up to 6 months) by a panel convened by the relevant Health and Social Care Trust:

    - The detention of a person in circumstances amounting to a deprivation of liberty in a hospital or care home in which care or treatment is available for that person;

    - The detention of a person in circumstances amounting to a deprivation of liberty while being taken, transferred or returned to a hospital or care home for the purposes of the provision to that person of care or treatment; or

    - The detention of a person in circumstances amounting to a deprivation of liberty in pursuance of a condition imposed during a permitted period of absence from a hospital or care home.

      (different provisions apply in relation to short-term detentions in hospital for examinations, which can be authorised on the basis of a medical report stating that the criteria for authorisation are met)

- It is of note that the deprivation of liberty provisions in the Bill have teeth – clause 135 proposes the creation of a criminal offence of the unlawful detention of a person without capacity;

- As with the MCA, deprivations of liberty arising in other settings will have to be authorised by a court (in the case of Northern Ireland, the High Court, as the decision has been taken that the size of the jurisdiction does not warrant the establishment of a dedicated Court of Protection). One suspects that this aspect of the Bill will be likely to be revisited during the passage of the Bill through the Assembly in light of the decision in *Cheshire West* and the implications (which we would say are not-jurisdiction specific) of the clarification of the 'acid test';

- Appeals against authorisations will be heard by a Review Tribunal – which is a renamed and reconstituted version of the Mental Health Review Tribunal. This is particularly interesting reading for all those who advocated that the DOLS regime should be brought within the ambit of the MHA 1983 in England, and it will be particularly interesting to see (assuming that this is what is brought into force) how this fares as a mechanism, especially if the numbers of individuals requiring authorisations for deprivations of liberty approaches the same proportions as in England. It is perhaps worth noting also in this regard that an individual deprived of their liberty in a care home who does not seek to exercise a right of review before the Tribunal will automatically have their case referred to the Trust after sufficient passage of time – the equivalence in the Bill between the position of those detained in hospitals and in care homes is in refreshingly stark contrast to the current major disparity between those subject to the compulsory provisions of the MHA 1983 and those deprived of their liberty pursuant to Schedule A1 to the MCA 2005;

- Other provisions adopted in England and Wales that are mirrored in the NI Bill include:

    - the replacement of EPAs by LPAs (and the creation of LPAs in relation to health and welfare matters). In respect of the replacement of EPAs, interestingly, one delegate expressed significant concerns to me about this, because of the greater expense that will be required in terms of their preparation and registration, which she considered in the particular circumstances of Northern Ireland may well lead to the unintended consequence that fewer powers will be drafted;

    - the creation of Court-appointed deputies for health and welfare and property and affairs (replacing in the latter regard controllers; the former being an innovation);

    - the creation of an Office of the Public Guardian;

    - the codification of the concept of payment for necessities;

    - provisions in relation to research upon those unable to give consent;

    - the creation of an offence of will-treatment or wilful neglect (which – no doubt reflecting the heavy judicial criticism of s.44 MCA 2005 – sets out much more precisely that the victim of the offence should lack capacity "in relation to all or any matters concerning his/her care;"

    - Exclusions in relation to best interests decision-making in relation to highly personal decisions such as sexual relations or consenting to marriage;

- As noted above, no equivalent to the Court of Protection will be created, although Part 6 of the Bill sets out the declaratory and decision-making powers of the High Court in terms broadly similar to those contained in ss.15-16 MCA 2005. It will be interesting to see in due course the extent to which the inherent jurisdiction in Northern Ireland develops along similar lines to the way it has in England and Wales to cater for the circumstances of vulnerable but capacitous adults;

- As with the position in England, those aged 16-17 will potentially continue to be considered by reference to legislation specifically referable to children and by this legislation, and similar considerations will operate to determine under which regime they will fall. Those under 16 will be excluded, and it is clear that precisely how their circumstances are to be considered is a distinctly hot topic – but a debate from which we are likely to learn a great deal in England in due course;

- Finally, it should perhaps be noted that the Bill rather delicately side-steps the issue of advance decisions to refuse treatment by giving them statutory force as but not defining them save by the reference to the common law relating to such decisions;

The criminal justice system

The provisions of the Bill relating to the criminal law have not yet advanced to a position where they can be put out for consultation, but the consultation document provides an indication of the direction of travel. It is clear from that the Department of Justice is making a sustained attempt to introduce a fully capacity-based approach to care, treatment and person welfare in respect of persons subject to the criminal justice system. This will have effect at a number of stages:

- Removing the equivalent to s.135 MHA 1983 allowing police to remove individuals to a place of safety upon the basis of mental disorder, instead making the operation of this power contingent upon the individual lacking the material capacity and that removal being necessary to prevent serious harm to themselves or another and it being in their best interests;

- Making court powers to impose particular healthcare disposals on offenders at remand, sentencing or following a finding of unfitness to plead (a test which will, itself, be revised to be based upon capacity) contingent on that individual's capacity (and – where they lack capacity – upon their best interests);

- The operation of prison powers by which the Department of Justice can transfer prisoners for in-patient treatment in a hospital.

It is very clear from the consultation document that these proposals are predicated on a radically different model of the treatment of those with mental disorder at al stage of their involvement with the criminal justice system. It is also clear that the formulation of the precise wording of the draft legislation to carry these principles into effect will be – to put it mildly – sensitive.

Conclusion

The 'fusion' model advocated here is one that has its critics (for a succinct summary with specific reference to the NI Bill, see the comment upon Alex's post on the Bill here, and for a detailed defence see the comment by Professor George Szmukler here). There are also a number of points of detail (discussed here) in the draft Bill which can no doubt be reflected on in due course. However, as so often, we have a great deal to learn in England by looking over the borders to see how other the jurisdictions in the United Kingdom (and, indeed in close proximity – in the shape of the Republic of Ireland) approach the question of how to balance autonomy and protection. The model set down in the draft Northern Irish Bill is one that we should be paying particular attention to, not least as the United Kingdom begins the process of engagement with the Committee on the Rights of Persons with Disabilities in the run up to the consideration of the United Kingdom by that Committee, as part of which the Bill will no doubt feature heavily.

Self-neglect – a resource

We would heartily commend to all those required to grapple with problems of self-neglect the (free) e-book called *Vile Bodies: Understanding the neglect of personal hygiene in a sterile society* by Peter Bates, which explores the question from every aspect in a profoundly humane, wise and practical fashion [full disclosure, Alex was asked to and very willingly cast an eye over the section relating to the legal options].

A thank you

We continue to welcome the valuable feedback and suggestions for fresh items which we receive. We thank all those who have assisted the development of the Scottish section of this Newsletter since its inception at the beginning of this year.

Powers of Attorney

The "bombshell" decision by Sheriff John Baird, which we described initially in our May Newsletter under "Registered Power of Attorney held to be invalid" and then, after receipt of Sheriff Baird's written Opinion, in our June Newsletter under "A majority of all Scottish Powers of Attorney invalid?" has now been reported in Scots Law Times as *Application for guardianship in respect of W*, 2014 SLT (Sh Ct) 83. The appeal was intimated. We shall continue to follow the progress of this case.

Adrian D Ward

Damaging illegality of Scottish Social Work Authorities

Our item under this heading last month has prompted feedback telling us about even worse examples than those described in that article, unfortunately not balanced by any similar competition to identify good practice. Pole place in the hall of shame is currently held by the authority which has "cases stretching back over a year still waiting for an MHO appointment", and that despite the solicitor providing this feedback having personally met the relevant Director of Social Services. She comments that: "*Most of our MHOs and social workers are of the opinion that guardianship is not necessary and unless there is some form of urgency I struggle to get an MHO appointed*". Most certainly, the obligation of social work authorities is to produce an MHO report within 21 days of intimation of intention to apply. It is absurd to suggest that they can form an opinion as to the appropriateness of the order sought until they have assessed and expressed that assessment in their report. Their report, each time, forms part of the evidence before the court. It is absolutely not for MHOs, or social work authorities, to usurp the role of the courts in deciding each case on the basis of all of the evidence before the court. It is troubling that it seems likely that this particular authority is the same authority as was the subject of the investigation reported in the next item.

References by this authority, and others, to "appointing an MHO" indicate that there may be a misunderstanding which may be causing local authorities to make matters unduly difficult for themselves. Section 57(4) of the Adults with Incapacity (Scotland) Act 2000 ("2000 Act") requires applicants, in welfare cases, to give notice to the chief social work officer. Except in cases where there is an inability to communicate only, s57(4) simply specifies that the report required for the application must be prepared by "the mental health officer" within 21 days. "The mental health officer" is defined in s87(1) simply by reference to s329 of the Mental Health (Care and Treatment) (Scotland) Act 2003 ("2003 Act"), which in turn refers to "a person appointed (or deemed to be appointed) under s32(1) [of the 2003 Act]". Section 32(1) of the 2003 Act requires a local authority to appoint "a sufficient number of persons" to discharge, in relation to their area, functions under the 2000 Act, the 2003 Act and the Criminal Procedure (Scotland) Act

1995. It is possible that the distinctions among the requirements of these three Acts has been lost sight of. Section 329 of the 2003 Act states that "in relation to a patient" the MHO is the MHO "having responsibility for the patient's care". The reference to a patient makes it clear that this part of the definition refers only to functions under the 2003 Act. Anyone subject to any provisions of the 2000 Act is so subject as an adult, not as a patient, and any medicalisation of the adult incapacity regime would of course be wholly inappropriate. We would re-emphasise that we have nothing but sympathy for overworked MHOs throughout Scotland all being asked to carry a cumulative caseload well beyond the numbers appointed. However, when an MHO is asked to prepare a report under the 2000 Act, that is a single "one-off" activity, and should not be seen as adding another "patient" for which that MHO acquires ongoing responsibility for "the patient's care". It may or may not help matters marginally if it is understood that although preparing a report under the 2000 Act is a significant and most important task, it is a single activity which does not add to that MHO's ongoing caseload.

Of course, references to appointing an MHO in guardianship cases will normally mean designating the MHO allocated to supervise the welfare guardians and, if necessary, in due course to provide the "Schedule 3 Report" for renewal of guardianship. However, there is no statutory requirement for this, and at a time of pressure upon MHOs it may assist short-term management to separate the two functions and perhaps recruit additional staff to clear any backlog of requirements for reports. Moreover, not all applications proceed to appointment. One way or another, the current unlawfulness of local authorities in this regard must be ended.

Adrian D Ward

"Left alone – the end of life support and treatment of Mr JL"

Yet again the title of a report (and related Executive Summary) from the Mental Welfare Commission for Scotland grabs attention in a manner which might be thought to be sensationalisation in a tabloid, but which in fact reflects plain and tragic truth. And yet again, the commendably clear and courteous language of an MWC report enhances the huge and wide-ranging impact of the findings, and of the concluding three pages of recommendations, addressed to the particular general medical practice involved; the relevant NHS Board; the governance, social care provision, and assessment and care management services of the relevant authority; the NHS Board, local authority and Adult Protection Committee together; Healthcare Improvement Scotland; and Scottish Government. The fact that MWC can thus make independent, impartial, constructive and authoritative recommendations to all of these players, including the last two, serves once more to emphasise the absurdity of the attempt by Scottish Government in 2009 to emasculate the role and status of MWC. The report is required reading for all providers in all of the above services, including independent social care providers as well as those with local authority social work functions and responsibilities. It is also required reading for all lawyers who act or advise in any matters engaging that range of functions.

Mr JL is described as having lived "in a remote area of Scotland". He had cognitive difficulties and significant communication difficulties due to a stroke, and to past alcohol misuse. He had a history of

depression. He could be unco-operative with medical and social care staff if they went against his wishes. He died after refusing medical examination and treatment, and refusing food and drink. A post mortem examination concluded that the cause of his death was pneumonia and carcinoma of the tongue and floor of the mouth. When eventually admitted to hospital a few days before his death, he was seriously emaciated. He was separated from his ex-wife and children, but they had tried to keep contact and to provide support. They were not informed of his death until three weeks after his funeral.

MWC was concerned that, although Mr JL apparently knew that he was dying, was in considerable pain but had decided to refuse medical help, he may not have had the capacity to consent to or refuse medical treatment. MWC were concerned that both social care and health service staff may have missed opportunities to intervene and afford him the benefit of a new assessment, and of a palliative care plan to give him as comfortable and dignified a death as possible.

MWC gave particular attention to the assessment of Mr JL's capacity in relation to making decisions about medical treatment; the actions of care staff and the multi-disciplinary team in response to his changing physical and mental presentation over the eight weeks prior to his death; their knowledge and understanding of capacity and consent to treatment during that period; and the need to make recommendations about the medical care and treatment of people where mental illness may impact on their ability to make decisions about their medical treatment.

MWC came to the clear conclusion that, in their view, Mr JL did not receive appropriate medical care in the last month of his life, and possibly before that. The causes which MWC identified were:

(1) The GP failed to arrange follow-up action when he became concerned about Mr JL's condition, and in particular when he was told that Mr JL had stopped eating in order to die. The GP made an urgent referral to the Community Mental Health Team but failed to follow it up when no action resulted.

(2) The social care provider relied too much on a sole care worker. Their supervisions and management of that worker was ineffective. In consequence they failed to identify and escalate concerns about an adult at risk.

(3) Both health and social care failed to initiate multi-disciplinary discussion despite Mr JL's deteriorating health, his failure to eat and his expressed wish to die, the dubiety about his capacity in specific areas, and his reluctance to accept medical treatment. There were crucial lacks of communication between the GP and the care provider, and between the GP and the CMH team.

(4) Although it was generally understood that Mr JL wanted to die at home, no palliative care plan was put in place.

(5) MWC highlighted poor knowledge of relevant legislation, and of options available under the legislation, on the part of some key medical staff. The GP had worked for seven years in Scotland, following 20 years in England. He told MWC that this was the first occasion when he had considered using the 2000

Act, which surprised MWC. He told MWC that he was sure that very few of his colleagues understood Scottish legislation compared with the English legislation.

(6) There was uncertainty over Mr JL's capacity to consent or refuse consent to medical treatment. The need for assessment had been raised on three occasions. A psychiatrist had expressed the view that "he was likely to lack capacity in various areas and should be assessed where appropriate". However, no specific assessment was ever carried out as to his capacity to refuse or consent to medical treatment.

(7) There was a lack of effective governance arrangements within the local authority in relation to the authority's responsibility for assessment, care management and service provision.

(8) It was acknowledged that a relevant factor was also Mr J L's own reluctance to accept medical intervention, and the pressure which he exerted on care workers in order to avoid visits which he did not want.

MWC in addition expressed concerns about:

(9) The quality of the Critical Incident Report, and the lack of a clear action plan and timescales to address the issues and ensure corrective action by both health and social work.

(10) The failure to provide information to Mr JL's next-of-kin, including the funeral arrangements.

Not mentioned in the report, but worthy of comment, is the apparent failure of anyone involved in this tragic scenario to take appropriate legal advice at any time. The GP had looked on the internet for information. He downloaded the 2000 Act, the shorter AWI form and guidance notes. He contacted the General Medical Council, spoke to the duty MHO and eventually spoke to MWC. He followed up on the documents to which he was referred. There appears to have been continuing uncertainty about scope and use of Part 5 of the 2000 Act, general confusion among relevant professionals about the possible use of legislation to admit Mr JL to hospital, and in particular no understanding of the common law doctrine of necessity (effectively preserved by section 47(2A)(a) of the 2000 Act. The passage of the 2000 Act was followed by a major programme of information and education, including such provision to and within GP practices, overseen by the Implementation Steering Group. There is perhaps need for repetition of such a process, in the case of health services to update personnel for whom the original processes are now perhaps a distant memory, and to educate those who qualified or have come to Scotland since then. More generally, there could well now be a role for a re-constituted equivalent of the original Implementation Steering Group: perhaps this is something which MWC itself could usefully address and in which – if found appropriate – it could take an initiative.

Finally, and at risk of yet again banging the same drum, one must point out that if the views of the UN Committee on the Rights of Persons with Disabilities were to be followed, it would no doubt be regarded as unacceptable to have done nothing other than allow Mr JL to end his life effectively starving himself to death, in pain and without even appropriate palliative care, on the basis that there was no scope to

consider his capacity or to intervene to relieve his distress. In reality, it is always important to recognise – as perhaps was not done in this case – that ability to communicate decisions, and consistency in doing so, do not guarantee that the decision was competent.

Adrian D Ward

Consent to sexual relations

Application for directions by West Lothian Council in respect of LY, Livingston Sheriff Court, 30th May 2014

Summary

Sheriff Kinloch at Livingston has issued a thoughtful and perceptive judgment in response to an application by a Council for directions in relation to a dilemma faced by the Council in relation to an adult woman LY.

LY first came before the court in September 2009 when the Council sought welfare guardianship powers. She had a learning disability. Concerns had developed since about 2005 about her relationship with an older male by whom she had two children. By August 2009 there were reports alleging violence by that male, and an allegation that he had forced her into prostitution. Emergency procedures were triggered following an allegation of attempted rape in September 2009. She was accommodated in a semi-secure unit and the Council sought a guardianship order, granted by Sheriff Kinloch in February 2010, for one year, and subsequently renewed at annual intervals, most recently on 14th March 2014. The guardianship powers included power to decide place of residence, with whom LY should have contact, and to supervise any such contact. There was also a power *"to decide the appropriate level of care for LY in respect of health and social issues restricted to promotion of the development of her personal resources and insight in respect of her lack of capacity in the area of sexual relationships and informed consent relative thereto*".

Prior to the latest renewal the Council also submitted the application for directions under s3(3) of the 2000 Act determined in this Judgment. The Council's dilemma arose because LY had formed a relationship with a new boyfriend, which, following "much discussion within the multi-agency group addressing her protection" was agreed to have been a positive step in her life. He was a "known service user". She had a child by him. He was supportive throughout her pregnancy. At the time of the Judgment that child was subject to child protection procedures and in the temporary care of the boyfriend's mother. While it was accepted that LY's relationship with her boyfriend was a loving relationship which improved her self-esteem, the Council were concerned that any encouragement of that relationship might cause the boyfriend to commit a crime under section 1 of the Sexual Offences (Scotland) Act 2009, and indeed anyone encouraging that to be art and part in the commission of that crime. The situation upon the child's birth had been reported to the Procurator Fiscal, who had decided that it would not be in the public interest to prosecute. The sheriff considered *inter alia* relevant guidance by the Mental Welfare Commission and decisions of the English courts including *D Borough Council and AB* [2011] EWCOP 101, Court of Protection, 28 January 2011; *YLA v PM and MZ* [2013] EWCOP 4020, Court of Protection, 20 November 2013; and *IM v Liverpool City Council* [2014] EWCA Civ 37, Court of Appeal, 23 January 2014. He concluded that as the application was predicated upon LY's incapacity to consent to sexual relations, he

could not encourage the Council to permit continuation of the sexual relationship, regardless of whether the new relationship was "positive and non-abusive".

Commendably, however, the sheriff went further than that. He had been shown a document completed by LY, with the assistance of an advocacy worker stating: "*I am pleased that the Sheriff is looking at whether I should be able to have 'safe' sexual relationships. I am 27 years old and I should be able to have a sexual relationship especially with [A]. I love him. I never knew what love was until I met him. He is very kind, loving and caring. I have had bad sexual relationships in the past. I am moving on now and I am looking to the future*". He had received evidence that LY was not capable of consenting to intercourse but was capable of making decisions to use contraception, which he found puzzling. Despite the medical evidence, he questioned the determination of incapacity upon which the application was predicated. He recommended that this be re-visited and continued the case. A Note to the Judgment narrates that at the continuation he was simply advised that no variation to the guardianship order was appropriate.

Comment

One suspects that professionals involved in LY's care, unlike the sheriff, still tended towards a black and white view of capacity. Under s17 of the 2009 Act a person is deemed incapable of consenting to conduct where, by reason of mental disorder, the person is unable to understand what the conduct is, to decide whether to engage in the conduct, or to communicate any such decision. Just as there has been increasing realisation that determination of capacity under the 2000 Act must be considered on a case by case, item by item basis, with the clear possibility that in different circumstances the same adult may be capable and incapable of substantially the same decision, it seems appropriate that s17 of the 2009 Act should be approached in the same light. In other words, there is no reason in principle why LY should not have been incapable of resisting encouragement to engage in conduct in a harmful and exploitative context, yet capable of validly consenting to physically identical conduct in a quite different loving and beneficial situation. Such an approach may have assisted determination of this case, and perhaps guidance should have been sought from the Lord Advocate rather than from the sheriff, given the obligation of prosecuting authorities to make clear - where appropriate - the basis on which they would decide whether or not to prosecute in particular circumstances (see the decision in *Nicklinson*, for example). There is nothing new about the Council's dilemma in this case, or in approaching the Lord Advocate for guidance: that was done in relation to s106 of the Mental Health (Scotland) Act 1984 as narrated in Chapter IX of my book *The Power to Act* (1990, SSMH). Finally, the court seems to have accepted without discussion that a guardian could not be empowered to consent to sexual relations. That is a topic beyond the scope of this note, except to point out that Scottish Ministers have opted not to exclude anything from the permissible scope of a guardianship order in accordance with the power expressly conferred upon them to do so, if they thought fit, under s64(11) of the 2000 Act; the unresolved issues about the relationship between guardians' powers and consent provisions of the Mental Health (Care and Treatment) (Scotland) Act 2003 (see the discussion by Jill in the February 2014 newsletter) and the discussion of Will-making under Part 6 of the 2000 Act (see, for example, the decision of the Sheriff Principal in *DC* (also covered in the March Newsletter).

Adrian D Ward

Comment from England

The position in relation to capacity to consent sexual relations is now – for the moment – clear-cut: it is 'act' specific rather than 'person' specific: IM v LM. The nuanced approach suggested by Adrian in his comment has therefore been ruled out for the time being (the Supreme Court in refusing permission to IM to appeal noted that "*There is definitely a point of law of general public importance here but this is not a suitable case in which to consider it*."). It will be very interesting to see if the Scottish jurisprudence develops in a different direction, and, if so, whether this, in turn, might feed back into a re-consideration of the position in England.

Alex Ruck Keene

General Comment on Article 12 Convention on the Rights of Persons with Disabilities (CRPD) (right to equal recognition before the law): Implications for Scotland

Introduction

The June 2014 edition of *Mental Capacity Law Newsletter* carried a discussion paper "The Mental Capacity Act 2005, the Adults with Incapacity (Scotland) Act 2000 and the Convention on the Rights of Persons with Disabilities: The Basics"[1]. The discussion paper considered the recently adopted Committee on the Rights of Persons with Disabilities General Comment No 1 (2004) *Article 12 Convention on the Rights of Persons with Disabilities (CRPD) (the right to equal recognition before the law)*[2]. This article follows on from this and from a seminar in June 2014 held by the Centre for Mental Health and Incapacity Law, Rights and Policy at Edinburgh Napier University which considered the General Comment and its possible implications for Scotland[3]. It will not contain a critique of the reasoning behind the content of the General Comment but focus on questions that potentially arise for law, practice and policy in Scotland.

Status of the CRPD in Scotland

The CRPD is not incorporated into UK and Scottish law in the same way as the ECHR and does not therefore carry the same legal weight nationally. However, the UK Government can prevent the enactment

[1] Authors Lucy Series, Anna Arstein-Kerslake, Piers Gooding and Eilionóir.
[2] Committee on the Rights of Persons with Disabilities, General Comment No. 1(2014) *Article 12: Equal recognition before the Law,* adopted 11 April 2014 http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G14/031/20/PDF/G1403120.pdf?OpenElement
[3] Speakers at the seminar were Colin McKay (Mental Welfare Commission for Scotland), Lynn Welsh (Equality and Human Rights Commission), Dr Jill Stavert (Centre for Mental Health and Incapacity Law, Rights and Policy). However, any views expressed in this article are those of the author and not necessarily of the other speakers or seminar attendees.

of devolved legislation in Scotland and actions of the Scottish Ministers where these contravene the UK's international obligations, including those under international human rights treaties[4]. Scotland must therefore comply with the UK's CRPD state party obligations although it will ultimately follow the UK Government's lead here[5].

The CRPD proceeds from the basis that it is society's approach to disabilities that creates the disability, not the disability itself. State Parties must therefore ensure that state authorities, private bodies and individuals actively promote the effective living and participation of persons with disability in society. There is accordingly a mismatch between the CRPD and the ECHR in that the focus of the ECHR is on when it is or is not possible to limit rights. However, in Scotland it is currently the ECHR and Scottish law (e.g. our mental health and incapacity legislation) that prevail[6].

Essential elements of the General Comment

By way of a reminder, the essential elements of the general Comment can be summarised as follows:

1. Equality before the law is universal. Everyone, including those with mental disorder, therefore has the same right to exercise their legal capacity. It is discriminatory to deny such exercise on the basis of mental capacity even where a functional capacity approach is used[7]. No one should be subjected to measures without their personal consent.

2. Everyone is thus deemed to have capacity and it is simply that some need more support to exercise such capacity.

3. Supported decision making is therefore to be promoted and substituted decision making should not take place because it is denying the right to exercise legal capacity and therefore discrimination. Laws providing for guardianship and compulsory treatment for mental disorder must accordingly be abolished.

4. Issues arising and matters requiring clarification

At this stage it remains to be seen what exactly the Committee on the Rights of Persons with Disabilities will ultimately require to be satisfied regarding law, practice and policy in Scotland. However, as with the rest of the UK, and indeed other jurisdictions, a number of issues need to be resolved. These include:

[4] ss35 and 58 Scotland Act 1998.
[5] General Comments are not legally binding they are highly influential and will be taken into account where a violation of the interpreted right is alleged.
[6] Violations of CRPD rights will therefore have to be raised during the periodic reporting process and/or through individual communications to the Committee on the Rights of Persons with Disabilities. There are international, not national, law consequences if the UK then decides not to follow any resultant recommendations of the Committee.
[7] This interpretation is therefore at odds with that adopted by the WHO and Article 8 ECHR (right to private and family life) e.g. *Shtukaturov v Russia* (2008) ECHR 223.

1. Inconsistencies between the General Comment and ECHR approaches. This is demonstrated, for example, in relation to Articles 8 (the right to private and family life) and 5 (the right to liberty) ECHR, the former being interpreted to advocate functional capacity assessment[8] and the latter requiring formal legal and procedural requirements for persons who lack capacity to consent to a deprivation of their liberty[9].

2. The fact that Articles 4, 5(4) and 16 impose an obligation to protect disabled persons from exploitation and how this can be achieved in light of the General Comment's requirement regarding recognition of the right to exercise legal capacity.

3. How the General Comment applies to children as it does not mention them.

4. In terms of equality, ensuring that in recognising the universality of capacity to the right to exercise ones legal capacity discrimination within non-discrimination does not occur. Sometimes it is arguably necessary to recognise the differences between people in order to respect full human flourishing.

5. The issue of criminal liability is also a consideration. Does excluding people with disabilities from recognition as moral subjects cause greater harm in that it in fact imposes even greater restrictions on rights and freedoms?[10]

Scottish legislation and the General Comment

Scottish mental health and incapacity legislation is internationally regarded as an example of good practice in terms of individual-centred and human rights based law. The principles underlying[11] both the Mental Health (Care and Treatment) (Scotland) Act 2003 (2003 Act) and the Adults with Incapacity (Scotland) Act 2000 (AWIA) promote participation of the individual concerned and shared decision-making even where interventions are applied. The wishes and preferences of the individual must be taken into account, intervention is seen as a last resort, the least restriction option must be used and any intervention must also benefit the individual.

However, both Acts run into General Comment difficulties in a number of ways. They both equate the denial of legal capacity with mental capacity (incapacity by reason of mental disorder[12] in the case of the AWIA and significantly impaired decision-making ability by reason of mental disorder in the case of the

[8] *Shtukaturov ibid*, paras 87-88 and 94.
[9] As was, for instance, reinforced in *P (by his litigation friend the Official Solicitor) (Appellant) v Cheshire West and Chester Council and another (Respondents); P and Q (by their litigation friend, the Official Solicitor)(Appellants) v Surrey County Council (Respondent)* [2014] UKSC 19.

[10] See various arguments for and against this standpoint in, for example, the responses to the UN Committee on the Rights of Persons with Disabilities consultation on the draft General Comment (e.g. those of Beaupert and Steel and Minowitz) and also of ML Perlin (2013) *A Prescription for Dignity: Rethinking Criminal Justice and Mental Disability Law*, Ashgate, chapters 6 and 7.
[11] Ss 1,2, 44(4) and 64(5) Mental Health (Care and Treatment) (Scotland) Act 2003 and s1 Adults with Incapacity (Scotland) Act 2000.
[12] Or inability to communicate because of physical disability.

2003 Act[13]). Moreover, whilst a conscious decision was made to adopt the benefit rather than the more paternalistic 'best interests' test when determining whether intervention is necessary under the AWIA[14], the General Comment makes it clear that it is the *effect* and not the wording of legislation that is crucial[15]. Thus, it will be necessary to be able to demonstrate that the benefit test is not in practice actually operating in some or many cases in the same way as a best interests test. Finally, the AWIA provides for guardianship and the 2003 Act for compulsory treatment for mental disorder (in other words, substituted decision-making).

Next steps and looking forward

How the UK and Scotland will ultimately respond to this General Comment remains to be seen. However, meanwhile, mindful that the CRPD does not provide for the progressive realisation of any of the rights it identifies and of the UK's international law obligations under the treaty, consideration needs to be given as to how the General Comment challenges will be met.

"Capacity"

What is now provided is the opportunity to revisit what is actually meant by "capacity", autonomous decision-making and exercising legal capacity. In this context, questions will inevitably arise as to whether it is possible to separate a person's choices from the choices influenced by mental disorder given that the disorder is part of them and whether it is possible to completely disentangle disability from assessments of capacity. Moreover, one might arguably ask whether it is actually assessments of 'capacity', not laws and interventions, that are the problem when it comes to the exercise of legal capacity.

In Scotland, it will be of course also be necessary to consider 'significantly impaired decision-making' (SIDMA) under the 2003 Act. The Act's Code of Practice[16] states that in assessing SIDMA similar factors to those in the assessment of incapacity should be taken into account. However, this concept requires medical professionals to consider whether or not a person with mental disorder lacks insight into what is the best treatment for them and permits the involuntary treatment of persons with capacity.

Supported decision-making

The opportunity also presents itself to give careful consideration as to what is meant by 'supported decision-making' and the forms this should take. In this context, it is also important to appreciate that shared decision-making is not the same as supported decision-making, that is to say that some persons may need to be supported to participate, as an equal partner, in shared decision-making. The AWIA and 2003 Act, as stated, both provide for a person's wishes and preferences to be taken into account. The AWIA[17] also provides for the encouragement and development of a person's skills in relation to their financial and

[13] s1(6) AWIA, ss36(4), 44(4) and 64(5) 2003 Act.
[14] Scottish law Commission (1995), *Incapable Adults*, Report No 151, paras 2.50-2.54.
[15] Para 9.
[16] Vol 2, Chapter 1, paras 22-27.
[17] s.1(5).

property affairs and personal welfare. In both cases, however, this falls short of what the General Comment is requiring in terms of supported decision-making.

The General Comment provides some rather general guidance on what supported decision-making might look like[18]. It states that "support" is a broad term and the type and degree of support required will depend on the circumstances at any given time. It may include, for example, a trusted person or persons, peer support, advocacy (including self-advocacy), assistance with communication, provision of clear and accessible information, and advance planning. In Scotland, this means, at the very least, providing greater support and encouragement for advocacy services and the use of advance statements as well as considering other approaches. Can we also make a case that powers of attorney are actually acceptable forms of supported decision-making and not, as seems to be implied by the General Comment, unacceptable on the basis that although these are created by the person concerned they are a form of substituted decision-making?

Serious consideration also needs to be given to those situations where supported decision-making is simply not a reasonable possibility. In this respect, the General Comment states[19] that where after significant efforts have been made and it is not practical to determine a person's will or preferences then one must use a "best interpretation of will and preferences" and this must replace a perceived and discriminatory "best interests" determination.

Finally, how do we guard against supported decision-making actually becoming, in effect, substituted decision-making? Article 12 and the General Comment both warn against 'undue influence' but it may nevertheless be difficult to practically ascertain at times.

We live in important and interesting times.

Jill Stavert

[18] Para 15.
[19] Para 18(b).

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Conferences at which editors/contributors are speaking

Implementing the Mental Capacity Act and the Deprivation of Liberty Safeguards

Alex and Tor are speaking at this conference arranged by Community Care in London on 8 October 2014, a re-run (with variations) of the sold-out and high octane conference held in March – on the day of the Supreme Court decision in *Cheshire West*. Full details are available here.

The Mental Capacity Act 2005: Annual Review 16 October 2014

Neil and Tor are speaking at the speaking at Langley's annual multi-disciplinary conference looking at the workings of the Mental Capacity Act 2005J in York on 16 October, alongside speakers including Mr Justice Baker and Fenella Morris QC. Full details are available here.

Court of Protection Practice and Procedure 2014

Alex and Tor are speaking at Jordan's annual Court of Protection Practice in London on 21 October, alongside Mr Justice Charles, Vice-President of the Court of Protection, the Public Guardian, Alan Eccles, District Judge Marin and David Rees. For further details and an early bird discount (for booking by 8 August), see here.

'Taking Stock'

Neil is speaking at the annual 'Taking Stock' Conference on 17 October, jointly promoted by the Approved Mental Health Professionals Association (North West and North Wales) and Cardiff Law School with sponsorship from Irwin Mitchell Solicitors and Thirty Nine Essex Street Barristers Chambers – and with support from Manchester University. Full details are available here.

Advertising conferences and training events

If you would like your conference or training event to be included in this section in a subsequent issue, please contact one of the editors. Save for those conferences or training events that are run by non-profit bodies, we would invite a donation of £200 to be made to Mind in return for postings for English and Welsh events. For Scottish events, we are inviting donations to Alzheimer Scotland Action on Dementia.

Chambers Details

We are taking a break over the summer; our next Newsletter will be out in October, but we will circulate a newflash in the interim with any judgments or developments that cannot wait that long. Please email us with any judgments or other news items which you think should be included. If you do not wish to receive this Newsletter in the future please contact marketing@39essex.com.

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THE QUEEN'S AWARDS FOR ENTERPRISE INTERNATIONAL TRADE 2013

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Alex been recommended as a leading expert in the field of mental capacity law for several years, appearing in cases involving the MCA 2005 at all levels up to and including the Supreme Court. He also writes extensively about mental capacity law and policy, works to which he has contributed including 'The Court of Protection Handbook' (2014, LAG); 'The International Protection of Adults' (forthcoming, 2014, Oxford University Press), Jordan's 'Court of Protection Practice' and the third edition of 'Assessment of Mental Capacity' (Law Society/BMA 2009). He is an Honorary Research Lecturer at the University of Manchester, and the creator of the website www.mentalcapacitylawandpolicy.org.uk. To view full CV click here.

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Victoria regularly appears in the Court of Protection, instructed by the Official Solicitor, family members, and statutory bodies, in welfare, financial and medical cases. She previously lectured in Medical Ethics at King's College London and was Assistant Director of the Nuffield Council on Bioethics. Together with Alex, she co-edits the Court of Protection Law Reports for Jordans. She is a contributing editor to Clayton and Tomlinson 'The Law of Human Rights', a contributor to 'Assessment of Mental Capacity' (Law Society/BMA 2009), and a contributor to Heywood and Massey: Court of Protection Practice (Sweet and Maxwell). To view full CV click here.

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Neil has particular interests in human rights, mental health and incapacity law and mainly practises in the Court of Protection. Also a lecturer at Manchester University, he teaches students in these fields, trains health, social care and legal professionals, and regularly publishes in academic books and journals. Neil is the Deputy Director of the University's Legal Advice Centre and a Trustee for a mental health charity. To view full CV click here.

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Anna regularly appears in the Court of Protection in cases concerning welfare issues and property and financial affairs. She acts on behalf of local authorities, family members and the Official Solicitor. Anna also provides training in COP related matters. Anna also practices in the fields of education and employment where she has particular expertise in discrimination/human rights issues. To view full CV click here.

Simon Edwards
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Simon has wide experience of private client work raising capacity issues, including *Day v Harris & Ors* [2013] 3 WLR 1560, centred on the question whether Sir Malcolm Arnold had given manuscripts of his compositions to his children when in a desperate state or later when he was a patient of the Court of Protection. He has also acted in many cases where deputies or attorneys have misused P's assets. To view full CV click here.

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Adrian is a practising Scottish solicitor, a partner of T C Young LLP, who has specialised in and developed adult incapacity law in Scotland over more than three decades. Described in a court judgment as: "*the acknowledged master of this subject, and the person who has done more than any other practitioner in Scotland to advance this area of law*," he is author of *Adult Incapacity*, *Adults with Incapacity Legislation* and several other books on the subject. To view full CV click here.

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Dr Jill Stavert is Reader in Law within the School of Accounting, Financial Services and Law at Edinburgh Napier University and Director of its Centre for Mental Health and Incapacity Law Rights and Policy. Jill is also a member of the Law Society for Scotland's Mental Health and Disability Sub-Committee, Alzheimer Scotland's Human Rights and Public Policy Committee, the South East Scotland Research Ethics Committee 1, and the Scottish Human Rights Commission Research Advisory Group. She has undertaken work for the Mental Welfare Commission for Scotland (including its 2013 updated guidance on Deprivation of Liberty) and is a voluntary legal officer for the Scottish Association for Mental Health. To view full CV click here.