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Mental Capacity Law Newsletter

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Introduction

Welcome to the December issue of the Mental Capacity Law Newsletter. In this issue, we cover an important application under s.21A MCA 2005, a decision (re)affirming the ability of social workers to give evidence as to capacity and a decision as to the discretion of the Court of Protection to make declarations as to capacity. We also highlight developments including a new COP3 form, the move of the Court of Protection, and a new dementia-friendly financial services charter. We also attach to this newsletter a bumper summary of October and November's evidence before the House of Lords Select Committee, including that given by Alex as part of a panel addressing the Court of Protection.

Readers will have noted that we have in the past covered some developments in Scotland, a trend continued in this month's issue. We are delighted to announce that, with effect from the next – January – issue we will be expanding our coverage significantly to give monthly coverage of matters north of the Border, with the addition to the contributor team of Adrian Ward, of TC Young Solicitors, a leading figure in Scotland in the field of mental capacity law, there termed adult incapacity law, and Jill Stavert, Director of the Centre for Mental Health Law and Incapacity Law, Rights and Policy at Edinburgh Napier University. More details will follow in the next issue.

Where transcripts are publicly accessible, a hyperlink is included. As a general rule, those which are not so accessible will be in short order at www.mentalhealthlaw.co.uk. We include a QR code at the end which can be scanned to take you directly to our previous case comments on the CoP Cases Online section of our website.

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Keeping alive at all costs is not a sufficient justification to deprive a person of their liberty

Re M (Best Interests: Deprivation of Liberty) [2013] EWHC 3456 (COP) (Peter Jackson J)

Article 5 ECHR – DOLS authorisations

Summary

This successful s21A appeal was brought by M, a 67 year old woman, through her IMCA as litigation friend, who had been resident in a care home since June 2012. M suffered from diabetes which was poorly controlled and lacked capacity due to her "*inflexible but mistaken belief that she can manage her own diabetes*" which resulted in her being unable to weigh up the serious risks to her health that would be posed by returning home, with an inevitable reduction in the level of supervision.

The two options for M's care were continued residence in the care home, or a return home with a "*standard care package*" which involved twice daily visits from district nurses to supervise M's insulin regime, and regular visits each day from carers. The CCG did not support a return home, relying on the historical evidence that at home, M had refused support, resulting in a serious deterioration in her condition and subsequent hospitalisation on around 7 occasions. In the view of the CCG, M required 24-hour care to manage the risks to her health, but 24-hour care at home would not be funded, and in any event, it was unlikely M would accept it. The CCG went so far as to submit that the administration of medication for M's diabetes could be seen as life-sustaining treatment within the meaning of s.4(10) MCA 2005. Since being at the care home, M's physical condition had improved, but her mental health had worsened. She was being treated for mild depression with antidepressants. She repeatedly and consistently said that she wanted to return home and had said that she would take her own life if that was not allowed to happen. She was still only partially compliant with her insulin regime and refused to eat any food provided by the home.

A psychiatrist commissioned to provide a report to the court under s.49 MCA 2005 took the view that it was in M's best interests to return home despite the risks to her health, and that all options to achieve this had not been fully explored.

The judge noted that there was no real dispute about the facts: the issue was the weight to be given to the various risks. A return home carried with it a real risk of death as a result of M's diabetes and her non-compliance. Remaining at the care home carried a real risk that M would self-harm because of her strongly held wish to return home. Concluding that it was in M's best interests for the standard authorisation to be terminated (after a month's grace for planning purposes), the judge stated that considerable weight had to be attached to M's wishes, bearing in mind that her incapacity extended only to one area of her life – her diabetes management – and that she was otherwise very aware of her circumstances. The judge also relied on the fact that M had always been a private and independent person, which made the impact on her of group living more difficult than it would be for other people. He summed up the position thus:

> "*38. In the end, if M remains confined in a home she is entitled to ask 'What for?' The only answer that could be provided at the moment is 'To keep you alive as long as possible.' In my view that is not a sufficient answer. The right to life and the state's obligation to protect it is not absolute and the court must surely have regard to the person's own assessment of her quality of life. In M's case there is little to be said for a solution that attempts, without any guarantee of success, to preserve for her a daily life without meaning or happiness and which she, with some justification, regards as insupportable.*"

Comment

This decision seems to the editors to be a model of best interests decision-making which reflects the guidance of Baroness Hale in the recent decision in *Aintree v James* [2013] UKSC 67, significant weight is given to the actual and likely

views of P, with the focus on what P's own view of his or her quality of life is, rather than an assumption that life should be preserved at all costs. In so many DOLS cases, there are real and serious risks to P's physical wellbeing if the less restrictive option is taken, and the emotional impact on P of being forced to comply with a care regime that she or he strongly objects is given much less weight. It is perhaps easier for the court to conclude that the physically riskier option is the right one than it is for a statutory body which will potentially be in the firing line if P becomes seriously ill or dies. As the judge observed:

> "*41.... my decision implies no criticism whatever of any of the witnesses from the local authority or by the CCG. I understand the position taken and the reasons for it; indeed it would be difficult for them to have taken a different view on the facts of the case. There are risks either way and it is perfectly appropriate that responsibility for the outcome should fall on the shoulders of the court and not on the shoulders of the parties.*"

Two procedural points of note:

1. So far as the editors are aware, this is the first publicly reported welfare case in which an IMCA has acted as litigation friend.

2. The judge endorsed the approach taken at an earlier stage in the proceedings when the District Judge visited M in her care home. He noted that "*A careful written record was made and placed with the papers. The visit has therefore had the dual purpose of informing the court of M's views and of making M feel connected to the proceedings without putting her into the stressful position of having to come to court in person. I commend this as an approach that may be of value in other cases of this kind."* The editors could not agree more, and hope that personal contact between the court and P, whether in court or in another setting, will become increasingly commonplace, particularly in cases where P's incapacity is borderline or limited in scope, or where P has strong views about what should happen.

And a small editorial point: it is common practice in Children Act cases to include in the title of the case a reference to the central issue. Given the alphabet soup nature of COP proceedings, it is extremely helpful – as here – to give an indication in the title of the case what it concerns.

'Non-marriage' and the Court of Protection

A Local Authority v SY [2013] EWHC 3485 (Keehan J)

COP jurisdiction and powers – interface with inherent jurisdiction - marriage

Summary

SY was a 19 year old woman with mild to moderate learning disability who was extremely vulnerable. A young man from Pakistan, TK, entered the country on a student visa. It expired and his appeal to remain was refused in June 2011. By then an illegal over-stayer, he began a relationship with SY in August 2011. In January 2012 her carers informed the local authority that she had said that he had locked her in his house when he went to work, that they had been visited by a 'lawyer' about a housing application, that they were to marry in six months and that he had taken her to a registry office to obtain a copy of her birth certificate. The carers also reported that they had overheard him speaking to her on the telephone in a controlling and aggressive manner.

A clinical psychologist had concluded that SY was unlikely to be able to make the relevant decisions and, on 24 May 2012, the local authority and the police told the man that, because of her learning disability, she was unlikely to have capacity to consent to sexual relations and marriage and that an offence would be committed. In spite of this, on 10 June 2012 the couple entered into an Islamic marriage ceremony at TK's property. Five days later, he was arrested for immigration offices and detained by the UK Border Agency pending deportation. That day, he claimed asylum on the basis that he feared he would be killed by his family who disapproved of his marriage to a white British woman. SY was moved to a specialist residential home and an urgent, followed by a standard, DOLS authorisation was granted.

The man's associates tried to bolster his asylum claim by attempting to enter the residential home to get SY to sign a pre-prepared statement of evidence. But on 17 July 2012 his appeal against being refused asylum was rejected on all grounds, the tribunal judge concluding that their relationship was insufficient to amount to family life under Article 8 ECHR. He had also not given a truthful account and was not a credible witness. Shortly before his deportation in August 2012, he was served with the COP papers but did not respond. However, he maintained telephone contact with SY until her mobile telephone broke in March 2013.

After at least 8 years of particularly difficult and turbulent life experiences, by the time of the final hearing in November 2013, SY was settled and content in her placement. She was enjoying her college course and was being successfully supported to lead a stable and happy life. Final incapacity declarations and best interests decisions were made for her to remain at the home and, were she to abscond, measures to convey her back which might amount to a deprivation of liberty were authorised by the Court. Although she was declared to lack capacity to enter a contract of marriage, she had capacity to consent to sexual relations.

One issue remained: the consequences of the Islamic ceremony. The man's involvement was "yet another abusive and exploitative episode in [SY's] life which could have had serious physical, emotional and psychological consequences for her" (para 49). The ceremony had formed the bedrock of his attempt to exploit and take advantage of her to bolster his prospects of staying in the country. However, it failed to comply with the essential requirements of the Marriage Acts 1947-1986. It was conducted in his home rather than in a registered place and by someone who was not a registrar or a priest according to Anglican rites. Nor was the ceremony intended to attract the status of a marriage under English law; it was undertaken to create a marriage expressly according to Islamic laws.

Keehan J was satisfied that this was a non-marriage. However, there was no provision in the Mental Capacity Act 2005 to make a declaration to that effect: a gap remained. In *XCC v AA and Others* [2012] EWHC 2183, Parker J had invoked the inherent jurisdiction of the High Court in Court of Protection proceedings to make a declaration of non-recognition of a marriage, observing (paras 54 and 85):

> *"The protection or intervention of the inherent jurisdiction of the High Court is available to those lacking capacity within the meaning of the MCA 2005 as it is to capacitous but vulnerable adults who have had their will overborne, and on the same basis, where the remedy sought does not fall within the repertoire of remedies provided for in the MCA 2005. It would be unjustifiable and discriminatory not to grant the same relief to incapacitated adults who cannot consent as to capacitous adults whose will has been overborne… I am satisfied that once a matter is before the Court of Protection, the High Court may make orders of its own motion, particularly if such orders are ancillary to, or in support of, orders made on application. Since the inherent jurisdiction of the High Court in relation to adults is an aspect of the parens patriae jurisdiction the court has particularly wide powers to act of its own motion."*

Parker J had held that such a decision was not dictated only by considerations of best interests but public policy considerations were also relevant (paras 56-57 and 71-76). In the present case, the Court was accordingly invited to similarly invoke the inherent jurisdiction of its own motion to make a declaration of non-marriage. Keehan J agreed with Parker J's reasoning and held:

> *"47. TK well knew that SY had learning difficulties and was a vulnerable young woman. He knew that the police and the care services were extremely concerned about his involvement with SY.*
>
> *48. I can reach no other conclusion than he deliberately targeted SY because of her learning difficulties and her vulnerability. The courts will not tolerate*

such gross exploitation…

50. In my judgment it is important for SY that a declaration of non-marriage is made in respect of the June 2012 ceremony. There are also, in my judgment, compelling reasons of public policy why sham 'marriages' are declared non-marriages. It is vital that the message is clearly sent out to those who seek to exploit young and vulnerable adults that the courts will not tolerate such exploitation."

Comment

This decision is significant for at least two reasons. The first is a procedural point but resonates way beyond COP proceedings. In this case, the COP3 form, which provides the initial evidence basis of incapacity to open the courtroom doors, was completed by SY's social worker. His Lordship observed:

> *"22. I am told by counsel that it is more usual for the assessment of capacity to be undertaken by a medical practitioner or a psychiatrist. The assessment in this case demonstrates that an appropriately qualified social worker is eminently suited to undertake such capacity assessments. I commend the practice which I hope will be followed in appropriate future cases."*

Coincidentally, this judicial endorsement of social work incapacity evidence reflects the new COP3 which has been reworded to make it clear that professionals other than medical practitioners can complete the assessment (see below). It also reflects the MCA Code of Practice (paras 4.38-4.43) which envisages that capacity is not exclusively within the purview of medical practitioners or psychiatrists.

Secondly, the inherent jurisdiction had never previously been called upon in Court of Protection proceedings to make a 'non-marriage' declaration – which differs to 'non-recognition' – and the flexibility of being able to do so, of the Court's own motion in order to avoid unnecessary freestanding applications, is to be welcomed. There are clearly significant public policy reasons for such declarations being made and to declare the legal reality of an emotional situation may also serve the best interests of the incapacitated participant of the ceremony.

When should the Court of Protection decline to make a declaration as to capacity?

YLA v PM and MZ [2013] EWHC 3622 (Fam) (Parker J)

Mental capacity - practice and procedure – other

Summary and comment

With thanks to Andrew Bagchi for bringing this our attention, this complex case concerned a woman, PM, with a significant global learning disability, who was married (first under a Muslim marriage ceremony and then in a Register Office) to a Pakistani man whose immigration status was under question. The woman gave birth to a child, B, and the local authority, YLA, brought both care proceedings in relation to B and COP proceedings concerning PM. In the care proceedings, Parker J approved a plan for PM, MZ and B all to go together to a parent and baby foster placement. The COP proceedings were brought on the basis of significant concerns as to PM's capacity to marry and to consent to sexual relations (and in light of those concerns, the foster placement plan was approved on the basis that PM and MZ were not to share a bedroom). An independent psychologist, Dr Joyce, was commissioned to produce an expert report addressing PM's capacity in various domains; it was agreed that no final planning could take place for B until capacity issues were decided, and at the forefront of the Court's concerns was the question of whether PM could live with MZ.

Discretion to make a declaration as to capacity

Shortly before the hearing listed for March 2013 to determine PM's capacity, applications were made on behalf of MZ and the Official Solicitor on behalf of PM effectively to abandon the hearing, essentially on the basis that it was not in PM's interests for any declarations be granted, because she wanted to live with MZ and be with B. It was

submitted that the Court had a discretion as to whether to make any declaration relating to capacity at all because it might not be in PM's best interest for any such declaration to be granted.

Parker J refused the applications, primarily on the basis that the hearing had been listed on the basis to determine PM's capacity in various domains, after which the parties and in particular the local authority could take stock. She proceeded to hear evidence including from Dr Joyce. The cases for both MZ and PM remained that the Court should not, at least not at that stage, make declarations as to PM's capacity in respect of sexual relations, marriage or residence. Particular emphasis was placed upon what were said to be PM's wishes and feelings and the negative impact upon her of being separated from MZ and her baby. By analogy with the guidance to CPR r.40.20 (governing the making of declarations in the High Court) in the White Book, it was also submitted on behalf of MZ that a relevant consideration was whether making the declaration would serve any useful purpose.

Parker J therefore embarked on a detailed analysis both as to the discretionary nature of the power to make declarations under s.15 MCA 2005 and to the factors going to the exercise of that discretion. She concluded that:

1. On a proper analysis, whilst s.15 MCA 2005 was framed in discretionary terms, she did not have any true discretion as to whether make a declaration regarding PM's capacity (para 110);

2. Wishes and feelings, together with the obligation to respect for private and family life under Article 8 ECHR, are relevant to the best interests test, rather than to capacity – it is not an invasion of private or family life to declare that a person lacks capacity in any particular respect (para 111);

3. The purpose of a declaration is to engage the powers of the Court of Protection. If a person lacks capacity then it is necessary and proportionate and has a use to grant a declaration that that is the factual position. The court's discretion in respect of best interests declarations depends on the assessment of best interests. That is not an unfettered discretion. The court has to apply the statute. However, the question of whether it is in the best interests of P is not a relevant consideration in deciding whether to make a declaration that PM lacks capacity (para 113);

4. Applying the dicta of Ryder J (as he then was) in *Oldham MBC v GW and PW* [2007] EWHC136 (Fam) [2007] 2 FLR 597 (to the effect that "[a] *judge in the Court of Protection – may feel drawn towards an outcome that is more protective of the adult and thus, in certain circumstances, fail to carry out an assessment of capacity that is detached and objective. On the other hand, the court must be equally careful not to be influenced by sympathy for a person's wholly understandable wish to return home*"), Parker J held that she had to decide on capacity in order to decide whether PM needs protection. She emphasised that she did not take into account in making a finding as to capacity that PM might need protection. "*If she needs protection I have to look at her welfare needs: over all, and taking into account her wishes and feelings, but without being bound by them*" (para 115).

Parker J did, though, go on to consider the position if she did have a discretion, and concluded clearly that this was a case where she would decline to make a declaration on the basis of wishes and feelings or of PM's welfare. In so doing she:

1. Accepted that PM would experience stress and anxiety if she cannot live with MZ and the baby, but did not accept as was being urged on her by MZ that she had truly found contentment and fulfilment or that she will do so in the future. She did not accept that PM's life had improved since leaving her family home. Parker J considered that she would be put at risk if she lived with MZ in the community, noting that her "'*feeling of being supported, protected, loved' as it is put, is not based on reality*" (para 124);

2. Rejected the proposition that there was no purpose in a declaration of incapacity because it was very unlikely that the Official

Solicitor would wish to seek the court's authority under section 18(1)(k) MCA 2005 to present a nullity petition, on the basis of PM's best interests. Parker J noted that "*If this marriage falls apart, or if I were to make the findings as to motivation sought by the authority* [which were strongly adverse to PM]*, or if there was harm asserted to PM, he might wish to do just that. If a final declaration is made as to incapacity and that it is not in PM's interests to live with MZ, then he might also think in her interests not to be tied to a limping marriage: or to consider that annulment might be better for PM than to be divorced by MZ's petition: which I perceive that he may very well want to do at some time in the future*." She also noted that in *XCC v AA and others* [2012] EWHC 2183 (COP) the Official Solicitor was reluctant, in a case of very gross incapacity to marry, to present a nullity petition on DD's behalf, but eventually agreed to do so after a further hearing when Parker J had made a declaration of non-recognition (paras 131-3);

3. Held that *Re MM (an adult)* [2007] EWHC 2003 (Fam) [2009] (in which Munby J as then was) had highlighted the need for the court to only exercise its protective powers where there was a need to protect a vulnerable adult from abuse was not authority for the proposition that the court should not make a capacity declaration because it will then have to make a best interest declaration. As she noted, "[t]*he whole point of a best interests declaration is that it weighs up the alternatives. Nor is it authority for the proposition that wishes and feelings as asserted should be followed or that the incapacitous person should be left in risky situation as opposed to public care. I have identified the risk. It is not fanciful*" (para 140);

4. Held that, if a person is not able to consent to sexual relations, then it cannot be in their best interests to have sexual relations (para 141);

5. Noted, finally, that she did "*not consider that the making of a declaration of incapacity in respect of PM will cause her any distress at all. She would not understand it. It is the consequences, if I make a declaration that she is not to live with him or have sexual relations with him, (and probably the former) which will cause distress, quite possibly grave distress. She is placed in this position though no fault or agency of her own. She is the victim*" (para 145).

Capacity

Having heard detailed evidence, set out at length in the judgment, Parker J made declarations that PM lacked:

1. capacity to consent to sexual relations, applying the issue-specific test set out in *D Borough Council v AB* [2011] EWHC 101 (COP) by Mostyn J, i.e. that the requirement is an understanding of the mechanics of the act; that there are health risks involved; and that heterosexual sex might result in the woman becoming pregnant (paras 148-9); and

2. capacity to marry (including at the time of her marriage) because (i) because she could not consent to sexual relations and (ii) she did not understand the obligations and responsibilities of marriage, and was unable to weigh up the options: paras 150-2;

Both these declarations were made on an interim basis on the basis of the evidence from Dr Joyce as to the possible potential for improvement with further education (para 74). She had reached them prior to the decision of the Court of Appeal in *PC & Anor v City of York Council* [2013] EWCA 478, and made clear in an supplementary section of the judgment that she considered the same result obtained following the approach set down in that decision (as a side-note, it seems that she considered PC to be authority for the proposition that capacity to consent to sexual relations is act-, not partner-specific (para 179(ii))).

Parker J also concluded, also an interim basis, that PM lacked the capacity to decide where to reside and concluded – "*with a very heavy heart*" (para 172) that she could not authorise PM living with MZ independently pending the consideration of further detailed plans for her residence and care arrangements.

It then became clear in further developments detailed in the judgment that any pretence that it was or could be a functioning marriage had evaporated, and MZ had abandoned any plan to seek to live with PM. It further appeared that further education as to sexual matters was unlikely to improve her capacity and might, indeed, make her more vulnerable by exposing her further to sexual terminology and ideas, particularly if she was not living with her husband.

Forced marriage

In a supplementary section of the judgment which, strictly, stands as obiter, Parker J examined in detail the proposition that she had previously set out in *XCC* to the effect that a marriage with an incapacitated person who is unable to consent is a forced marriage within the meaning of the Forced Marriage Act 2007. The police, it appears, had taken the view that this analysis was incorrect, and Parker J invited submissions from the parties, which were provided in agreed form. It is not necessary to do more here than set out her conclusions in this regard that if a person does not have capacity to consent they cannot give the requisite full and free consent, such that "*in cases of an incapacitous individual, the reality of consent is already absent, and that if P lacks capacity this renders the marriage involuntary, in contrast to Lord Lester's word 'voluntary'*" [used in introducing what became the 2007 Act] (see para 214). Such a marriage would therefore be 'forced' within the meaning of the 2007 Act.

The duties upon Registrars

The evidence before Parker J showed that the marriage that had taken place at the Register Office had taken place in troubling circumstances. "*There were two medical opinions, one of which, provided by the local authority, was carefully and rigorously analysed and argued, and stated that PM lacked capacity… The documents provided by the Registrar's office are peppered with concerning comments about Mr S's aggression and persistence, and PM's demeanour and vulnerability. The overwhelming concern was that MZ was marrying PM for a visa, thus communication with the UKBA, yet the Registrar accepted without challenge almost helplessly it seems, the bare assertion that this was not the motive for the marriage*" (para 229).

Parker J went on to consider in some detail what, if anything, could be done to prevent such problems arising again. She indicated that she considered that protection might have been effected by a Forced Marriage Protection Order ('FMPA Order'), which could be applied for (without leave) by a local authority or (with leave) by a police force. Whilst she expressed herself sure that if a declaration of a lack of capacity to marry under s.15/48 MCA 2005 was served on the Office of the Registrar General and/or a Register Officer, such order would be respected even without an FMPA Order, it might be necessary, in future, to decide whether a FMPA Order could be made, if necessary, against the Registrar General.

Comment

The question of capacity to consent to sexual relations is shortly to be revisited by the Court of Appeal, and we hope that they will give clarity one way or another as to exactly how the test is to be applied.

This decision, though, is of particular interest for the detailed consideration given by Parker J to the role of declarations as to capacity and the very clear distinction she draws between such declarations and those relating to best interests. For our part, we have some doubts as to whether the court has no discretion to make a declaration as to capacity given the clear wording of s.15 MCA 2005, but we would certainly agree that the factors going towards whether such discretion should be exercised are – and should be – different to those going towards the discretion regarding the making of declarations as to best interests. Capacity is a jurisdictional question and is therefore in an entirely different conceptual category to best interests.

Parker J's detailed and extensive commentary on both forced marriages and the duties upon Registrars picks up on the themes already developed by Bodey J in *A Local Authority v AK & Ors* [2012] EHWC B29 (COP), and reinforce the position that local authorities – and Registrars – must be extremely astute to ensure that proper steps are taken to prevent marriages being

entered into where, on a proper analysis, they should be considered not just incapacitous, but forced.

'Forcible' Caesarean section authorised for Italian national present temporarily in England and Wales

Without in any way intending disrespect to our numerous journalist readers, we usually wish only to report cases where we have a transcript of a judgment, as opposed to relying upon press coverage. We make two exceptions, however, in this issue.

The first is to make brief note of this story that has been reported in a number of places, including the Sunday Telegraph on 30 November 2013 and the Daily Mail on 1 December. The headlines in the press are distinctly alarmist, and – it would appear – unfortunately not entirely accurate, and we would wish to be able to report this story by reference to the transcript of the actual Court of Protection proceedings, which appear to have taken place in August last year. We cannot do so at this stage, although there is a judgment from 1 February 2013 in the proceedings relating to the child which sheds a little light on matters. A statement of facts has also been issued by Essex County Council. **NB, what follows is based on our best understanding of the position as at 3 December 2013.**

It would appear, from the judgment and the statement of facts, that the woman in question was Italian, with two previous children. She had had problems with her mental health since 2007, and there were admissions to psychiatric hospitals in Italy. As of 2011, her two children were in the care of their grandmother, and proceedings relating to the children were on foot in 2012 when the mother came to England. The woman, whom it appears suffered from bi-polar disorder, became very unwell during a work-related visit to England in 2012, a visit she undertook whilst pregnant. On 13 June 2012 she was detained under s.2 and subsequently s.3 of the Mental Health Act. She was profoundly unwell. The relevant NHS Trust, issued proceedings in the Court of Protection, for permissions to deliver her unborn baby by caesarean section because of concerns about risks to mother and child. According to the judgment of HHJ Newton (paragraph 7), an "*unusual order was made in the Court of Protection on 23rd August 2012 by Mr Justice Mostyn, who apart from giving various directions in relation to the Local Authority and others, gave permission for the birth by way of* caesarean section." The media reports suggest that the order authorised the forcible sedation of the woman for purposes of carrying out the Caesarean section, although we wait to see the actual order made. The local authority issued proceedings upon the birth of the child, an interim care order was granted and has been renewed ever since. The mother then returned to Italy in circumstances which troubled the Circuit Judge in February – as he noted at paragraph 9 of his judgment dealing with a hearing in the care proceedings in October 2012:

> *"By that stage it was being asserted by the treating doctors that the mother had regained capacity under the relevant test. I have to say that when the mother appeared before me at that time she did not appear to be at all well, and I am surprised that it was being claimed that she had legal capacity. I am critical of the doctors because it appears to me that she was despatched (in deed escorted) from the UK with undue haste simply because she wished to go back to Italy. I was led to believe that the mother was in a good state and a good frame of mind but frankly nothing could have been further from the truth, because if one looks at the reports of the admitting Doctors in Italy, it is clear that the mother when she arrived in Italy was in a very poor state. She should in my view have been assisted here to participate in these proceedings. I know she wanted to go to Italy but by going to Italy any realistic prospect of P returning to her care was diminished substantially. It is for that reason it seems to me that it was a most ill-advised thing to have occurred. I was critical at the time and I remain critical to this day.*

The mother's mental health then improved substantially (it appears because she complied again with her medication), and she then taking active steps to bring about the return of her child. The care proceedings concluded on 1 February 2013. The mother then applied in May 2013 to the Italian Courts for order to return the child to Italy. Those courts ruled that child should remain in England. In October 2013 Essex County Council obtained permission from the County Court to place child for adoption.

We will not address the case further absent a transcript of the judgment of the Court of Protection proceedings (which we are taking steps to pursue), save to note that the question of the authorisation by the Court of Protection of the medical treatment of those habitually resident other than in England and Wales upon the basis of presence alone raises some jurisdictional questions that are not entirely straightforward. In particular, treatment of the nature of that which appears to have been undertaken in this case can only properly be done where the matter is urgent (paragraph 7(1)(c) of Schedule 3 to the MCA 2005). Although the UK has not ratified the 2000 Hague Convention on the International Protection of Adults in respect of England and Wales, Schedule 3 effectively implements the Hague Convention in English law. The approach of the Court of Protection has therefore been to interpret the provisions of Schedule 3 to the MCA 2005 as if the Hague Convention were binding, and to have to regard to the Explanatory Report to the 2000 Hague Convention (see *Re M* [2011] EWHC 3590 (COP), a decision of Mostyn J's). 'Urgency' for purposes of the Hague Convention purposes is addressed in paragraph 78 of the Explanatory Report thus:

> "*A situation of urgency arises where the situation, if remedial action were only sought through the normal channels of Articles 5 to 9* [i.e., crudely, basing jurisdiction upon habitual residence, with the possibility of transferring consideration to a court better placed to consider the adult's interests]*, might bring about irreparable harm to the adult or his or her property. The situation of urgency therefore justifies a derogation from the normal rule and ought for this reason to be construed rather strictly. In medical matters particularly, Article 10* [founding jurisdiction on the basis of presence and urgency] *must not be used as general justification for the jurisdiction of the authorities of the State where the adult is present. An example which has been given is termination of the pregnancy of a young incapacitated woman. Although such an operation necessarily has to be performed within a certain time-limit, this is not normally a case of urgency of the kind covered by Article 10. In this field, some delegations would have liked to see jurisdiction of the place where the adult is present, but the rejection of the proposals to that effect cannot justify abuse of jurisdiction in case of urgency.*"

Whilst we have no reason at all to doubt the propriety of the judgment made by the Court of Protection in this case, Alex for one would be particularly interested to see what, if any, discussion was had before the Court as to its jurisdiction over a person whom it appears from the press reports was clearly habitually present in Italy at the time the orders were sought and obtained.

Court of Appeal re-affirms sole responsibility of advocates for conduct of cases

R v Farooqi & Ors [2013] EWCA Crim 1649 (Court of Appeal: Lord Judge, LCJ, Treacy LJ and Sharp J)

Practice and procedure – other

Summary and comment

We report this frankly extraordinarily appeal in a criminal case for one very specific reason, namely the very strong comments of the Lord Chief Justice (giving judgment on behalf of the Court of Appeal) as to the responsibilities of trial advocates. Whilst the context is entirely different, and the facts therefore do not bear any repetition here (but are worth – sorry – reading), the comments of the Lord Chief Justice do merit setting out here in their entirety because of their

wider relevance. In criticising in extremely strong terms the conduct of a criminal trial of a very senior junior, a Mr McNulty, the Lord Chief Justice noted that:

> "*107. The question was raised whether Mr McNulty discussed his proposed forensic strategy* [of what was described in the preceding para as *'an all-out attack on every aspect of the prosecution case, sometimes at a very late stage in the process, in circumstances which can be described as "ambush" and of confrontation with and disobedience to the judge'*] *with his client. However, whether he did or not, and even assuming that his client agreed or encouraged it, the client's 'instructions' were irrelevant. The client does not conduct the case: that is the responsibility of the trial advocate. The client's instructions which bind the advocate and which form the basis for the defence case at trial, are his account of the relevant facts: in short, the instructions are what the client says happened and what he asserts the truth to be. These bind the advocate: he does not invent or suggest a different account of the facts which may provide the client with a better defence.*
>
> *108. Something of a myth about the meaning of the client's 'instructions' has developed. As we have said, the client does not conduct the case. The advocate is not the client's mouthpiece, obliged to conduct the case in accordance with whatever the client, or when the advocate is a barrister, the solicitor "instructs" him. In short, the advocate is bound to advance the defendant's case on the basis that what his client tells him is the truth, but save for well-established principles, like the personal responsibility of the defendant to enter his own plea, and to make his own decision whether to give evidence, and perhaps whether a witness who appears to be able to give relevant admissible evidence favourable to the defendant should or should not be called, the advocate, and the advocate alone remains responsible for the forensic decisions and strategy. That is the foundation for the right to appear as an advocate, with the privileges and responsibilities of advocates and as an advocate, burdened with twin responsibilities, both to the client and to the court."*

We would suggest that exactly the same holds true in proceedings before the Court of Protection, an arena where – especially in the context of personal welfare proceedings – the emotional temperature can frequently run very high with knock-on consequences for the nature of the instructions given by lay clients.

Lay deputies facing custodial sentence after conviction for theft from compensation fund

The second media-report only exception to our normal rule is to make brief note of the case of two lay deputies facing substantial custodial sentences after conviction on a total of seven counts of theft (amounting to some £500,000) from a £2.6 personal injury compensation fund they were administering as first Receivers and Deputies for Samantha Svendsen. Press coverage suggests that Cathy Watson, Samantha's mother claimed that the Court of Protection never briefed her on her role as Receiver or Deputy. It would also appear that Robert Hills said they had been given no advice, warnings or directions about what the compensation money could and could not be spent on spent. It further appears that the bulk (if not all) of the transactions in question took place prior to 2007: it would appear that the couple spent £200,000 on cars between 1999 and 2004, £18,000 on jewellery from March 2000 to December 2001, and more than £22,000 on a property in Cleethorpes, Lincolnshire.

The facts of the case appear extremely stark, as do the consequences both for Ms Svendsen herself and the public purse (her compensation having come in the first place from the NHS). It is, though, difficult absent a transcript of the proceedings (and/or, which may be forthcoming

in due course, a written copy of the remarks made upon sentencing) to assess the extent to which the case throws light upon the current, as opposed to the previous regime. In particular, it is unclear precisely when investigations started into suspicious transactions that started well over a decade ago.

The Ombudsmen and DOLS

With thanks to Lucy Series for bringing this to our attention, we note a recent joint finding of maladministration by the Local Government and Health Service Ombudsmen by Kirklees Metropolitan Borough Council and the South West Yorkshire Partnership NHS Foundation Trust. The finding is of particular relevance given the conclusions relating to the use of the DOLS regime.

A couple suffered from dementia. In April 2009, the husband was admitted to hospital with acute glaucoma. The couple's son - himself a doctor - told the authorities that he believed the injury had been caused by a blow from his mother, who was beginning to show signs of dementia. This report was not followed up, and a safeguarding plan was never implemented. Instead the father's discharge from hospital was hastily arranged and he returned home without any protection.

The wife's needs increased and in April 2009, she was admitted to hospital whilst her husband went into respite care. The woman stayed in hospital for six weeks whilst her son arranged a care package, employing a RGN to provide care when her husband came home. However, both the local authority and the Trust considered that this was inadequate, and instead instituted a care package requiring the father to stay in the respite placement. A DOLS authorisation was sought and granted, the authorities recognising that the result gave rise to a deprivation of the husband's liberty. The son was not involved in the decision. In addition, when the Trust wrote to the son recommending that his parents be placed in separate care homes, they sent a copy to his mother – causing her a great deal of distress.

The investigation also found that the Trust failed to reassess the father's prescription for dementia drug, Aricept, in line with NICE guidance.

Dr Jane Martin, Local Government Ombudsman, said:

"As a result of actions by both the council and the Trust, the couple were denied the chance of living at home together in a settled lifestyle for longer than they did. The couple suffered a needless loss of dignity, while their son felt ignored, undermined and excluded from any decision about their care.

> *I am pleased that both the council and the Trust have agreed to our recommendations and hope they go some way to remedy the poor treatment and upset the family has endured."*

Julie Mellor, Health Service Ombudsman, said:

> *"Involving their son could have led to better outcomes for the couple. Families and carers can have the key to understanding the needs of their loved ones. sThat's why public services must, in law, involve families and carers in making life changing decisions for vulnerable people."*

Both the council and the Trust agreed to apologise to the man and his parents, and to review the way they involve relatives in assessing and planning care for family members with dementia and review their joint arrangements for responding to complaints.

The Trust also agreed to review the way it reassesses prescriptions for Aricept in line with guidance. Both the council and Trust agreed to make a payment of £1,000 to the couple to acknowledge their distress. The Trust will also give the woman an additional payment of £250 in recognition of the distress caused from reading the report about her future care. The authorities have also agreed to make a payment of £500 to the son to acknowledge his distress.

As Lucy notes, the Ombudsmen provide a useful route by which the inappropriate use of DOLS can be reviewed by bodies which have jurisdiction to consider past conduct; they provide a useful alternative to the Court of Protection whose primary focus is forward-looking.

Transparency in the Court of Protection

We reported in August upon the draft Guidance issued by Sir James Munby P on the publication of judgments. He has been warming to his theme of increasing transparency in the Court of Protection, in speeches both to the Jordans' Court of Protection Conference in October and, in more detail, to the Society of Editors in November. In the latter speech, the President indicated the likely direction of travel thus:

> *Changes to primary legislation are unlikely in the near future, so the necessary changes must be achieved, as I believe they can be, within the existing framework.*
>
> *The first step will be the introduction, later this year, of the final version of the Practice Guidance: 'Transparency in the Family Courts and the Court of Protection – Publication of Judgments'. This is currently being revised and adjusted to take into account the many comments and suggestions I have received.*
>
> *The next step is to consider practical steps to enable the media to have access to some at least of the documents used in court. That access by the media to documents is essential if there is to be any meaningful use of their right of access to the court hearing seems to me to be obvious. The questions of course, and the answers are not immediately apparent, are: What documents? In what form (for example, anonymised or redacted)? And subject to what safeguards? Public consultation and debate, including consultation and debate with the media, will be essential, but I am confident that we will be able to make progress, even if initially on a cautious and limited basis.*
>
> *The third step is to consider appropriate amendments to, as well as the aligning of, the rules governing the family courts and the Court of Protection. Rule changes always take time, which is why I propose in the first instance to proceed with changes that do not require any amendments to the rules.*

New COP3 published

Tying in neatly with the case of *SY* discussed above, a new COP3 has been published, available here. The most important changes are:

a. rewording the form to make clear that the range of practitioners appropriate to complete assessments of capacity for the purposes of proceedings before the COP is not limited to medical practitioners (as was sometimes – erroneously – assumed to be the case). In particular, the new form makes clear that social workers are recognised as appropriate professionals for these purposes;

b. rewording the form to make clear (section 5.3) that the important information that the Court requires in terms of assessing the quality of the assessment includes not just the professional qualifications of the individual concerned but their 'practical experience with making assessments of capacity in accordance with the Mental Capacity Act 2005 and associated Code of Practice';

c. Removal of the reference to charging at the front of the form, as the majority of professionals do not charge to carry out assessments of capacity;

d. adding (in section 7.1) a requirement that, where there is a specific diagnosis giving rise to the impairment of or disturbance in the mind or brain, this is expressly set out;

e. removing an anomaly in section 7.2 that appeared to treat difficulty in communication differently as a ground for incapacity, by making it clear that it can stand alongside the other three limbs of s.3 MCA 2005 as an additional/alternative basis upon which the functional test is satisfied;

We welcome these changes (not least because they reflect, in part, the input of one of the editors, Alex!). We would, however, emphasise that they should not be seen as limiting the ability of the Court to receive evidence from any appropriate person as to capacity (including not solely professionals but also family members and P themselves: see, above all, *CC v KK* [2012] EWHC 2136 (COP)).

Costs in s.21A applications round 2

We provided with the November issue a paper drafted by the Law Society's Mental Health and Disability Committee relating to the effect of Civil Legal Aid (Financial Resources and Payment for Services) Regulations 2013 introduced in April 2013 on applications made under s.21A MCA 2005. We are pleased to be able to bring you news, courtesy of Richard Charlton, that a recent decision of Charles J and concessions by the Ministry of Justice to be recorded in that decision will – hopefully – resolve the central problem that was caused by the Regulations, namely the apparent removal of non-means tested public funding in s.21A cases where the Court itself authorises the deprivation of liberty and the standard authorisation ceases to be in force.

We hope to able to bring you an approved note of the judgment of Charles J /a copy of the transcript in short order, but in the interim we want to ensure that the developments are given circulation as quickly as possible. To this end, we would refer readers to the following article in the Law Society Gazette.

Department of Health response to post-legislative scrutiny of MHA 2007

Readers will no doubt remember the less than complimentary views expressed by the Health Select Committee in its post-legislative scrutiny of the MHA 2007 (and, in particular, its remarks regarding the DOLS regime introduced by that Act into the MCA 2005). The Department of Health has now published its response. We reproduce the material section relating to DOLS below:

R12. The Department to initiate an urgent investigation into the implementation of Deprivation of Liberty Safeguards with a report and action plan to deliver early improvement to be submitted to Parliament within a year.

R12.1 We consider that the Deprivation of Liberty Safeguards provide an important statutory framework of scrutiny, checks and balances which both empower people and protect their rights. The Government led a major programme over five years to implement the 2005 Act, including the Deprivation of Liberty Safeguards, which made a significant contribution to changing practices. However, the Government recognises that further progress needs to be made and welcomes the work of the Health Select Committee and that of the House of Lords Committee conducting post legislative scrutiny of the 2005 Act in helping it understand what further action is needed.

R12.2 The Department will work with national and local partners through a newly set up Mental Capacity Act Steering Group to examine the evidence to understand the progress which has been made so far implementing the Deprivation of Liberty Safeguards. As part of this, it will look closely at the evidence heard by the Health Select Committee during its work and the current evidence being gathered by the House of Lords Committee conducting Post Legislative Scrutiny of the Mental Capacity Act 2005.

R12.3 Working together, we will identify the key priorities to make further progress and agree the actions each organisation can take to continue to implement the Mental Capacity Act and the Deprivation of Liberty Safeguards in health and care settings. The Department considers that improvements in the understanding and

use of the Mental Capacity Act 2005 amongst health and care professionals will support improvements in the use of the Deprivation of Liberty Safeguards.

R12.4 As a first step, the Government is revising the Code of Practice for the 1983 Act for publication in 2014. This will include new guidance on the interface between the 1983 Act, the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. In response to concerns we have heard about the complexity of the forms which support the process for depriving someone of their liberty, the Department will review and simplify them, learning from experience over recent years.

R12.5 The Department will work closely with NHS England which is committed to supporting further action to implement the Deprivation of Liberty Safeguards. NHS England has appointed safeguarding leads throughout England to support CCGs to deliver safeguarding assurance and accountability. Training is offered to staff using e-learning tools and through multi-agency workshops with local Safeguarding Adults Boards. Each commissioner has a named lead with responsibility for supporting clinicians with advice relating to these issues.

R12.6 The Department will also work closely with CQC which is responsible for monitoring compliance with the Deprivation of Liberty Safeguards. CQC will continue to develop its view of the Deprivation of Liberty Safeguards as it monitors compliances, engages across the system and develops its annual report. CQC will use its next report, which will be published at the end of this year, to promote examples of good practice, including evidence from a sample of Independent Mental Capacity Advocacy services on the operation of the Safeguards and to extend the work it started last year looking at the activities of local authorities as supervisory bodies.

R12.7 The Government will publish an assessment of progress and the actions taken to continue to improve the implementation the Deprivation of Liberty Safeguards by the end of 2014.

We would also note that the Department of Health declined to accept the recommendation of the Health Select Committee (as is the case in Wales) to extend entitlement to the services of Independent Mental Health Advocates to all mental health patients in England rather than only those detained under the Mental Health Act 1983. Responding to the concern expressed by the Committee as to 'de facto' detentions where informal patients are told that they will be detained if they try to leave, the Department of Health stated (at R.26) that: "*Voluntary inpatients should never be told that if they try to leave hospital they will immediately be detained under the 1983 Act. It is, however, important to ensure that no clinician feels constrained from making correct use of section 5 of the 1983 Act (emergency holding powers) when appropriate. It may be necessary to detain an inpatient under section 5 where they seem likely to pose a risk to themselves or others if they were to leave hospital*." The Department of Health further promised that the principles of the use of the power to detain and the principle of least restriction would be made clear when the Code of Practice to the MHA 1983 is revised in 2014.

AM – a BIA/AMHP responds

In our case report upon *AM v SLAM*, we invited comments from our readers, and received the following views from Justin Griffiths, a BIA/AMHP with North Staffordshire NHS Trust. As they represent the view from the ground, we reproduce them in full with no editorial intervention from us:

"As a practicing BIA and AMHP I take a keen interest in any case law around "eligibility". When considering AM v South London & Maudsley NHS Foundation Trust, I agree with the overall decision relating to use of the Mental Health Act, however I am

concerned about key aspects of the judgement.

DOLS is less restrictive?

I believe that the view that DOLS represents a less restrictive regime in this case is unnecessary. There is little evidence in the judgement to suggest that increased stigma will inevitably lead to more restrictions. I also struggled with the assumption that AM would have more community access / family visits under DOLS than she would under the MHA. Under DOLS this would depend on a BIA setting conditions, but could equally be achieved by under the MHA by application of the least restrictive principle. In addition to this, the lack an accessible independent process of review under DOLS is inherently restrictive. In my experience the Mental Health Tribunal can be a very important driver for least restrictive practice.

I am also concerned that about how this case will be interpreted, although Justice Charles stresses that generalisation is dangerous, I believe that the ability to 'pick and choose' between regimes will be misinterpreted, just as the primacy of the Mental Health Act was following the GJ case.

Article 8 Issues

The judgement fails to consider the core Article 8 issues within the case as there is clearly a dispute between the care team and AM's daughters about her care and treatment. There is also a decision not to release AM into the care of her daughters, which I assume is the factor that indicates a DOL. Although HL v UK is considered, there is no mention of Neary v Hillingdon and that cases direction that Article 8 disputes should be considered by the Court of Protection. It is therefore concerning that the AM case does not advise an application to the Court of Protection.

That aside, in practice I have found that the involvement of BIAs and IMCAs via DOLS, in the initial stages of dispute cases can occasionally help to resolve them before they escalate to lengthy court proceedings.

Nearest Relative Rights

Considering the case from an AMHP perspective, I also have concerns that the use of DOLS would have effectively ended the right of the Nearest Relative to object to her mother's care and treatment. The Nearest Relative is a key safeguard for people detained under the Mental Health Act and without any direction to apply to the Court of Protection, the outcome of the case denies any formal court process that deals with the dispute / objection.

Finally, as a practitioner I believe that that this case only adds to the complexity surrounding interface of mental health legislation and ultimately makes it more difficult for practitioners to safeguard the people the law is meant to protect."

New Mental Health Tribunal Practice Direction directs specific consideration of whether MCA would be less restrictive

Tying neatly to the article immediately above, and with thanks to Steve Benson for bringing this to our attention, we note that the new Practice Direction issued in respect of statements and reports required for proceedings before the Mental Health Tribunal requires that the reports prepared by Responsible Clinicians for in-patients specifically identify "*in the case of an eligible compliant patient who lacks capacity to agree or object to their detention or treatment, whether or not deprivation of liberty under the Mental Capacity Act 2005 (as amended) would be appropriate and less restrictive*" (para 12(m)). The same information is required in Social Circumstances Reports (para 14(t)). It would appear that this change has been brought in to respond to the *AM* case, albeit that it is unlikely save in the case of automatic referrals that any

patient would be before the Tribunal who would not be considered to be objecting in some fashion to their treatment (and hence ineligible to have any deprivation of liberty authorised by way of a DOLS authorisation under the MCA 2005).

Dementia-friendly financial services charter

The difficulties experienced by customers (and professionals advising them/attorneys acting upon their behalf) in dealing with banks at or after the onset of a lack of capacity to manage property and affairs is something that we have reported on several times in the past. It is good, therefore, to be able to report a development that on its face appears to offer some practical assistance. The Alzheimer's Society launched at the end of October a Dementia-friendly financial services Charter. The Charter sets out a number of commitments for organisations signing up to it, including such important (but we are aware all too often neglected) matters as committing to giving their relevant staff basic awareness training as to dementia, and training upon legislation including the MCA 2005. Perhaps more importantly, because it was developed in conjunction with representatives from the financial services industry, the Charter sets out practical and detailed steps for banks and other financial institutions to take to respond to specific matters that may arise in dealing with clients with dementia, and sets them out in the language of the financial services industry. We can but hope that with this degree of 'buy-in' from the industry this Charter will go some way to alleviate problems that cause very real and immediate distress and difficulty for those suffering from dementia and for their loved ones.

Canadian Supreme Court case sheds light upon the scope of duties on doctors at the end of life

Cuthbertson v Rasouli [2013] SCC 53

Medical treatment – treatment withdrawal

In light, in particular, of the continuing discussions as to the implications of the decision of the Supreme Court in *Aintree v James*, we think that it is apposite to put before you a brief note on the recent decision of the Supreme Court of Canada in a case about withdrawal of life-sustaining treatment from a man in a persistent vegetative state. The framework for decision-making about medical treatment in Ontario is very different from that under the MCA, with substitute decision-makers able to give or withhold consent to treatment. The substitute decision-maker will usually be a close family member, applying a statutory hierarchy of substitute decision-makers a little like the hierarchy in the MHA 1983 for identifying nearest relatives. Mr Rasouli's wife was his substitute decision-maker under the relevant statute, and refused to consent to treatment being withdrawn. That dispute would be capable of resolution by an independent quasi-judicial Board under the relevant legislation.

The Supreme Court had to decide whether withdrawal of ANH amounted to 'treatment', and determined that it did, since a strict distinction between acts of treatment and acts of withdrawal could not be maintained in the particular context, even though not all withdrawals would constitute treatment (for example refusal to renew a prescription of a drug that may harm the patient). Next, the court grappled with the thorny issue of what happens if the physicians consider treatment is futile and are therefore unwilling to provide it, but a decision-maker decides that it is in P's best interests. The court referred to *R (Burke) v General Medical Council*, [2005] EWCA Civ 1003, [2005] 3 WLR 1132 at para 34 as authority for the proposition that a physician's duty of care may require that treatment not be withdrawn despite the physician's ethical objections to its administration. The relevant passage in *Burke* considers the case of a "*competent patient who, regardless of the pain, suffering or indignity of his condition, makes it plain that he wishes to be kept alive. No authority lends the slightest countenance to the suggestion that the duty on the doctors to take reasonable steps to keep the patient alive in such circumstances may not persist. Indeed, it seems to us that for a doctor deliberately to interrupt life-prolonging treatment in the face of a competent patient's expressed wish to be kept alive, with the intention of thereby terminating the patient's life, would leave the*

doctor with no answer to a charge of murder." Whether that observation exactly translates into the position that an incompetent patient who would have wanted treatment to continue must therefore be treated even by a doctor who judged treatment to be futile or harmful, is open to debate – certainly, our Supreme Court in *Aintree* did not take the view that medical practitioners could be required to provide treatment they judged to be futile. The point highlights the peculiar situation in English law in which PVS is treated differently to all other conditions. Logically, it would seem to be the case that if P's views about the quality of his life are of critical importance (as per Aintree), then whether or not doctors think ANH is futile is not the end of the matter, and in PVS cases there may be a balancing exercise to be carried out which does not always generate the same answer. Is there any principled basis on which to accept that medical futility is determinative in PVS cases where there is a tiny but not non-existent prospect of improvement, but not in other cases?

The dissenting judges in the Canadian case took the view that "[w]*hen the issue is the withdrawal of treatment that is no longer medically effective or is even harmful, a patient's choice alone is not an appropriate paradigm. A patient's autonomy must be balanced against broader interests, including the nature of her condition, the implications of continuing the treatment, the professional obligations of her physicians, and the impact on the broader health care system..... such an extension of patient autonomy to permit a patient to insist on the continuation of treatment that is medically futile would have a detrimental impact on the standard of care and legal, ethical, and professional duties in the practice of medicine*."

Intervention Order integral to successful settlement of Scottish criminal injuries compensation claim after 24 years

We note this case, brought to our attention by Adrian Ward, the solicitor involved, who (as noted above) will from next month be one of our two Scottish contributors, as a good example of the operation of Intervention Orders under the Scottish regime.

In Scotland, both Intervention Orders and Guardianship Orders may be obtained under Part 6 of the Adults with Incapacity (Scotland) Act 2000. The application procedure for both is the same. An Intervention Order is a lesser intervention, and a Guardianship Order may not be granted where an Intervention Order will suffice. Both forms of order are obtained upon application to the Sheriff Court having jurisdiction, the primary ground of jurisdiction being habitual residence of the Adult. Guardianship is appropriate where ongoing financial management or welfare decision-making is likely to be required. An Intervention Order may either authorise actions specified in the Order, or authorise a person to take action or make decisions as may be specified. The Order may cover a single act such as signing a document, or a linked series of acts and decisions. With fairly limited exceptions, an Intervention Order can authorise anything which the Adult, if capable, could have done in relation to the Adult's personal welfare and/or property and financial affairs.

By way of an example of the use of an Intervention Order is the case of 'L,' in which a compensation claim on behalf of a woman who was sexually and physically abused as a child was very recently settled after 24 years.

The victim's mother had first applied for criminal injuries compensation in 1989, but for a variety of reasons the case was never brought to a conclusion, and no one was appointed to represent her as an adult. In 2011, however, with the agreement both of the victim's family and of the Criminal Injuries Compensation Authority ('CICA'), Adrian Ward applied for an Intervention Order to authorise him to represent the victim before the CICA. The Order was expressly sought, and granted, on the basis that the solicitor would act as appointee for the victim, rather than as solicitor instructed directly by the victim. Thus appointed, it was possible for instructions to be given to Leading Counsel (acting pro bono, as did medical experts instructed) and settlement negotiations to be conducted, ultimately leading to a six figure settlement for the victim. By virtue of the

powers granted under the Intervention Order, arrangements can be made for the compensation, insofar as it is not immediately applied for any purposes, to be held under arrangements such as a Personal Injury Trust, or for an annuity to be bought.

Mental Welfare Commission for Scotland recruiting new Chief Executive

The current Chief Executive of the MWC is retiring; details of the application process to recruit his successor can be found here. The deadline for applications is 9 December.

Mini call for evidence

As some of you know, Alex is on sabbatical this academic year, researching and writing upon (amongst other things) the 2000 Hague Convention on the Protection of Adults and the wider issues arising in the cross-border protection of incapacitated adults. He would very much welcome any experiences that readers are able to share of cross-border problems experienced in the health and welfare context. Whilst he has been in a number of cases involving such questions and is possessed of a vivid imagination, real life always trumps fiction and he would very much welcome news of issues that have been encountered. A particular issue that he would welcome experiences of is medical treatment in the cross-border context (topical in light of the case of the Italian national discussed above), possible examples being attempted reliance in Scotland of an advance decision to refuse treatment made in England or the 'outsourcing' of care and treatment options to a foreign country. All contributions to alex.ruckkeene@39esssex.com will be very gratefully received.

Conferences

Shameless plugs for:

1. A seminar being given by Tor and others at Irwin Mitchell on 10 December 2013 entitled "What Case Managers and Financial Deputies need to know about personal welfare and the Court of Protection." Full details are available here;

2. The Law Society of Scotland's Mental Health and Incapacity Law Conference being held on 21-21 March 2014 at the Fairmont Hotel in St Andrew's. This conference, held in conjunction with the Mental Welfare Commission for Scotland and the EHRC, is the first of its kind to be held since the introduction of the Adults with Incapacity (Scotland) Act 2000 and the Mental Health (Care and Treatment) (Scotland) Act 2003. Both Adrian and Alex will be speaking, and Jill is acting as a session facilitator. Full details, including early bird rates, are available here.

Our next Newsletter will be out in early January. 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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Victoria regularly appears in the Court of Protection, instructed by the Official Solicitor, family members, and statutory bodies, in welfare, financial and medical casses. 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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Michelle's broad range of experience in the Court of Protection encompasses deprivation of liberty, residence and contact, forced marriage, serious medical treatment, capacity to consent to marriage and capacity to consent to sexual relations as well as applications for financial deputyship. She is recommended as "responsive and approachable" and a "formidable presence" in the Court of Protection in Chambers and Partners 2013. **To view full CV click here.**