



Mental Capacity Law Newsletter

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Introduction

Happy New Year, and welcome to the February issue of the Mental Capacity Law Newsletter. This issue, in some ways, represents the lull before the storm, because by the time of the March issue we will have seen the report of the House of Lords Select Committee upon the MCA 2005 and – we very much hope – the decision of the Supreme Court in the *Cheshire West* case. We have, though, plenty to keep us busy in the interim.

From England, undoubtedly the most important decision is that of the Court of Appeal in *IM v LM, AB and Liverpool City Council*, providing the first answer at appellate level to the very vexed question of whether capacity to consent to sexual relations is person- or act-specific. The decision in *RC v CC* is of considerable significance for its authoritative discussion of the principles governing non-disclosure in the Court of Protection. The decision in *Re UF*, trailed last month, provides important guidance as to the circumstances under which it is appropriate for a family member to act as litigation friend for P, along with recording significant concessions from the Ministry of Justice as to public funding in cases under s.21A MCA 2005. We also cover cases on the scope of s7 MCA 2005 ('necessaries'), 'enforced' Caesarean sections, DNACPR notices, important guidance from the President upon the publication of judgments, and the CQC's most recent report upon the operation of the DOLS safeguards.

Our Scottish contributors are Adrian Ward, of TC Young Solicitors, and Jill Stavert, Reader in Law and Director of the Centre for Mental Health Law and Incapacity Law, Rights and Policy at Edinburgh Napier University. Developments for reporting in the Scottish section of the newsletter should be

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sent in the first instance to [Adrian](#) or [Jill](#).

In the Scottish section this month is included a discussion of the potential inconsistency between the 2000 and the 2003 Acts insofar as they relate to the ability for substitute decision-makers to consent to compulsory treatment, as well as of guidance recently issued by the Mental Welfare



Commission for Scotland relating to covert medication. This guidance is of particular interest for English practitioners because there is no equivalent coming remotely close south of the Border in terms of the detail of the analysis. We also include with this newsletter the first in an series of short articles by Adrian introducing some of the key principles relating to Scottish adult incapacity law, and highlighting some of the profound differences in approach that exist between the two jurisdictions.

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.

From this issue onwards, we are introducing – by request – a facility to advertise conferences and other training events of interest to practitioners concerned with mental capacity/adult incapacity law. 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 be made to Alzheimer Scotland Action on Dementia. Please contact one of the editors if you would like to discuss placing a posting. We should note that we will continue to reserve the right to plug – for free – those conferences and training events that one of us is speaking at!

Finally, we would be very grateful if you could spend a couple of minutes completing the [survey](#) that we have put together to seek your feedback on the newsletter and other ways in which we provide information about the law relating to mental capacity. We are conscious that the newsletter has grown organically over time, and, whilst we regularly get very useful ad hoc feedback, we thought that it was time that we took more formal stock. Rest assured, we have no plans either to (1) cease production; or (2) start charging!

Court of Appeal clarifies (civil) law on capacity to consent to sexual relations

IM v LM and Others [2014] EWCA Civ 37 (Court of Appeal) (Sir Brian Leveson, President QBD, Tomlinson and McFarlane LJ)

Mental capacity – Sexual relations

Summary

This decision of the Court of Appeal considers the test of capacity to consent to sexual relations. LM was a 41 year old woman who had three children. She was also described as having an extensive history of drug and alcohol abuse and convictions for offences related to prostitution. After having her children she had suffered a hypoxic brain injury following a medical procedure, which had caused her problems with her memory. A consultant psychiatrist advised that LM lacked capacity to consent to sexual relations because she could not weigh up foreseeable risks to her and potential children from becoming pregnant. Nor was LM able to weigh up the risks of acquiring a sexually transmitted infection, and she was unlikely to initiate any action to avoid acquiring such infections. At first instance however, Peter Jackson J concluded that LM had capacity to consent to sexual relations, noting that *'She is somebody who has been [fully] sexually active in the past; she has had children; she understands the rudiments of the sexual act; she has a basic understanding of issues of contraception and the risks of sexually transmitted diseases. The area in which she is weakest is her ability to understand the implications for herself should she become pregnant. Pregnancy for [LM] would be an extremely serious state of affairs; there can be no doubt about that. But her weakness in that respect does not, for me, lead to the conclusion that her capacity is absent; it argues for her to receive continued safeguarding and help, advice and explanation as and when the question of sexual activity might become a reality.'* Peter Jackson J went on to explain that the declarations as to incapacity and best interests regarding care, residence and contact which he was making in



respect of LM would be sufficient to provide her with the support and protection she required.

Having waded through the previously decided cases concerning sexual relations, contraception, and the common law test of capacity, Sir Brian Leveson P, giving the judgment of the Court of Appeal, concluded that there was no difficulty in reconciling the authorities. It was clear that the decisions of Munby J (as he then was) in *Re MM; Local Authority X v MM & KM* [2007] EWHC 2003 (Fam) and *X City Council v MB, NB and MAB* [2006] EWHC 168 (Fam), [2006] 2 FLR 968 had not suggested that the ability to use or weigh information was not part of the test for capacity to consent to sexual relations: what Munby J had recognised was that the extent of the judicial enquiry into P's ability to use or weigh the relevant information was much less than in other spheres, since capacitous people do not, generally speaking, agonise over such decisions. That was not inconsistent, Sir Brian Leveson P considered, with the House of Lords decision in *R v Cooper* [2009] UKHL 42.

Further, the comments of Baroness Hale in *R v Cooper* as to the person-specific nature of a decision to consent to sexual relations were not inconsistent with a generic approach to capacity being taken in the civil sphere. The civil and criminal courts were considering different issues, and it was correct to draw "*a distinction between the general capacity to give or withhold consent to sexual relations, which is the necessary forward looking focus of the Court of Protection, and the person-specific, time and place specific, occasion when that capacity is actually deployed and consent is either given or withheld which is the focus of the criminal law*" (paragraph 75) It was therefore possible for the Court of Protection to make a '*general evaluation*' of capacity.

The Court of Appeal expressly relied on policy reasons for adopting that approach, accepting that "*it would be totally unworkable for a local authority or the Court of Protection to conduct an assessment every time an individual over whom there was doubt about his or her capacity to consent to sexual relations showed signs of immediate interest in experiencing a sexual encounter with another person. On a pragmatic*

basis, if for no other reason, capacity to consent to future sexual relations can only be assessed on a general and non-specific basis" (paragraph 77).

Sir Brian Leveson therefore held that it followed that the first instance decision was correct, as LM's ability to use or weigh information, although limited, was not beneath the low level called for in the context of a '*visceral*' decision rather than a '*cerebral*' one.

Comment

For the time being at least, the question of the correct approach to capacity to consent to sexual relations is relatively clear. The test is general in its application, and the relevant information does not include more 'remote' factors such as the implications of pregnancy, as opposed to the risk of becoming pregnant. The ability to use or weigh information, while essential, is required at a low level only, given the nature of the decision.

Does the judgment provide the simple, workable guidance sought by the parties? On one hand, it is helpful in its clarification of the content of the test and the manner in which it should be applied. On the other hand, because of the factual matrix of LM's case, it does not grapple with the more complex cases that tend to trouble statutory authorities involving individuals who are being sexually exploited. The first sentence of the judgment gives readers a clue as to the direction the Court is going to take on this controversial issue: 'When is it appropriate for society to intervene paternalistically in a decision or decisions that individuals make as to their sexual relations?' An alternative set of facts might have resulted in the question being framed as 'When is it appropriate for society to intervene to prevent individuals from being the subject of sexual assault?' It is interesting that in many of the other reported cases concerning capacity to consent to sexual relations, P is reported as having made allegations of sexual assault, but there is no mention of criminal proceedings having been brought. There may be other policy considerations in favour of a more nuanced approach to capacity in the civil context if it is right that the criminal system is not in fact able to protect people with mental impairments from



sexual assault.

The Court of Appeal proceeded on the basis that “if, in any case, there is a declaration of lack of capacity, the relevant local authority must undertake the very closest supervision of that individual to ensure, to such extent as is possible, that the opportunity for sexual relations is removed” (paragraph 1). It is not obvious that this is necessarily correct. Is it axiomatic that a person who lacks capacity to consent to sexual relations but who does not actively seek out sexual partners and lives in an environment where the opportunities for sexual contact are limited must be supervised 24 hours a day to avoid such a low probability risk?

The Court was also troubled by the practical difficulties of evaluating P’s capacity in respect of each potential sexual partner. This concern, though often raised, is rarely analysed. Why is it more onerous to assess capacity in respect of different potential sexual partners than in respect of different people with whom P may have contact – an approach which, it appears to the editors, is required by the [City of York](#) decision in cases where P’s incapacity is not of a global nature. Should not more care be taken rather than less when assessing capacity in respect of a decision which can have such significant consequences (STIs, pregnancy and the emotional trauma of sexual assault) compared to, for example, a decision to go to the cinema with someone? And if capacity is not assessed in relation to specific individuals, might P be at risk of a declaration of incapacity which would not apply in a particular situation – imagine the situation in which P is in a longstanding relationship with a sexual partner who has no sexually transmitted infections and is willing to be regularly tested to confirm that position, but where P is unable to understand or retain information about STIs despite support.

Given the obvious attractiveness of a low-threshold approach which limits State intervention in people’s private lives, it seems likely that the policy considerations in favour of positive autonomy (the right to sexual freedom) are likely to trump those of negative autonomy (the right not to be sexually assaulted), in line

with this decision. Statutory bodies anxious about the repeated sexual assault or exploitation of mentally impaired adults will have to consider whether the exercise of the court’s inherent jurisdiction, or other civil remedies ought to be sought in these more complex cases.

We might, finally, note that the answer to the dichotomy set out above that the bar would appear to be set higher for a trip to the cinema than a decision to engage in sexual relations might be that the threshold for the former should be lowered – which would represent at least a move in the direction of the UN Convention on the Rights of Persons with Disabilities.

When can a family member act as litigation friend for P (and how should the Court proceed on a s.21 MCA application)?

Re UF [\[2013\] EWHC 4289 \(COP\)](#) (Charles J)

Litigation friend – family member – Article 5 ECHR – DOLS authorisations

Summary

UF, aged 84, suffered from vascular dementia of a moderate level. She had lived at home alone for some years until, after her release from detention under s.2 MHA 1983, she was placed in a residential care home. She was the subject of a DOLS authorisation at the care home. Her daughter, AF, brought an application under s.21A MCA 2005, on the basis that she was her mother’s litigation friend, and on the basis that her mother was expressing in strong and, to her, worrying terms that she did not wish to be there. UF was, at that point, eligible for non-means-tested public funding.

UF’s other children, with whom it appears that AF had had long-standing difficulties, considered that her best interests were served by remaining at the care home. AF was appointed her mother’s litigation friend on an interim basis at a hearing before a District Judge; it appears on a largely pragmatic basis given that the Official



Solicitor would not be able to accept any invitation to act within an appropriate time-frame for purposes of a s.21A application. In line with the approach that had been adopted by Charles J in [Re HA](#) [2012] EWHC 1068 (COP), the standard authorisation was therefore terminated and the Court itself authorised any deprivation of liberty to which UF was subject pending the determination of the s.21A challenge. A problem then arose because the Legal Aid Agency, implementing an approach set down in Regulation 5(1)(g) of the Civil Legal Aid (Financial Resources and Payment for Services) Regulations 2013 (which came into force on 1 April 2013), took the view that, as UF was no longer the subject of a standard authorisation, she was no longer entitled to non-means-tested public funding. When the impact of this problem became clear, the District Judge joined the LAA, through its Director of Casework and (it appears) transferred the matter to be heard by Charles J. The LAA applied to be discharged, which Charles J refused, but he did accede to their invitation to add the Ministry of Justice, as the Department responsible for the policy underlying the change in the Regulations. It became clear that, in fact, there had been no intention by changing the Regulations to address the decision in *Re HA* and to alter the legal aid regime in this specific regard.

Charles J therefore had two discrete issues to consider (1) whether AF should continue as litigation friend; and (2) precisely how the court should proceed in *Re HA*-type case.

Litigation friend

Charles J noted that it appeared that the possibility of the RPR bringing an application under s.21A (as had happened in *AB v A Local Authority and The Care Manager of BCH* [2011] EWHC 3151 (COP)) had not been investigated in any detail. As the RPR was in agreement with the relevant decisions reached, however, Charles J noted that it was very understandable why it was that AF had been advised to bring the application as UF's litigation friend as she was and continued to be the person who disagreed with the decisions made at the best interests meetings.

Looked at in isolation, Charles J, it could be said that there might be some force in the argument put that there was no conflict between her and her mother in the sense that AF genuinely believed that what she was asserting was in her mother's best interests. Charles J held that it was, though, necessary to consider Rule 140 of the COPR 2007 in the context of the overriding objective contained in Rule 3 and having regard to the circumstances of each case. At paragraphs 23ff, he continued:

"23. In general terms Mr O'Brien asserted that if a member of the family cannot act as a litigation friend that severely restricts the number of available people who might be able to act as a litigation friend and thereby cause problems in litigation of this type. I agree that members of a family, even if there is a family dispute concerning P's best interests could, albeit I think rarely, appropriately act as P's litigation friend in proceedings relating to that dispute. However, it seems to me that he or she would need to demonstrate that he or she can, as P's litigation friend, take a balanced and even-handed approach to the relevant issues. That is a difficult task for a member of the family who is emotionally involved in the issues that are disputed within the family and it seems to me an impossible task for AF to carry out in this case. One only has to look at her statements to see that she is clearly wedded to a particular answer. You do not see within her statements a balanced approach or anything approaching it, such as: "This is the problem. These are the relevant factors for and against". That is not a criticism. Rather it seems to me that it is a product of the result of there being long-standing family disputes and the existing clear divisions of opinion within the sibling group as to what will best promote UF's best interests.

24. In the context of the disputed issue relating to where it is best for UF to live and thus how she should be supported



there, to my mind, the history of dispute within the family and the issues relating to the funding of the necessary support mean that it is simply not possible for AF to conduct the proceedings fairly in the way in which that concept should be interpreted in Rule 140 or in a way, in which AF's interests are not or cannot be said to be adverse to those of UF. Essentially this is because AF has an argument which she definitely wishes to run in advancing the best interests of her mother and this, coupled with the family history, means that AF cannot realistically consider the alternatives dispassionately. When you add in the need to construe the words of Rule 140 by reference to the overriding objective, it seems to me clear that this is a case in which AF should not continue to be the litigation friend of UF."

Charles J therefore found that this was a last resort case, in the sense in which there was not somebody else suitable and willing to act as litigation friend. This, therefore, triggered the need for the Official Solicitor to act. Indeed, Charles J held (at paragraph 25) that this was "a case which cries out for somebody with the independence of the Official Solicitor to address both UF's capacity to litigate and to make the relevant decisions" such that "the court should not take the course set by the District Judge of embarking on getting evidence on what is in effect a preliminary enquiry as to UF's capacity to make decisions on where she should live and how she should be supported there until the Official Solicitor, or some other independent person, has addressed this task in an appropriate timescale, or in light of this judgment has refused to do so." Charles J had not been in receipt of submissions as to whether the role of litigation friend should be discharged by the RPR or the Official Solicitor; this, therefore "was a matter for another day" and would probably require wider representation (it appears, though, from the concluding paragraph of the judgment that Charles J was of the view that the Official Solicitor should, if possible, discharge the role).

Court authorisation vs continuing standard authorisations?

By the time the issue of funding came on for final determination by Charles J, the position had become significantly clearer, and he was able to record it thus:

"31. [...] [I]t has been made clear by [the Ministry of Justice and LAA] that if the Court was to exercise powers under s.21A, or indeed any other powers, to bring about the result that a standard authorisation remained in place no point would be taken that that was a contrivance or would be a ground for not granting legal aid on a non-means tested basis.

*32. On the issue of contrivance I should record that the general position helpfully adopted by the Ministry of Justice and the LAA was that if applying the approach in *Re HA* the Court would have authorised a continuing deprivation of liberty of P (here UF) or such deprivation of liberty as there was arising from the implementation of the relevant placement plan, whilst the Court considers the issues under s.21A, the achievement of that result by the Court taking a different route that provides that a standard authorisation is in force would not be regarded as a contrivance.*

33. That stance means that in all or the vast majority of applications under s. 21A that have and will come before the court it is open to the court, without being accused of being a party to any contrivance by the relevant funding authorities, to:

- a. abandon what I still think is the more sensible course set out in *Re HA* of taking control of the matter itself and granting interim relief and authorisation, and instead*
- b. to reach effectively the same result, if it has the power to do so, under*



s.21A, by continuing in force the relevant authorisation, or otherwise bringing about the result that a standard authorisation is in existence.”

Charles J took the opportunity to express his views as to the powers of the CoP in relation to standard authorisations, thus:

“34. It seems to me that the combination of s. 21A (2)(b) and (3)(a) and (b), s. 47 and s. 48 and paragraph 61(2) of Schedule A1 of the MCA empowers the Court of Protection to vary an existing standard authorisation by extending (or shortening) it and that if and when it exercises that power it would normally be sensible for the court to give consideration to whether it should then exercise its powers under ss. (6) and (7) or give directions concerning its future exercise of those powers.”

At paragraph 35, Charles J expressed the view that the Court, unlike the supervisory body, was not limited to the period stated in the best interests assessment upon which it was based if that period was less than the maximum one year provided for in para 42(2)(b) of Schedule A1. This, he considered, was *“the Court is exercising its discretion and powers, and so is in effect carrying out its own (interim) best interests assessment.”* Whilst any Court-ordered variation extending or directing the extension of a standard authorisation pending the determination of a s.21A application would not normally extend beyond the possible maximum of one year, Charles J posed the question as to whether – but did not decide – the Court would have the power to extend the authorisation any further, or whether it would be necessary for it to grant a limited authorisation for purposes of ‘holding the ring’ pending the implementation of a further standard authorisation.

On the facts of UF’s case, and because the *Re HA* course had previously been adopted, there was no longer in place any standard authorisation. Charles J held (at paragraph 37) that the court had no power under s.21A to grant a new one.

At paragraph 42, he was, however, able to approve a course of action which would circumvent this problem:

“a. The authorisation given by the District Judge will continue to an identified date.

b. If, having reassessed the position, they are so minded to do so the local authority as the supervisory body will give a standard authorisation from that date (see paragraph 52 of Schedule A1).

c. I invite them to do that for a short defined period, say 14 days or a similar period ending on a date that the courts are open.

d. Without further application or hearing, I will exercise my powers under s.21A to extend it for six months or to such other date as the court may from time to time direct. That will provide ample time to resolve the application.

e. At the same time, I will exercise my power to exclude the local authority from any liability arising from the grant of that standard authorisation.”

Charles J concluded with some observations upon the argument that *“the Court could and should simply leave matters to a local authority to continue authorisation of a deprivation of liberty during the currency of s.21A proceedings. In this case, and others, this would mean that the relevant public authorities should take the responsibility for and the risks arising in respect of a challenged placement that involves or may involve a deprivation of liberty. That argument is founded on the duties imposed upon the relevant authorities both by Schedule A1 and 1A and their more general duties.”* Whilst he did not rule out this course of action, in his view:

“44. [...] having regard to the obligations and duties of the Court under s.21A and more generally under the MCA and its DOLS, it will normally be appropriate for the Court to satisfy itself as to and to



take control of the interim position by exercising its powers under s. 21A and/or other provisions of the MCA. Not only does that accord with the Court's role, if it is not done it would be likely to impose difficulties for the individuals and bodies involved in the proceedings and unnecessary responsibilities on assessors and decision makers that could render constructive consideration of P's best interests more difficult."

Comment

Litigation friends

It is not clear from the transcript of the judgment whether Charles J's attention was drawn to the dicta of Ward LJ in [AVS v An NHS Foundation Trust & Anor](#) [2011] EWCA Civ 7. In that case, the brother of a patient with vCJD who had very strong views as to the medical treatment which should be offered to his brother sought to appeal (inter alia) against his removal as litigation friend by Sir Nicholas Wall P. The main basis for his removal had been attacks made on clinicians at the hospital at which the patient was being treated. At paragraph 29, Ward LJ noted the argument advanced on the brother's behalf that "*there is no suggestion that the brother has any interest adverse to that of the patient: he is doing what he genuinely believes the patient would want. The attack on the hospital may raise the temperature in the litigation but does not imperil its fairness. Leading counsel are instructed and the proceedings are in competent hands. I see the force of these arguments.*" These dicta have subsequently been interpreted as supportive of the position of family members acting as litigation friends, even if they have very strong views as to what may be in the best interests of P which they do not express with the objectivity to be expected of a litigation friend such as the Official Solicitor. In [WCC v AB and SB](#), a 2012 case, HHJ Cardinal appointed P's aunt as litigation friend even though the main issue in the case was whether the care being given by P's mother (i.e. her sister) was inadequate, and in the face of submissions from the local authority that her position would therefore be intolerable. HHJ Cardinal's decision was driven, in considerable

part, by the need to progress the case and the fact that the Official Solicitor (then operating his waiting list in welfare cases) would not be in a position to accept any invitation to act until after a substantial delay. He did, though, note that the commentary to Rule 140 of the Court of Protection Rules in Jordan's Court of Protection Practice 2012 was "*perhaps a little excessive*" in stating that a relative or concerned person would be likely to have a conflict of interest in acting as P's litigation friend.

These dicta must now be read in light of Charles J's analysis of the position of family members, which represents the most comprehensive discussion of the competing factors. Whilst it would appear that he did not rule out entirely that a family member could act as P's litigation friend, it is clear that he, for one, would look upon any such application with a considerable degree of caution, especially where there was any hint that the dispute went wider than between a family and a public authority to incorporate an aspect of family dissension.

We would, perhaps, though, emphasise if – as does not appear to have been disputed here – P is expressing to at least one person strong views that they do not wish to be in the care home or hospital in question, but none of those involved in the process (including the RPR) had any intention of bringing the matter to Court, then it would be a highly unsatisfactory result were P to have the door to a challenge shut by (for instance) the fact that the family member to whom the concerns were being expressed was not eligible for legal aid but unable to afford the cost of representation for bringing an application.

In such a case, then, whilst, in theory, the Official Solicitor could act as P's litigation friend for purposes of bringing the application, it would in our experience be unlikely that he would do so, not least because the Official Solicitor – whilst the litigation friend of last resort – will not proceed in such a case unless he has security for the costs of legal representation of P.

The family member would then be faced with the choice of (1) acting as a litigant in person for purposes of bringing the proceedings (for which



they would need permission); or (2) seeking to act as P's litigation friend for purposes of bringing the proceedings (for which they would not need permission and would, in principle, be eligible for non-means tested legal aid). If the family member is not entitled to act as litigation friend, at least for purposes of getting the s.21A application off the ground, before stepping back in favour of – say – the RPR, an IMCA, or the Official Solicitor, how would P be put in the position of being enabled effectively to challenge the authorisation?

We note in this regard both the provisions of Article 5(4) ECHR (and the analogies to be drawn with the position of detained patients under the MHA 1983 post [MH v United Kingdom](#)) and the case of *A v A Local Authority & Ors* [2011] EWHC 727 (COP). This case arose in a slightly different context, namely where the evidence at an interim hearing of a s.21A application being on its face clear that a deprivation of liberty was in A's best interests, and submissions being made by the local authority to the effect that the proceedings being summarily determined at that stage. However, the then-President, Sir Nicholas Wall, authorised the instruction of a visitor to report under the provisions of MCA 2005 s49. In so doing, Sir Nicholas Wall P noted (at paragraph 15) that he was: *"very conscious that the Act has laid down stringent conditions for the deprivation of liberty, and that the court cannot simply act as a rubber stamp, however beneficial the arrangements may appear to be for the individual concerned. In the instant case, A wishes to challenge the authorisation, which deprives him of his liberty. Parliament has decreed that he should be entitled to do so, and has created safeguards to protect those deprived of their liberty against arbitrary action."* (We would perhaps note A was one of the very few reported cases where the Official Solicitor has, in fact, brought CoP proceedings on behalf of P).

In the circumstances, it would be a concerning development were another AF not be able to bring proceedings in the name of another UF – so long as she made it clear that this was for purposes solely of getting the application off the ground and was willing to step back in favour of another litigation friend thereafter.

Finally, perhaps, we might note the apparent divergence in practice between the Court of Protection and civil courts as regards the appointment of litigation friends. The test under CPR r.21.4 is, materially, the same to that under COPR r.140. In *Folks v Faizey* [2006] EWCA Civ 381, the Court of Appeal appeared to suggest that the process for determining whether a proposed individual should be appointed a litigation friend should be a fairly summary one. Keene LJ held, for instance, that, *"in the situation where the proposed 'patient' and the litigation friend both consent to the appointment of the latter, where there is adequate evidence to support the application for an order appointing a litigation friend, and where there is no evidence suggesting that the application is anything but a bona fide one, the court should make the order sought"* (paragraph 26). By contrast, *Re UF* would seem to suggest that the Court of Protection should take a considerably more hands-on approach to assessing the suitability of litigation friends.

Funding

It would appear that the offending parts of the 2013 Regulations represented, in essence, a legislative mistake, and it is fortunate that the concessions recorded on the face of the judgment remove what was, otherwise, a very troubling position.

Standard authorisations vs Court authorisations

Charles J, it is clear, remained of the view that the approach that he had adopted in *Re HA* – i.e. dispensing with the standard authorisation – was the appropriate course to have taken, and it is in many ways easy to see why. Whilst it is undoubtedly true that the Court would have power to extend a standard authorisation pending the determination of the application, it is – we suggest – reasonably clear from the face of the provisions of s.21A that this is not something that Parliament had in mind as the primary purpose of the powers granted the Court under that section. Moreover, and as Charles J noted, a jurisdictional problem poses itself immediately if there arises a need to extend the standard



authorisation beyond the maximum one year period.

It is also clear that Charles J had in the back of his mind a potential problem that local authorities are beginning to wake up to, namely what would happen where a Court on a s.21A application finds that, in fact, the qualifying conditions are not made out. Does this mean that the local authority is therefore liable to be the subject of an action for declarations and/or damages from P on the basis that P had been unlawfully deprived of his liberty? Charles J floated this question at paragraph 10, and, whilst not deciding the point, seemed to take the view that, given the approach adopted to s.21A cases – i.e. that they represent the assessment by the CoP itself of the position rather than an appeal or review – there may, in principle, be the potential for damages to flow if the CoP reached the conclusion that the conditions were not made out at the time of the hearing (and, presumably, had either not been made out from the outset or that they had ceased to be satisfied at some identifiable point thereafter). By the Court transferring the responsibility for the authorisation of a deprivation of liberty onto itself – either by exercising its powers under s.21A to extend a standard authorisation or by exercising its powers under s.16 – the clock would be stopped for purposes of any claim for unlawful deprivation of liberty at least as at the point of the initial Court order.

Principles set down for non-disclosure in CoP proceedings

RC v CC and X Local Authority [2014] EWHC 131 (COP) (Sir James Munby P)

Best interests – Duty to consult – Practice and procedure – other

Summary

With thanks to Adam Fullwood and Malcolm Chisholm for bringing this to our attention, this is an important decision on the approach to be adopted to the withholding of documentary material from a party to CoP proceedings.

CC, a young adult who lacked capacity in all material domains, was adopted as a very young child. For many years her birth mother, RC, had indirect 'letter-box' contact with her. It then stopped. CC lived in the area of X Local Authority. RC did not know where CC lived or the identity of X Local Authority. RC issued an application in the Court of Protection seeking contact with CC. In accordance with directions given by the court, X Local Authority filed a report by a clinical psychologist and three social worker statements by employees of X Local Authority. All relate to CC. The issue of whether they should be seen by RC came before HHJ Cardinal, whose decision in May 2013 (*RC v CC* [2013] EWHC 1424 (COP)) we [covered](#) in our June 2013 issue.

HHJ Cardinal concluded that although RC should be permitted to see a redacted version of the clinical psychologist's report, she should not be permitted to see any of the three social worker statements. His order included a provision enabling RC's legal representatives to see the three statements "*on the basis that the material contained therein is not divulged to RC without further leave of the court.*"

RC was refused permission to appeal by HHJ Cardinal; she renewed her application before the President, Sir James Munby P at an oral hearing in October 2013. Sir James Munby P gave her permission at the outset of the hearing, under COPR r173(1)(b), on the basis that, irrespective of the merits of the appeal, there was a compelling reason why the appeal should be heard, namely the need for an authoritative ruling on the very important point of principle that has been raised.

In his reserved judgment handed down on 30 January 2014, the President reviewed the jurisprudence relating to the proceedings in wardship and more generally in other cases involving children, in which it had been held on very high authority that the special nature of the jurisdiction justified departure not merely from the principle of open justice but also from other aspects of ordinary civil procedure. It was, he held, clearly established that the court in children cases has the power to refuse disclosure of materials to the parties to the proceedings. Further, on the basis of *In re D*



(Minors) (Adoption Reports: Confidentiality) [1996] AC 593; *Re B (Disclosure to Other Parties)* [2001] 2 FLR 1017; and *Dunn v Durham County Council* [2012] EWCA Civ 1654, [2013] 1 WLR 2305, it was clear that the test for when the power should be exercised could be summarised thus:

1. The court should first consider whether disclosure of the material would involve a real possibility of significant harm to the child;
2. If it would, the court should next consider whether the overall interests of the child would benefit from non-disclosure, weighing on the one hand the interest of the child in having the material properly tested, and on the other both the magnitude of the risk that harm will occur and the gravity of the harm if it does occur;
3. If the court is satisfied that the interests of the child point towards non-disclosure, the next and final step is for the court to weigh that consideration, and its strength in the circumstances of the case, against the interest of the parent or other party in having an opportunity to see and respond to the material. In the latter regard the court should take into account the importance of the material to the issues in the case.

Citing the decision of the Court of Appeal in *Dunn v Durham* (in which he had himself participated), the test, the President held, was whether non-disclosure was strictly necessary. He noted, further, that consideration should always be given to the fact that disclosure is never a binary exercise, and a proper evaluation and weighing of the various interests may lead to the conclusion that (i) there should be disclosure but (ii) the disclosure needs to be subject to safeguards such as limits to the use that may be made of the documents, in particular so as to limit the release into the public domain of intensely personal information about third parties. Further, the position initially arrived at is never set in stone and that it may be appropriate to proceed one step at a time.

The President concluded without hesitation that the same jurisdiction - and the same approach - was applicable when it came to incapacitated adults: “One really needs look no further than *Scott v Scott* [[1913] AC 417] to see that the same fundamental principles underlie both jurisdictions. If more is needed, there is, it seems to me, some support to be derived from *In re E (Mental Health Patient)* [1985] 1 WLR 245. More recently, and more to the point, there are the powerful observations of *McFarlane J*, as he then was, in *Enfield London Borough v SA, FA and KA* [2010] EWHC 196 (Admin), [2009] COPLR Con Vol 362, para 58, with which I respectfully agree” (paragraph 21).

When it came to the question of whether HHJ Cardinal was entitled - in principle - to limit disclosure to RC’s legal representatives, the President noted that disclosure limited to a party’s legal representatives had been acknowledged as a recognised practice in wardship in *Official Solicitor to the Supreme Court v K and Another* [1965] AC 201. The President, further, considered that there could be no doubt as to the legality of the practice, citing in support *R (Mohammed) v The Secretary of State for Defence* [2012] EWHC 3454 (Admin). The President noted, however, that there were obviously practical difficulties to such an approach, chief amongst them being the requirement that such disclosure cannot take place without the consent of the lawyers to whom the disclosure is to be made; and they may find themselves, for reasons they may be unable to communicate to the court, unable to give such consent. Moreover, he noted, the lawyers cannot consent unless satisfied that they can do so without damage to their client’s interests.

Turning to the appeal before him, the President found that HHJ Cardinal had correctly directed himself as to the law, save for one point where HHJ Cardinal had appeared to suggest that the rules applicable to disclosure in family proceedings would differ from those in CoP proceedings: had he so held, that would have been incorrect, the President found, although HHJ Cardinal was undoubtedly correct to find that the application of the principles may differ between the two categories of proceedings.



Sir James Munby P endorsed HHJ Cardinal's decision insofar as it related to the disclosure of the redacted psychological report. He considered that it appeared to provide RC with all the material she needs to be able to conduct her case. HHJ Cardinal who (unlike Sir James Munby P) had read the full report, was that there was nothing in the full report "which assists RC any further." On the other hand, the President noted, "*there are – there must in the nature of things be – compelling reasons why someone in RC's position should not have disclosed to her (at least at this stage) information about CC's whereabouts and private circumstances which, but for the current litigation, she would have no right to know and no means of finding out. As Baroness Hale of Richmond JSC pointed out in In re A (A Child) (Family Proceedings: Disclosure of Information) [2012] UKSC 60, [2012] 3 WLR 1484, para 21, in the passage I have already quoted, the court must 'prevent the proceedings which are there to protect the child being used as an instrument of doing harm to that child.'... there is in my judgment no proper ground of challenge [to this aspect of HHJ Cardinal's decision]*" (paragraph 31).

Sir James Munby P took a different view in relation to HHJ Cardinal's refusal to allow RC to see even redacted versions of the three social work reports. His decision to set aside the decision and remit it to HHJ Cardinal was reached on three bases:

1. The President found that he could not be confident that HHJ Cardinal had not inverted the test that he had correctly formulated by asking himself whether it was necessary for RC to see the documents, but whether non-disclosure was necessary in CC's interests;
2. Whilst not ruling out that the decision might have been appropriate, the President also found that HHJ Cardinal had given inadequate justification for the decision that nothing in the three witness statements could be disclosed, noting that a large amount of sensitive personal information about CC had been disclosed

to RC in the redacted psychological report;

3. Whilst rejecting the submission that the 'closed material procedure' (a phrase the President did not find helpful) adopted by HHJ Cardinal was inappropriate as a matter of principle, he questioned whether the procedure was appropriate on the facts of the case. In particular, he noted that HHJ Cardinal did not seem to have explored the questions of the necessity of counsel's agreement, nor did he consider other possible solutions: allowing RC to read, but not to borrow or copy, suitably redacted copies of the documents, or directing that there be disclosure to her of a document setting out the gist of what is being said by the social workers.

The appeal was therefore allowed to the extent that the decision related to the social work reports and remitted to HHJ Cardinal.

As an aside, Sir James Munby P noted that he could not help thinking that in an unusual case such as this it might have been better if, instead of giving RC permission in accordance with COPR r 55(a), the District Judge who had initially granted permission to RC on the papers had instead fixed a date for the hearing of the application for permission in accordance with COPR r 55(c).

Comment

This decision is of very considerable importance in terms of clarifying once and for all that the principles relating to withholding of disclosure in Court of Protection proceedings are identical to those that have been developed in relation to children. In our experience, disclosure and non-disclosure are two of the areas of the Court's practice and procedure that most often give rise to the appearance that decisions are taken on the basis of pragmatism rather than any detailed consideration of the principles involved. It is fair to say that this is not helped by the way in which the current rules relating to disclosure in the COPR are modelled upon the adversarial model contained in the CPR, whereas, as noted by McFarlane J, as he then was, in *Enfield London*



Borough v SA, FA and KA [2010] EWHC 196 (Admin), [2009] COPLR Con Vol 362, the approach in the family court is that there is a duty to give the court all relevant material. As McFarlane J noted in the welfare case of SA (in observations endorsed by the President in CC as ‘powerful’ (paragraph 20):

“58. There can, in my view, be no justification for there being a difference of this degree on the issue of disclosure between the family court and the Court of Protection in fact-finding cases of this type where really the process and the issues are essentially identical whether the vulnerable complainant is a young child or an incapacitated adult. For the future in such cases in the Court of Protection it would seem to be justified for the court to make an order for ‘specific disclosure’ under COPR 2007, r 133(3) requiring all parties to give ‘full and frank disclosure’ of all relevant material.”

This, we would note in passing, appears to have been an observation that has been almost universally ignored in the years since it was given; we would hope that it will be brought back to the forefront of judicial minds in light of this decision.

Further, we now - for the first time - have a clear set of principles which can be applied when a judge is considering whether to make an exceptional order for non-disclosure.

Turning to the question of disclosure solely to counsel (or other legal representatives), we may perhaps, be excused, if we take a brief moment to note with appreciation that our comment upon this aspect of the case in the June 2013 issue of the newsletter was cited by the President in his judgment as being ‘characteristically thoughtful.’ We hope that, in the same vein, we may respectfully note that the decision in *Mohammed* which we noted in that comment, and relied upon by the President in his judgment has now (and, rather ironically, in the same month as the newsletter in question came out) been doubted. In *AHK, AM, AS, FM v Secretary of*

State for the Home Department [2013] EWHC 1426 (Admin), Ouseley J expressed considerable disapproval about lawfulness of lawyer-only rings in the judicial review arena, in particular because of the ‘very serious problems’ it creates between lawyer and client (see paragraph 27, and the reference there to strong terms in which the practice had been disapproved of in the House of Lords in *Somerville v Scottish Ministers* [2007] 1 WLR 2734). The decision in *AHK* is under appeal to the Court of Appeal; whilst, as Sir James Munby P noted, the practice appears to be one of long-standing in relation to wardship proceedings, it may be that this is yet to be the end of the story.

C-sections back before the Court of Protection

Great Western Hospitals NHS Foundation Trust v AA, BB, CC, DD [2014] EWHC 132 (Fam) (Hayden J)

Best interests – Medical treatment

Summary

AA was 25 years old with bipolar disorder. She was 38 weeks pregnant with her first child. During the evening of 26 January 2014 she presented to hospital in a confused and disorientated state. Her waters had broken and she was admitted to the labour suite. At 7am the following day she was detained there under s.5(2) of the Mental Health Act 1983. Described as suffering from hypomania and puerperal psychosis (despite not yet having gone into labour), she was highly agitated, exhausted by lack of sleep, and was largely uncooperative with almost every aspect of her obstetric care. At 9.30pm that evening, the hospital Trust made an emergency application, the clinical team unanimously favouring the safest option of a caesarean section under a general anaesthetic.

The matter was held over until the next day. During the night AA had become more distressed. Her father described how she had run at the window trying to get out, telling him that she wanted to go to heaven. According to the



psychiatric opinion, she simply did not believe that she had begun the labour process and held a strong and fixated belief that her baby could only be born on or after her due date. It was almost impossible to engage her to discuss the concerns. Hayden J declared that she lacked capacity to decide whether to undergo a caesarean section and to make decisions generally about her care and treatment in connection with her ongoing pregnancy.

The ruptured membranes significantly increased the risk of both maternal and foetal infection until delivery. And the usual plan to induce a natural labour was plainly unsuitable: AA had already removed intravenous lines on more than one occasion and would be unable to co-operate with the necessary degree of monitoring. Moreover between one third and a quarter of patients requiring inducement required an emergency caesarean section in any event which, in this case, would be particularly dangerous. However, an “elective caesarean” might require restraint to be used prior to administering the general anaesthetic and after delivery of the child if she became agitated.

In determining AA’s best interests, and emphasising that the Court must focus on the welfare of the mother, and not the foetus, his Lordship observed that a survey broader than just her medical interests was required. Her partner, BB, and her parents, CC and DD, together with the Official Solicitor on her behalf, supported the caesarean option, and Hayden J believed that, were AA rational at that time, she would also have adopted that course. His Lordship continued:

“21. It is necessary to add a few further remarks about the appropriate legal framework for this application, the Trust recognising that the treatment envisaged involves a facilitative deprivation of liberty. The power under the Mental Capacity Act 2005 for the Court to make orders for AA’s welfare [the declarations sought under s.16(20(a) and 17(1)(d)] include the power to make an order that deprives her of her liberty, subject to the

*qualifications set out in s.16A, entitled ‘Section 16 powers: Mental Health Act patients etc’. In short, a welfare order cannot authorise a deprivation of liberty if AA is ineligible to be deprived of her liberty under paragraph 17 of Schedule A1 of the MCA. That provision stipulates that Schedule 1A of the MCA applies for the purpose of determining whether or not she is ineligible. The treating team view the obstetric care not as treatment for AA’s mental illness, which could be provided under the MHA, but as physical treatment. Paragraph 2 is the central provision in determining whether ‘P’ is ineligible. Because she is detained under s.2 of the MHA, AA falls within Case A of paragraph 2 as she is both subject to and detained under a hospital treatment regime. In **A NHS Trust v Dr A [2013] EWHC 2442 (COP)**, Baker J endorsed the view that ‘Case A is clear indication of the primacy of the MHA 1983 when a person is detained in hospital under the hospital treatment regime and it would seem that when it applies P cannot be deprived of liberty under the MCA in a hospital for **any purpose.**’ (§87) and held that force feeding (which was not treatment for P’s mental disorder) could not be ordered under the MHA or MCA. The inherent jurisdiction provided the route by which treatment in the patients best interest should be authorised. The Applicant NHS Trust contends that the same analysis applies here. The Official Solicitor agrees and so do I.” (emphasis in the original)*

The case for treatment was compelling and accordingly it was considered to be in her best interests to have the caesarean section, if necessary under general anaesthesia. Provision was also made for the minimal use of physical restraint or force to administer the treatment/anaesthesia/sedation and/or to prevent her from leaving the ward until it was clinically appropriate to be discharged. The terms of the declaratory order are helpfully set out in an appendix to the judgment.



Finally, the Court observed:

“23. Although BB and DD were both highly supportive of the actions of the clinicians, BB told me that he was concerned by even the short delay in this case in bringing the matter to court. These issues he considered ought to be resolved in the clinical situation at the hospital. How, he asked politely and genuinely, could a judge be better placed than a doctor to take these decisions? I hope that in analysing my reasoning in the way that I have, I have already to some extent answered that question. But I would add this: the decision to restrain and compel medical procedures on those who do not have the capacity to take them themselves is an onerous one. The declaratory relief is sought for two purposes: firstly, the legal purpose, which is to cloak the Trust with the legal authority to carry out the procedure and to provide them with a defence to any allegation of criminal or tortious liability for trespass to the person (see Re W (a minor) (Medical treatment: Court’s jurisdiction) [1993] Fam 64); secondly, the clinical purpose, which stems from the fact that in many instances the co-operation of a patient, or at least a patient’s confidence in the efficacy of a treatment, is a major factor contributing to the treatment’s success. Failure to obtain the consent of a patient not only deprives the patient but the medical staff of this advantage. The court has the jurisdiction over the legal purpose; it does not have jurisdiction over the clinical one, and its approval helps to ameliorate that disadvantage.”

Comment

This was clearly a compelling case insofar as AA’s incapacity and best interests were concerned. All parties agreed that a caesarean section was best, with her partner even querying whether the matter needed to go to Court. An enforced caesarean section evidently amounts to “serious medical treatment”. Practice Direction E would

tend to suggest that where a medical procedure or treatment must be carried out “using a degree of force to restrain the person” lacking capacity to consent to it, the matter “should” be brought to court. Countless medical procedures are undertaken and treatments provided each year which involve the “restraining” of incapacitated persons. “Restraint,” that is, in the broad sense in which that term is defined in the s.6 of the MCA: namely, where one “(a) uses, or threatens to use, force to securing the doing of an act which P resists, or (b) restricts P’s liberty of movement, whether or not P resists.” Few such cases pass through the doors of the Court of Protection.

We would, however, suggest that ‘enforced’ caesarean sections, particularly if they necessitate the deprivation of the mother’s liberty, are in a category of case for which very careful consideration must be given to the making of a court application.

But to which court should the application be made? In this case, Hayden J used the inherent jurisdiction of the High Court to authorise the treatment because AA was considered to be ineligible to be deprived of her liberty under the MCA. Her status under the MHA was somewhat ambiguous. On the one hand, if she was detained under MHA s.5(2) (as per paragraph 6 of the judgment), unlike [Dr A’s](#) case she was not detained under a “hospital treatment regime” (as defined by MCA Sch 1A para 8). It follows that the Court of Protection could have authorised her deprivation of liberty. On the other hand paragraph 21 of the judgment refers to AA being detained under “s.2 of the MHA.” Given that she remained on the labour ward throughout, this would be surprising unless that ward was registered to take MHA-detained patients or she was there under MHA s.17 leave. The first possibility seems unlikely, but if true would mean that recourse to the inherent jurisdiction was necessary (subject to any residual liberty argument – see our [commentary](#) on Dr A’s case). The second possibility would have enabled the Court of Protection to authorise her deprivation of liberty, given the finding that the caesarean section was physical treatment and not for her mental illness.



Against the urgent backdrop with which the application had to be made and dealt with, the complex intricacies of MCA Schedules A1 and 1A and their interface with the inherent jurisdiction were perhaps the last thing that anyone needed! Even if the MCA had been relied upon, the same outcome would no doubt have been achieved. However, the jurisdictional issue is important because the inherent jurisdiction should only be invoked where the repertoire of MCA remedies leaves a lacuna. Moreover, the MCA provides the treating team with a defence and an emergency procedure to deprive liberty under MCA s.4B whilst getting such a case before the Court. The inherent jurisdiction, in contrast, can only be exercised by a judge of the High Court, and – at least insofar as any deprivation of liberty was concerned – the treating clinicians would be on legally thin ice before the judge was seized of the matter: (see *Re A and C (Equality and Human Rights Commission Intervening)* [2010] EWHC 978 (Fam) [2010] COPLR Con Vol 10 at paragraph 74 per Munby LJ (as he then was), in which his Lordship made clear that procedures available under the inherent jurisdiction had to be invoked before embarking upon any deprivation of liberty).

According to news [reports](#), later that same week Hayden J was again called upon to authorise a caesarean section. This time it was Royal Free London NHS Trust that applied to the Court of Protection in respect of a 32 year old who was 32-weeks pregnant. She is reported to have had diabetes and paranoid schizophrenia, to have stopped eating and to have attempted suicide. A safe delivery was necessary to enable her unstable mental state to be treated. His Lordship is reported to have held:

“The decision to compel a Caesarean section on an incapacitous woman who is mentally and physically ill is an extremely draconian one...”

Doctors do not embark upon this lightly. It occurs extremely rarely. It is one that the lawyers also take very seriously indeed...

I am perfectly satisfied that at the moment [this woman] is not able to make any reasoned evaluation of the advantages and disadvantages of a Caesarean section.”

Unlike AA’s case, no force was to be used against her as, it seems, her treating team believed that she could be persuaded to agree to sedation. It was then subsequently [reported](#) that no restraint was necessary, her baby was delivered without any problem, and she hugged the surgeon after recovering consciousness.

Scope of ‘necessaries’ under s7 MCA 2005 examined in detail in the context of care home fees

Aster Healthcare Limited v The Estate of Mr Mohamed Shafi [\[2014\] EWHC 77 \(QB\)](#) (Andrews J)

Mental capacity – finance

Summary

The Claimant company owned and ran six care homes registered under the Care Standards Act 2000, including Raj Nursing Home, (‘the Home’) a residential nursing home in Southall, which specialised in caring for elderly persons suffering from dementia. The majority of referrals to the Home were made by the local authority, Brent Council (‘Brent’). Mr Shafi, who suffered from dementia, was detained under the MHA 1983 for a period of time in a hospital. He was assessed as lacking the capacity to make decisions regarding his future care; he was referred to Brent for placement. Brent, in turn, referred him to the Home. The precise basis upon which he entered the home was a matter of some considerable dispute. In any event, he lived at the Home from 29 January 2010 until his death on 28 March 2012, incurring total fees of £62,199.94. The Claimant company initially looked to Brent for payment, but then to Mrs Shafi, who refused to pay.

The Claimant company sought recovery of the fees by way of a claim against Mrs Shafi



personally; this was struck out by a District Judge on the basis that she had never entered into any contract with the company. The same District Judge held that the Estate was liable to pay because there was an unanswerable claim under s.7 of the MCA 2005, and there was no prospect of it being established that Brent had a primary responsibility to pay. The Estate (by Mrs Shafi) appealed the decision.

In setting aside the decision and setting the matter down for trial, Andrews J examined the factual and legislative position in some detail. After a lengthy examination of the relevant provisions of the community care legislation and the facts as they appeared (hampered in some measure by the fact that, as matters stood, Brent was not a party to the proceedings), she found that such evidence as there was tended *“towards the conclusion that the admission of Mr Shafi to the Home on 29 January 2010 was probably made pursuant to a contractual arrangement between Brent and the Claimant, under s.21 and s.26(2) of the [National Assistance Act] 1948...”* (paragraph 40).

For reasons that need not detain us here, Andrews J concluded that – contrary to the conclusion reached by the District Judge – there was insufficient evidence to enable the Court to conclude upon a summary judgment application that Brent was not liable to make payment of fees to the Claimant, or that its duties under Part III of the National Assistance Act 1948 did not continue to be engaged after it had sent a letter which purported to suggest that Mr Shafi was a self-funder and the Home should make appropriate arrangements thereafter to ensure payment of the fees.

Andrews J then came on to consider the relevance of s.7 MCA 2005. This had not been pleaded by the Claimant initially, but was then pleaded in response to the contention in the Defence that Mr Shafi had at all material times lacked capacity to contract.

The answer to the question of what, if any, bearing any duty on Brent to pay the Home’s fees had on the claim against Mr Shafi’s Estate under s.7 MCA 2005, Andrews J found, depended on a

proper understanding of what s.7 was intended to achieve. In order to reach that understanding, she undertook a historical tour d’horizon, starting with the Court of Appeal’s decision *Re Rhodes* [1890] 44 Ch Div 94, and the process by which the common law rule on the supply of “necessaries” set down in the case became enshrined into s.7 MCA 2005. She noted that the definition of ‘necessary’ precisely mirrored that given over a century earlier by the Court of Appeal in *Re Rhodes*.

Andrews J rejected the submission made on behalf of the Claimant company that it was arguable that the services supplied by the Claimant did not fall within the scope of the definition of “necessaries” because it could not be said that they were either suitable or fulfilled Mr Shafi’s actual requirements, because the Home was not readily accessible by his family. At paragraph 54, Andrews J held that *“[t]he services were suitable to his condition in life, being specialist services having regard both to his dementia and to his other physical disabilities, and fulfilled the requirements for care and accommodation to which his physical and mental condition gave rise. The definition relates only to the nature of the services themselves. The word ‘requirements’ does not extend to the recipient’s subjective wishes, however reasonable, as to the location at which those necessary services are to be provided.”* (emphasis added).

She continued:

*“55. Section 7 was intended to, and did, enact the common law rule. It was designed to cure the hardship that would otherwise arise where a supplier who intended the person under a mental incapacity to pay for necessary goods or services would be unable to recover payment from him under a contract, if there was one. There is no need to show that there was any purported contract between them. The Law Commission Report expressly refers to the fact that the common law rule may be engaged when the arrangements with the supplier have been made by third parties. However, as *Re Rhodes* makes*



clear, it does not come into play in circumstances in which it was not intended by the supplier that the recipient should pay for those goods and services, but that the person making those arrangements, or someone else, should. That restriction on the common law rule must apply equally to the statutory enactment of it. Parliament did not intend to create a situation in which the supplier could recover payment for the supply of necessities to a person under a mental incapacity in circumstances in which he never intended that person to make that payment.

56. It is well established that if A contracts with B to provide services to C on the express basis that B will pay A for those services, and B fails to do so, A has no cause of action against C. The rules of unjust enrichment are not engaged in those circumstances. See the commentary in the 8th edition of Goff & Jones on The Law of Unjust Enrichment, Chapter 4 at 4-32 and Chapter 17 at 17-11 and 17-12 and Burrows, The Law of Restitution, 3rd Edition, pages 74-75, and the cases there cited.

57. If Mr Shafi had been of full mental capacity but was physically disabled, and the Claimant had provided him with necessary services pursuant to a contract made with a third party under which the third party was to pay for them, or in any other circumstances in which it was not intended that he should pay, then there would be no legal or equitable basis for pursuing him or his Estate for payment if the intended payer failed or refused to pay. Section 7 of the Mental Capacity Act cannot be construed in such a way as to put a person under a mental incapacity in any worse position than a person in identical circumstances suffering from a physical incapacity.”

Andrews J rejected the submission

that [Wychavon DC v EM \(HM\)](#) [2012] UKUT 12 (AAC) was authority for the proposition that s.7 is applicable in circumstances where the supplier never intended to impose a liability on the person without capacity and only ever intended that a third party should pay for the “necessaries.” She noted that *Wychavon* “was a case in which the provider of the accommodation did intend to impose a liability to pay rent upon the incapacitated party (his daughter) under the ostensible tenancy agreement even though, on the facts, by reason of the nature of her incapacity the agreement was void and not merely voidable, and was made purely in order that she could claim housing benefit. If *Wychavon* had decided that s.7 applied in circumstances in which there was no intention on the part of the supplier to impose liability for the debt on the incapacitated party, it would have been contrary to the common law principle expressed in *Re Rhodes*, a decision of the Court of Appeal, to which the statute gives effect, and thus wrong in law...” (paragraph 58, emphasis in original)

Andrews J therefore concluded that:

“59. It follows that s.7 of the Mental Capacity Act is not, and cannot be engaged in circumstances in which the services in question are being provided to the mentally incapacitated individual pursuant to an arrangement made by the service provider with a local authority exercising its statutory duty under Part III of the 1948 Act. In those circumstances, even if an arrangement is in place under s 26(3A), it is never intended that the individual will be indebted to the service provider for those services. The debt, if any, is owed by the individual or his Estate to the local authority. That is the position even if the local authority has a right to recoupment of 100% of the costs. There is no unfairness in this. Indeed it would be invidious if the statutory scheme under the 1948 Act and 1990 Act could be bypassed by a direct claim in debt against the individual concerned merely because he suffers from a mental



incapacity. Matters would be different if the local authority had no obligation to pay; in those circumstances it is still possible that the service provider could recover under s.7 of the Mental Capacity Act, provided that he could establish, on the balance of probabilities, that it was his intention at the time of making the arrangements for the supply of the services that the individual should pay the fees if the local authority had no obligation to do so.

60. If the services are not being provided under an agreement with the Local authority exercising its duties under s.21, but pursuant to an arrangement made with a third party, then the question whether s.7 of the Mental Capacity Act is engaged will depend on the facts and circumstances and in particular whether the arrangement made with the third party contemplated that payment would be made by that person (and possibly recouped by him or her in due course under s.8 of that Act) or by the person under the incapacity.”

In the circumstances, Andrews J found that – given the limited evidence available that any arrangements in respect of the provision of services to Mr Shafi by the Home were made by anyone other than Brent – she could not say that there was an unanswerable claim against the Estate under s.7 at least in respect of the fees that fell due after the date when Mrs Shafi refused to pay them, or even after the date when the claim against her was struck out. She noted that “[t]he possibility remain[ed] that Brent may be liable for all the fees, subject to its right to recoup them in whole or in part from the Estate.” (paragraph 61). She concluded by noting that it seemed inevitable that the legal costs of the action would exceed the amount in issue, and urged settlement or mediation on the parties.

Comment

This judgment provides a helpful summary of the relevant legislative framework in relation to the charging of accommodation arranged by a local

authority for a person lacking capacity. Ensuring that those unable to decide whether to enter a care home are not disadvantaged, in terms of liability for care home fees, compared to those with capacity is welcome. The outcome illustrates the importance of being able to identify the legal basis upon which a person is so accommodated, the financial intentions of the parties at the time, and identifying the correct debtor and debtee.

Court of Appeal to consider law relating to imposition of DNACPR notices

R (David Tracey) v Cambridge University Hospitals NHS Foundation Trust & Ors [2014] EWCA Civ 33 (Court of Appeal) (Lord Dyson Mr, Longmore and Ryder LJ)

Best interests – medical treatment

Summary

David Tracey, acting personally and on behalf of the estate of his deceased wife, Janet Tracey, brought an application for judicial review against (i) Cambridge University Hospitals NHS Foundation Trust in relation to the placing of two Do Not Attempt Cardio-Pulmonary Resuscitation (“DNACPR”) Notices on Mrs Tracey’s medical notes at Addenbrooke’s Hospital and (ii) the Secretary of State for Health for failing to promulgate a national policy in relation to DNACPR notices.

Mrs Tracey was diagnosed with lung cancer on 5 February 2011 and, at that time, it was estimated that she had approximately nine months to live. On 19 February 2011 she sustained a serious cervical fracture after a major road accident and was admitted to Addenbrooke’s Hospital. She also developed a chest infection and pneumonia and it was the view of her treating clinicians that it would not be appropriate for her to be resuscitated in the event of cardiac arrest. Mrs Tracey died on 7 March 2011 and no resuscitation was given.

There was a factual dispute between Mrs Tracey’s family and the responsible clinicians over the



circumstances in which two DNACPR notices had been placed on Mrs Tracey's notes and what prior consultation had taken place. Nicola Davies J conducted a 7-day fact-finding hearing to determine these issues. She found, amongst other things, that the doctor who completed the first DNACPR notice believed that Mrs Tracey's daughter had agreed to the imposition of such a notice but rejected the doctor's evidence that he spoke to Mrs Tracey about resuscitation before he signed the first notice. That first notice was subsequently withdrawn when it became apparent that Mrs Tracey strongly objected. Nicola Davies J found that Mrs Tracey did not herself wish to discuss the second DNACPR notice with professionals, nor did her daughters wish to discuss it with her, but all members of her family who were present or available understood and agreed with the responsible professionals that that it was the appropriate course.

Having made those findings of fact, Nicola Davies J held that no further substantive hearing of the original application for judicial review should take place. She ruled that any breach of Mrs Tracey's Article 8 rights that arose because of the failure to consult with her about the first DNACPR notice was academic as any failure to follow policy or have the right policy did not cause Mrs Tracey's death. She also held that the determinations sought by Mr Tracey, including in relation to his allegations that the Hospital failed to communicate its DNR policy and that its policy was, in any event, defective and confusing, *"would involve the court grappling with issues of policy and clinical decision-making upon the basis of limited evidence such that the court would not have a full appreciation of all relevant considerations, still less the implications resulting from such determinations."*

Mr Tracey appealed to the Court of Appeal and his appeal was allowed. Longmore LJ (with whom LJ Ryder and the Master of the Rolls agreed) held that the submissions made on behalf of Mr Tracey could not be dismissed out of hand and the judicial review application (which was substantially refocused before the Court of Appeal), should therefore go forward to a hearing. Longmore LJ said (at paragraphs 17-19):

"17. It does not appear that the judge thought that the points in relation to explanation or consultation with the patient or the right to a second opinion were themselves unarguable. She thought that in the light of her findings of fact they were 'academic' and that any failure to follow policy or have the right policy did not cause Mrs Tracey's death. I do not agree that the case can be disposed of in this way. It is not academic because there can be no doubt that ... Mrs Tracey was distressed when she learnt that the first notice had been placed on her notes. Part of that distress was because she thought that her family had either asked for it to be so placed or had, at least, agreed to it. When that became plain, it distressed the family as well. In these circumstances, the judgment's reference to the absence of causation is, with respect, misplaced since there were consequences of the first notice. If those consequences had been 'trifling' the judge might have been correct to say the case should go no further but it cannot be right to call the distress suffered by Mrs Tracey and her family as 'trifling.' The points on consultation and a second opinion are, moreover, matters of some general importance.

18. The judge's fear of a wide ranging inquiry which might need expert evidence is likewise misplaced now that Mr Havers [acting for Mr Tracey] has confined his case The question whether the absence of explanation or consultation or the failure to offer a second opinion means that the placing of the first DNACPR Notice was unlawful as being an unjustified breach of Article 8 of the Convention is, of course, a question of law on which expert evidence would be neither admissible or appropriate.

19. Mr Havers has argued that the Hospital's policy, the relevant provisions of which were set out at paragraph 14 of the first judgment, was misleading



and/or contradictory. I did not, for my part, altogether understand why this was so, but I would not wish here and now to rule out any argument to that effect.”

Longmore LJ held that it was also appropriate for the claim against the Secretary of State to be heard as permission had been granted and nothing emerged during the fact-finding hearing which impinged upon the strength or weakness of the claim. If the court was to conclude, for example, that the doctor’s failure to consult Mrs Tracey about the first DNACPR notice meant that the Hospital Trust was in breach of Article 8, it could be said that that failure might show there should be some national policy promulgated by the Secretary of State.

Comment

We note with interest that the important issues raised in this case about decisions not to attempt resuscitation will be the subject of a substantive judgment from the Court of Appeal in the not-too-distant future. Longmore LJ considered that the case should be retained by the Court in the light of the very considerable public resources already expended as, in his view, there was a great danger that any decision at first instance would itself be appealed.

Readers are likely to be particularly interested in the Court of Appeal’s adjudication upon the lawfulness of the DNR policy and whether Article 8 imposes a duty upon medical professionals to consult with a patient (or their family, if they are incapacitated) before imposing a DNACPR notice, bearing in mind the weight of judicial authority establishing that neither a patient nor their family can require a doctor to administer treatment which that doctor does not consider to be clinically indicated (see *R (Burke v General Medical Council* [2006] QB 273 paras 50-55 per Lord Phillips and *Aintree University Hospitals NHS Trust v James* [2013] 3 WLR 1299 para 18 per Baroness Hale, cited by Longmore LJ at paragraph 11).

Litigation capacity vs litigation ability

Durkan v Madden [2013] EWHC 4409 (Ch) (Norris J)

Practice and procedure – Other

Summary and comment

We note briefly this complicated civil case arising – ultimately – out of unsuccessful litigation brought by as Ms Madden because of the approach adopted by Norris J to the question of the determination of whether or not Ms Madden had capacity to conduct the two proceedings with which he was immediately concerned. It is of note for the following reasons:

1. As was emphasised in [Baker Tilly v Makar](#) [2013] EWHC 759 (QB), Norris J reminded himself that treating a person as lacking capacity is an important interference with their civil rights and ought only to be done after proper consideration;
2. Adopting the issue-specific test, Norris J proceeded on the basis that it was necessary to identify specifically whether Ms Madden had capacity to conduct those proceedings, as opposed to bankruptcy proceedings which were at that stage on foot before the Court of Appeal in which, it appeared, she had been held to lack litigation capacity and was represented by the Official Solicitor as litigation friend;
3. Norris J noted that it would be open to him to invite the Official Solicitor to consider the evidence, to appoint an expert and then to hold a hearing to determine capacity. In so saying, he relied upon the case of *Lindsay v Wood* [2006] EWHC 2895, although it is perhaps to be noted that Stanley Burnton J in that case suggested that this was a course open to the court; he did not, in fact (as Norris J appears to have considered) order such a course himself. Norris J, reminding himself of the need not to generate satellite litigation but to proceed in “*a pragmatic way*,



*asking as to the consequences that will flow from continuing with the litigation without the appointment of a litigation friend or of the Official Solicitor,” sought to find a way to avoid taking the *Lindsay v Wood* course;*

Norris J found that from “*the terms in which the evidence is couched that there may be confusion between Ms Madden’s capacity and her ability, personally, to conduct litigation. It seems to be that it may well be the case that she is legally capable of making the relevant decisions but apprehensive about appearing in court, an experience that she would find stressful*” (paragraph 20). Reviewing the evidence of her treating practitioner and her GP (who had signed her off work and indicated that she would find attendance at court and participation in legal proceeding stressful), Norris J considered that he could not be confident that either had addressed the requirements of ss.2-3 MCA 2005 rather than “*simply assessing what impact attendance at court and participation in court proceedings might have on Ms Madden’s health.*” He therefore held that the material adduced in evidence did not raise such an issue of capacity as to cause the adjournment of the proceedings before him.

This case sits together with that of *Baker Tilly v Makar* as a reminder of the need for caution before a court takes the significant and draconian step of declaring that a party to proceedings before them lacks the capacity to conduct that litigation.

We would, perhaps, note that the procedure adopted in *Lindsay v Wood* is a very unusual one (that case involved a situation where the claimant’s representatives had doubts upon his litigation capacity which they put to the Court, but did not argue a positive case one way or another as to whether he had litigation capacity). Indeed, on the facts of the case as set down by Norris J, it is not at all clear that the procedure would have applied to the circumstances of Ms Madden. In any event, it should also be borne in mind that the Official Solicitor has limited resources, and funding for his involvement in any such procedure would always have to be considered carefully.

Further light shed by analogy on the meaning of habitual residence for purposes of Schedule 3 to the MCA 2005

Re LC (Children) [2014] UKSC 1 (Supreme Court) (Lady Hale, Deputy President, Lord Wilson, Lord Sumption, Lord Toulson, Lord Hodge))

COP jurisdiction and powers – International jurisdiction

Summary and comment

We have for some time commented upon a stream of jurisprudence from the higher courts as to the proper approach to the determination of the habitual residence of children for the analogies that this jurisprudence sheds upon the approach that should be adopted to determining where adults are habitually resident for purposes of engaging the jurisdiction of the Court of Protection under Schedule 3 to the MCA 2005 (i.e. in relation to cases with a cross-border element). We have drawn attention, in particular, to the decision of the Supreme Court in *A v A* [2013] UKSC 60.

The decision in *Re LC* is perhaps even more pertinent. The facts are irrelevant, the central question being whether it was appropriate (for purposes of the 1980 Hague Child Abduction Convention) to take into account the state of mind of an adolescent child in determining whether she had acquired the necessary degree of integration into a social and family environment in Spain so as to become habitually resident in that country. The Supreme Court, by a majority, held (at paragraph 37):

“Where a child of any age goes lawfully to reside with a parent in a state in which that parent is habitually resident, it will no doubt be highly unusual for that child not to acquire habitual residence there too. The same may be said of a situation in which, perhaps after living with a member of the wider family, a child goes to reside there with both parents. But in highly unusual cases there must be room for a different



conclusion; and the requirement of some integration creates room for it perfectly. No different conclusion will be reached in the case of a young child. But, where the child is older, in particular one who is an adolescent or who should be treated as an adolescent because she (or he) has the maturity of an adolescent, and perhaps also where (to take the facts of this case) the older child's residence with the parent proves to be of short duration, the inquiry into her integration in the new environment must encompass more than the surface features of her life there. I see no justification for a refusal even to consider evidence of her own state of mind during the period of her residence there. Her mind may – possibly – have been in a state of rebellious turmoil about the home chosen for her which would be inconsistent with any significant degree of integration on her part. In the debate in this court about the occasional relevance of this dimension, references have been made to the "wishes" 'views' 'intentions' and 'decisions' of the child. But, in my opinion, none of those words is apt. What can occasionally be relevant to whether an older child shares her parent's habitual residence is her state of mind during the period of her residence with that parent. In the Nilish Shah case, cited above, in which he propounded the test recently abandoned, Lord Scarman observed, at p 344, that proof of ordinary (or habitual) residence was 'ultimately a question of fact, depending more upon the evidence of matters susceptible of objective proof than upon evidence as to state of mind'. Nowadays some might not accept that evidence of state of mind was not susceptible of objective proof; but, insofar as Lord Scarman's observation might be taken to exclude the relevance of a person's state of mind to her habitual residence, I suggest that this court should consign it to legal history, along with the test which he propounded."

Lady Hale and Lord Sumption did not dissent from this proposition; rather, they went further to suggest that the perceptions of children of any age could be relevant.

In [JO v GO & Ors](#) [2013] EWHC 3932 (COP), a cross-border case concerning whether the habitual residence of an adult without capacity to decide as to her residence had changed from England to Scotland after she had been moved by family members across the border and then placed in a care home, Sir James Munby P took into account that the adult in question was settled in her care home, and, "seemingly, expressing her contentment at being there," as well as the fact that she was "not now expressing a desire to return either to her own home or to Worcestershire" (paragraph 23). He did not give specific reasons as to the basis upon which he considered that he was entitled to take these factors into account, but it is suggested that *Re LC* provides further endorsement of the position that it is both necessary and appropriate to consider the views of an adult without capacity when determining whether their habitual residence has changed. The weight to be attached to these views will depend very greatly upon the precise factual scenario under consideration, but that is a second order question to whether they are relevant in the first place. It is also suggested that the phrase 'state of mind' may also be of some utility when considering the position of adults for purposes of Schedule 3. Whilst it is tempting to use the phrase 'wishes and feelings,' this would give rise to a risk that the analysis would be conflated with a best interests analysis when the exercises required by Schedule 3 are distinct to those required by the balance of the MCA 2005 (see, in this regard, both *JO* and [Re MN \(Recognition and Enforcement of Foreign Protective Measures](#) [2010] EWHC 1926 (COP)).

Jail sentences for lay deputies who squandered PI award

We reported upon the depressing case of Cathy Watson and Robert Hills in our December newsletter. In brief, they were convicted 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, Cathy Watson's daughter. It has been [reported](#) in the press that they have now been sentenced to 5½ and 3 years and 4 months in prison respectively.

All change in the publication of judgments

On 16 January 2014 the President, Sir James Munby, published Practice Guidance on transparency in the Court of Protection and the publication of judgments. This followed a period of comment and discussion on the draft guidance, which readers will recall was published in July 2013.

The new Practice Guidance takes effect from 3 February 2014 and differs from the terms of the draft guidance in a number of respects. In outline, the key points are as follows:

- The Practice Guidance applies to all judgments in the Court of Protection delivered by the Senior Judge, nominated Circuit Judges and High Court Judges. In due course consideration will be given to extending it to judgments delivered by other judges.
- Permission to publish a judgment should always be given whenever the judge concludes that publication would be in the public interest and whether or not a request has been made by a party or the media.
- Where a judgment relates to particular matters (summarised below) and a written judgment already exists in a publishable form or the judge has already ordered that the judgment be transcribed, the starting point is that permission should be given for the judgment to be published unless there are compelling reasons why the judgment should not be published. The specified matters are as follows:
 - the giving or withholding of serious medical treatment and any other hearing held in public;
 - a deprivation or possible deprivation of liberty;
 - a dispute as to who should act as an attorney or a deputy;
 - whether a person should be restrained from acting as an attorney or a deputy or that an appointment should be revoked or his or her powers should be reduced;
 - moving an incapacitated adult (P) into or out of a residential establishment or other institution;
 - the sale of P's home;
 - a property and affairs application relating to assets (including P's home) of £1 million or more or to damages awarded by a court sitting in public;
 - capacity to marry or to consent to sexual relations; and
 - restraint on publication of information relating to the proceedings.
- In all other cases, the starting point is that permission may be given for the judgment to be published whenever a party or an accredited member of the media applies for an order permitting publication, and the judge concludes that permission for the judgment to be published should be given.
- In all cases where a judge gives permission for a judgment to be published:
 - (i) public authorities and expert witnesses should be named in the judgment approved for publication, unless there are compelling reasons why they should not be so named;



- (ii) the person who is the subject of proceedings in the Court of Protection and other members of their family should not normally be named in the judgment approved for publication unless the judge otherwise orders;
- (iii) anonymity in the judgment as published should not normally extend beyond protecting the privacy of the adults who are the subject of the proceedings and other members of their families, unless there are compelling reasons to do so.

CQC Report upon DoLS for the year 2012-3

The CQC's latest [report](#), *Monitoring the use of the Mental Capacity Act Deprivation of Liberty Safeguards in 2012-13*, latest report provides a fascinating insight into the operation of the Safeguards. Aside from the important statistical information, the CQC undertook surveys with some local authority supervisory bodies and IMCA services which provide a useful view from the coalface. Our summary cannot do the report justice but amongst the CQC's key findings were:

- There was a 4% increase in the number of applications compared to the previous year (11,393 to 11,887);
- Number of authorisations increased (6339 to 6546);
- Unexplained regional differences in their rate of use;
- Some people cannot properly exercise their legal rights and cannot challenge their detention;
- Level of awareness and understanding on the part of managing authorities is still low but knowledge of the system amongst local authorities generally appears to be good;
- Around two-thirds of those managing authorities requesting authorisations are

failing to notify the CQC of their DoLS applications and their outcomes;

- 88 unlawful deprivations of liberty were identified (compared to 93 the year before).

The fact that the majority of DoLS activity is not being brought to the attention of the CQC, contrary to regulation 18 of the Health and Social Care Act 2008, is very worrying indeed. Unnoticed liberty deprivations of the most vulnerable constitutes a serious failure. It leaves the most vulnerable without the protective scrutiny of the national monitoring body and risks placing the UK in breach of its international obligations, given that the CQC is part of the UK's National Preventive Mechanism under the UN Optional Protocol to the Convention against Torture.

Another concerning feature is the finding that 13.4% of the 7-day urgent authorisations were extended by up to another 7 days. This is a high proportion, given that such extensions are only permitted for "exceptional reasons" which do not include staffing shortages: see DoLS Code of Practice para 6.24. As the CQC remarks:

"For the individuals involved each extension means that they were detained for more than seven days without the full protection of the assessment and authorisation processes of the Deprivation of Liberty Safeguards. This is a significant proportion of the total number of applications over the year and could potentially cause confusion or distress for the individuals involved, as well as any families or close friends."

Throughout the report are examples of good practice, some of which we thought it might be useful to collate:

(a) *The relevant person and their representatives (beyond initial contact)*

- Full, pro-active involvement by the assessors of relatives in the assessment of the person's application, and in deciding what is in the person's best interests.



- Family carers consultation event to get feedback on their experience of the Deprivation of Liberty Safeguards, and discover what further information/ support they needed or would have found of benefit.
- Accessible, easy read information being made available to the person and their representative to explain the Deprivation of Liberty Safeguards system.
- Additional funding arranged for one-to-one support for someone to enable contact with friends and outings into the community, rather than physical restraint, after deprivation of liberty was identified but not authorised.
- Successful use of conditions on authorisations, after discussion with relatives, such as making sure the person is taken out regularly.
- IMCA re-contacted the representative half way through the authorisation period and a month before the end of the authorisation. This was to remind them that, if they needed support, they could ask for a re-referral to be made by the local authority.
- Regular meetings between local authorities (commissioners and professionals) and IMCAs to explore any practice issues.
- Local authority assisted a self-funder to challenge her authorisation.

(b) The DoLS Process

- For supervisory bodies to carry out a review, particularly for longer periods of authorisation, if they think it might be necessary and to be assured that it is easy for the detained resident (or their representative) to request a review whenever they want one.

- A quality assurance team developed standards to assess whether the MCA principles are embedded in care planning.
- A regional Deprivation of Liberty Safeguards leads' network where information on numbers and types of referrals are discussed, together with discussion of difficult or novel situations.
- Best interest assessor forums, encouraging BIAs to attend by managing workloads.
- Having agreements with neighbouring local authorities to use BIAs from elsewhere, for example, if the person was in a local authority managed home, such arrangement would be essential as a BIA employed by the local authority is forbidden to carry out assessments if that local authority is also the service provider.
- Having agreements with neighbouring local authorities so they can call on BIAs from elsewhere if there is an unexpected surge of requests accompanied by urgent authorisations.
- Quarterly reports to MCA/Deprivation of Liberty Safeguards committees or multi-agency local networks, to oversee and analyse activity, numbers and deadlines.
- Independent reviews of Deprivation of Liberty Safeguards activity.

(c) DoLS Signatories

- Applying lessons learned from the Steven Neary case – making sure the authoriser is not a commissioner responsible for the service where the person is living.
- Making sure the authoriser is not also responsible for agreeing funding for the person.

(d) Support for managing authorities

- MCA helplines and clear web-based information.



- Regular e-bulletins.
- Provider forums where the MCA and the Deprivation of Liberty Safeguards are regularly discussed.
- Focused training on care homes and hospitals where monitoring data shows low activity.
- Commissioning contracts which include knowledge requirements around the MCA and the Deprivation of Liberty Safeguards.
- Audits to check hospital staff knowledge of the MCA, including the Deprivation of Liberty Safeguards, with follow up workplace-based information provided.
- ‘Train the trainer’ programmes for hospital and care home staff so MCA and Deprivation of Liberty Safeguards training can be run in-house.
- Placing the Deprivation of Liberty Safeguards clearly in terms of a personalisation and human rights context when training, to enable them to be viewed more positively.

So useful are these practice points, in fact, that we have taken the liberty of attaching them as a separate page to this newsletter so that they can be pinned to the wall of the appropriate offices.

The Care Bill – update

In its [report](#) upon the Care Bill published on 27 January 2014, the Joint Committee on Human Rights welcomed the introduction of the new duty in (as it stands) clause 42 on local authorities to make enquiries where they reasonably suspect that an adult is at risk of neglect or abuse as promoting the Government’s positive obligation to take appropriate steps to safeguard the lives of those within its jurisdiction and to protect vulnerable individuals from ill-treatment. The Committee welcomed these provisions as “human rights enhancing measures.”

The Committee was also clear that the

amendment passed in the Lords to the Bill to extend the Human Rights Act to all providers of care and support regulated by the CQC should stand so as to ensure that all providers of publicly arranged social care services are bound by the Human Rights Act.

Prior to the publication of the report, however, the Government narrowly won a [vote](#) at the Public Bill Committee stage in the House of Commons to reverse the amendment. It also appears that the Government has its face set against the introduction of any power of entry (or other supporting power) to accompany the Clause 42 investigative duty. In a Public Bill Committee debate on 21 January 2014, the Minister of State, Norman Lamb MP made clear, in response to sustained pressure from, inter alia, Paul Burstow, the former care minister, that the Government remained of the view that the existing powers available to social workers were sufficient. He noted the existence of:

“The Police and Criminal Evidence Act 1984, the Domestic Violence, Crime and Victims Act 2004, the Fraud Act 2006 and, for those lacking capacity to make decisions, the Mental Capacity Act 2005 provide a wealth of powers for use on the front line. I want to develop the point, because I suspect that there is widespread ignorance of what those powers amount to. That is no one’s fault; it is just the case.”

My right hon. Friend [Paul Burstow MP] has been, as I would always expect of him, diligently exploring the various powers. The court can also hear any matters that come before it, unless excluded by a rule or statute. That enables the common law to develop and adapt as is required on a case-by-case basis to provide the remedy needed. We think that this inherent jurisdiction can meet the need of protecting vulnerable adults more readily than legislation may. There is a risk that by legislating, Parliament would oust the court’s inherent jurisdiction in this area and so limit the scope and means by which the



courts can safeguard adults in need of care and support.

As for the ability to gain access to assess the mental capacity of a person suspected of being an adult at risk of abuse, that route is already available via the Court of Protection. The court is accessible, and can make orders, 24 hours a day.

Further legislation for a new power of access would risk sending the message that legal intervention takes primacy over negotiations and consensus, which, as I said, are at the heart of the skills of a good social worker”

Later, Norman Lamb MP noted that:

“We propose that case studies and possible scenarios illustrating the powers will be included in practical guidance that can be developed jointly by the Department of Health, the Local Government Association and ADASS so that, possibly for the first time, there is a clear guide to all the legislative provisions available and what they actually amount to. When I have sought to understand precisely what the various pieces of legislation provide for, I have found a degree of opaqueness. I suspect that many social workers out there in the field are not aware of what powers are available to them.”

Alex’s paper addressing the practical operation of the Scottish legislation, legislation that has been advanced as a partial model for a power of entry, is available [here](#). We look forward to seeing the guidance promised by Norman Lamb MP in due course, and in particular insofar as it sets out the

Government’s views regarding both the powers of the High Court under the inherent jurisdiction and the Court of Protection under the MCA 2005. We would note at this stage that it is far from easy to say as a blanket statement that the Court of Protection is able to bring about access to assess the mental capacity of a person suspected of being an adult at risk. Indeed, some of the most difficult cases in which we have been involved have been those in which access has been denied by family members (or purported carers) to social workers to adults whom the social workers suspect, but cannot establish even on the low threshold set by s.48 MCA 2005, may lack capacity in one or more domains.

Books

Two recently published books merit a mention in the pages of this newsletter:

1. *The Mental Health Law Online Annual Review 2013*, collecting all the updates from 2013 from this invaluable site run by Jonathan Wilson.
2. *Where Memories Go: why dementia changes everything*, by Sally Magnusson, daughter of the late Magnus Magnusson, a memoir of living through the dementia of her mother.

Both are, as they say, available from good booksellers and on the internet.



Substituted decision makers and the interaction between the Adults with Incapacity (Scotland) Act 2000 and Mental Health (Care and Treatment) (Scotland) Act 2003¹

Introduction

It is sometimes the case that separate pieces of legislation which, in some respects, cover similar issues, produce anomalies. This would appear to be the case with the Adults with Incapacity (Scotland) Act 2000 ('the 2000 Act') and the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the 2003 Act') in the context of medical treatment for mental disorder and substituted decision-makers.

Substituted decision-makers and medical treatment for mental disorder

Section 47 of the 2000 Act (the general authority to treat) permits certain medical and healthcare professionals² to issue a certificate authorising what is reasonable in the circumstances to medically treat an adult with incapacity in order to safeguard or promote their physical or mental health.³

Where there is an existing guardian or welfare attorney then they may legitimately consent to the proposed medical treatment on behalf of the adult⁴ except where it involves placing the adult in hospital for treatment of a mental disorder against their will.⁵ A second opinion procedure exists where the guardian or welfare attorney refuses to consent to the treatment but the doctor or healthcare professional still wishes that it be administered.⁶

Potential inconsistency between the 2000 Act and 2003 Acts

The general authority to treat is, however, also subject to, amongst others, sections 234, 237, 240 and 242 of the 2003 Act.⁷ Sections 234-240 provide for medical treatments that are subject to special safeguards in terms of obtaining the patient's consent, obtaining second medical opinion, the involvement of the Mental Welfare Commission and, in the case of neurosurgery, the Court of Session where the patient is incapable of giving valid consent or refuses to give consent. The special safeguarded treatments include neurosurgery,⁸ ECT⁹ and drugs (other than surgical hormone implant) to reduce sex drive, any other drugs given over a period of more than two months (although the 2003 Act special safeguards for such long term drug use do not apply to adults being treated under the 2000 Act¹⁰) and artificial

¹ This article is based on the paper by Jill entitled *Autonomy, consent to treatment, substituted decision makers and the interaction between the Adults with Incapacity (Scotland) Act 2000 and Mental Health (Care and Treatment) (Scotland) Act 2003* which currently appears on the [webpage](#) of the Edinburgh Napier University Centre for Mental Health and Incapacity Law, Rights and Policy.

² The medical practitioner primarily responsible for the adult concerned, dentists, ophthalmic opticians, registered nurses and anyone else as shall be specified by regulations (s.47(A) 2000 ACT).

³ s.47(2) 2000 Act.

⁴ Anyone with an interest, and this includes the adult, may challenge the decision to treatment by applying to the Court of Session (s.50(3) 2000 Act).

⁵ Ss.64(2)(a) and 16(5)(a) 2000 Act.

⁶ ss50(5)-(6) 2000 Act.

⁷ s.243 2003 Act relates to urgent medical treatment.

⁸ s.234 2003 Act.

⁹ s.237 2003 Act. This section, as with ss240 and 242, applies where this treatment is authorised either by the 2003 Act or under the Criminal Procedure (Scotland) Act 1995.

¹⁰ Whilst long term drug therapy may be justifiable in some cases there have been concerns about its inappropriate use, particularly in regard to persons with dementia. See, for example, Care Commission and Mental Welfare Commission



nutrition.¹¹

Section 242, on the other hand, relates to treatment for mental disorder other than that requiring special safeguards. However, where section 50 of the 2000 Act permits a substitute decision maker to consent to such treatments when administered under the 2000 Act, section 242 of the 2003 Act appears to provide no such ability. In essence, this therefore suggests that welfare attorneys or guardians may not be able to consent to medical treatment that they would be able to consent to under the 2000 Act were the adult not subject to compulsory care and treatment for their mental disorder under the 2003 Act.

It is questionable whether section 242 can be construed in such a way that would permit guardians or welfare attorneys to give consent despite the 2003 Act's underlying general principles requiring that their views must be sought and taken into account when interventions are being considered. Indeed, one might well assume that it was the intention that they not be so authorised given that, even in the context of considering the views of others, section 242(5)(a) specifically directs that the views of the patient, their named person and any advance statement must be taken into account but throughout section 242 there is no express mention of guardians and welfare attorneys.

The denial of the right of substitute decision makers to consent to treatment for mental

disorder must also be considered in human rights terms given the requirement that Scottish devolved legislation and its interpretation and implementation must be compatible with ECHR rights.¹²

Human rights considerations

The European Court of Human Rights has made it clear that treatment of an individual without consent may amount to a violation of that individual's right to private life (autonomy) under Article 8(1) ECHR where there is no legal basis and it is not in pursuit of a legitimate aim.¹³ However, as yet, it has not been invited to directly address the issue of a substitute decision maker appointed by an individual consenting on that individual's behalf to medical treatment for mental disorder.¹⁴

That being said, the appointment of a **welfare attorney** may nevertheless be regarded as an expression of such autonomy. For instance, whilst only persuasive and not legally binding, Council of Europe *Recommendation of the Committee of Ministers to Member States Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder*¹⁵ advocates patient

¹² S.29(2)(d) Scotland Act 1998 and ss.3 and 6 Human Rights Act 1998.

¹³ As permitted under Article 8(2) ECHR. See *Bensaid v UK* (2001) 33 EHRR 10 at para 46; *Pretty v United Kingdom* (2002) 35 EHRR 1 at para 6; *Y F v Turkey* (2004) 39 EHRR 34 at para 33; *Glass v United Kingdom* (2006) 43 EHRR 6 at para 82; *Storck* (2006) 43 EHRR 6 at para 143; *Silver v United Kingdom* (1983) 5 EHRR 347 at paras 88 and 90. *Silver v United Kingdom* (1983) 5 EHRR 347 at paras 88 and 90; *X v. Finland* (Application no. 34806/04) Court (Fourth Section) judgment 3 July 2012.

¹⁴ Case law to date has tended to concentrate largely on the inappropriate use of guardianship.

¹⁵ Council of Europe, Recommendation Rec. No. (2004)10 concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder (Adopted by the Committee of Ministers on the 22 September 2004 at its 896th meeting of Ministers' Deputies).

for Scotland, *Remember, I'm still me: joint report on the quality of care for people with dementia living in care homes in Scotland*, pp52-53; Bruce Guthrie *et al* (2010), 'The burden of psychotropic drug prescribing in people with dementia: a population database study', *Age and Aging* published online 12 July 2010, <http://ageing.oxfordjournals.org/content/39/5/637.full.pdf+html>.

¹¹ s.240 2003 Act.



involvement, and respect for their opinions, in preparation of treatment plans is required wherever possible¹⁶ including in involuntary treatment situations.¹⁷ However, more specifically, Council of Europe *Recommendation on principles concerning continuing powers of attorney and advance directives for incapacity*¹⁸ promotes the use of powers of attorney and advance statements as an expression of self-determination and autonomy. This is said to build on the principles of subsidiarity and necessity in Council of Europe's earlier *Recommendation on principles concerning the legal protection of incapable adults*¹⁹.

Both the 2000 and 2003 Acts largely address these requirements where they provide for seeking of views of the adult/patient and substitute decision makers and, in the case of the 2003 Act, those views expressed in advance statements when interventions are being considered. The 2000 Act also permits, under section 50, welfare attorneys to consent to some types of medical treatment. As already indicated, however, neither Act goes as far as recognising the right of welfare attorneys to consent to medical treatment for mental disorder in compulsory treatment situations.

UN Convention on the Rights of Persons with Disabilities (CRPD)

Further potential interpretational considerations

also arise in connection with the CRPD. Whilst the scope of this paper does not allow for an extensive discussion of this topic, it should be noted that several commentators²⁰ and, indeed, the Committee on the Rights of Persons with Disabilities in its recent *Draft General Comment on Article 12 of the Convention – Equal Recognition before the Law*²¹ appear to adopt a radical interpretation of the Convention in its shift away from the traditional paternalistic medical model approach to disability towards a full embracement of a social, facilitating, model. In essence, such an interpretation, referring in particular to articles 5 (equality and non-discrimination), 12 (equal recognition before the law), 14 (liberty) and 25 (the right to health), advocates no removal of legal capacity on the basis of disability, strongly promotes supported (not substituted) decision making (and the removal, therefore, of guardianship) and the abolition of laws providing for the compulsory treatment of mental disorder.

Conclusion

An absence of clear direction from Strasbourg on Article 8 in this context, together with the somewhat ambiguous wording of section 242, it is

²⁰ For examples and discussion on this see European Union Agency for Fundamental Rights, *Legal Capacity of Persons with Intellectual Disabilities and Persons with Mental Health Problems*, Report, 2013, pp15-18; UN General Assembly, *Report of the Special Rapporteur on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment*, UN Human Rights Council, A/HRC/22/53, 1 February 2013, paras 57-70; P. Bartlett, "The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law" (2012) 75(5) MLR 752; and O. Lewis, "Advancing Legal Capacity Jurisprudence" (2011) 6 EHRLR 700.

²¹ Committee on the Rights of Persons with Disabilities *Draft General Comment on Article 12 of the Convention – Equal Recognition before the Law* (Adopted by the Committee at its tenth session (2-13 September 2013) <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/DGCArticles12And9.aspx> (accessed 17 December 2013). The ultimately interpreted remains to be seen.

¹⁶ Article 12.

¹⁷ Articles 18, 19 and 28.

¹⁸ Council of Europe Recommendation CM/Rec(2009) 11 *on principles concerning continuing powers of attorney and advance directives for incapacity* (Adopted by the Committee of Ministers on 9 December 2009 at the 1073rd meeting of the Ministers' Deputies).

¹⁹ Council of Europe Recommendation No. R(99)4 *on principles concerning the legal protection of incapable adults* (Adopted by the Committee of Ministers on 23 February 1999 at 660th meeting of Ministers' Deputies), Principles 5 and 6.



difficult to assess with any certainty whether or not this section violates Article 8 thus rendering it an invalid and unenforceable statutory provision.²²

How the CRPD will ultimately be applied in the context of medical treatment for mental disorder is still to be determined. If this interpretation is to be strictly adhered to then this may well, of course, render the issue of the ability of substitute decision makers to consent to treatment for mental disorder under the 2003 Act irrelevant.²³

Whether the Scottish Government will address this inconsistency in its forthcoming Mental Health Bill remains to be seen. Meanwhile, it would appear that direction should be sought from the Sheriff Court²⁴ where situations arise involving the interpretation of section 242 of the 2003 Act and substitute decision makers authorised under the 2000 Act. Alternatively, the

Mental Health Tribunal may be prepared to direct that a guardian's or welfare attorney's authority to consent to treatment in these circumstances is a recorded matter. There is, however, support for the view that where compulsory treatment for mental disorder is concerned then the provisions of the 2003 Act take precedence over the 2000 Act.²⁵

Jill Stavert

Covert medication: Scottish legislation, human rights and the Mental Welfare Commission for Scotland's updated guidance

Introduction

There are indications that the use of covert medication - in other words, medication given to someone without their knowledge or consent, usually in their food or drink - is on the increase in Scotland particularly in relation to individuals with dementia and learning disabilities.²⁶

Non-consensual medical treatment is permissible under Scottish legislation. Subject to certain criteria being fulfilled, Part 5 of the Adults with Incapacity (Scotland) Act 2000 permits such treatment in the case of adults with incapacity²⁷ and Part 16 of the Mental Health (Care and Treatment)(Scotland) Act 2003 authorises it in the case of adults and children who are subject to

²² Under s.29(2)(d) Scotland Act 1998. See, for example, *Cameron v Cottam* 2012 SLT 173 and *Salvesen v Riddell* 2012 SLT 633.

²³ It should be noted that ss. 242(5)(a) and (b) of 2003 Act may fall foul of this strict interpretation on the basis that they state that part of the criteria for compulsory treatment the determination is that such treatment will be in the patient's "best interests" such terms being regarded as being symptomatic of the paternalistic medical model. The fact that the 2000 Act refers to "benefit" rather than "best interests" is likely to place it in a better position in this respect. See again, for example, UN General Assembly report and Bartlett in n.20 above and Committee on the Rights of Persons with Disabilities Draft General Comment in n.21 above.

²⁴ Under s.3. 2000 Act although this, of course, relates to only interventions under the 2000 Act. In the case of *guardians with welfare powers* it may also possible to utilise s.70(2) 2000 Act in terms of the Sheriff Court requiring the healthcare professional to implement the guardian's decision. However, this would only be effective if there is acceptance of the guardian's ability to give valid consent under s.242 2003 Act.

²⁵ Scottish Government, Adults with Incapacity (Scotland) Act 2000, Part 5, *Code of Practice*, para 2.50 and Mental Welfare Commission for Scotland, *Consent to Treatment*, 2010, p.14. Indeed, this approach was followed in in the recent Court of Session (Outer House) decision *In Petition of PW and JW joint guardians to their adult son DW*, 18th December 2013, Lord Kinclaven at 29-33. However, this does not definitively resolve the issue of whether a substitute decision maker's consent should, from a human rights perspective, be valid for the purposes of treatment covered by s.242 2003 Act.

²⁶ *Ibid*, p3.ed.

²⁷ Defined as anyone aged 16 years and over (s.1(6)).



compulsory measures. However, neither Act specifically refers to covert medication, and the 2000 Act's accompanying Code of Practice recommends that the Mental Welfare Commission for Scotland's guidance is followed regarding this. This guidance has just been updated.²⁸

The Mental Welfare Commission does not condemn the use of covert medication in all cases stating that occasionally it may be the best way to provide an individual with necessary medical treatment.²⁹ However, it stresses the need for its use to be considered and administered in accordance with ECHR rights and relevant Scottish legislation which, despite its silence on the subject, does provide a framework which allows for non-consensual treatment that arguably includes administering medication covertly. The provisions of the ECHR and of the Scottish legislation will both be discussed briefly in turn before the key provisions of the guide are considered.

Relevant ECHR considerations

In Scotland, devolved legislation and the actions of the Scottish Government must be ECHR compatible,³⁰ as must as the actions of public authorities.³¹ The State may also be held responsible for ECHR violations by private individuals or bodies in that it has a positive obligation to protect individuals against such interferences with their rights³² (for example, through registration and inspection for

requirements and/or access to the justice system) or where it directly colludes with such violation.³³ Indeed, the Scottish Law Commission has commented³⁴ that care and treatment arrangements in Scotland are such that deprivations of liberty in violation of Article 5 are highly likely to be imputable to the state.³⁵ It seems logical, therefore, that this applies to other breaches of ECHR rights.

Whilst specific Strasbourg direction is lacking, certain ECHR rights are particularly relevant - namely the right to life (Article 2), to be free from torture and inhuman or degrading treatment (Article 3), to liberty (Article 5) and to private and family life/autonomy (Article 8) - to covert medication situations.

Firstly, compatibility with Article 8 requires that capacity be assessed on a functional basis³⁶ recognising that capacity can fluctuate. Thus, where an individual is able to give full and informed to treatment this must be sought and refusals of such treatment must normally be respected.

Secondly, Article 8(2) does permit non-consensual medical treatment of incapacitated individuals but only where it is lawful, proportionate and in pursuit of a legitimate aim (in other words, it is therapeutically necessary).³⁷ To inappropriately medicate someone against

²⁸ Mental Welfare Commission for Scotland, [Covert Medication: A Good Practice Guide](#), 2014.

²⁹ *Covert Medication*, p10.

³⁰ Ss29(2)(d) and 57 Scotland Act 1998.

³¹ S.6 Human Rights Act 1998.

³² See Article 1 ECHR (general State obligation) and Article 5(1) ECHR (positive obligation on the State to protect the right to liberty), and *Costello-Roberts v UK* (1995) 19 EHRR 112 at para 26 and *Stanev v Bulgaria* (2012) 55 EHRR 22 at para 120.

³³ See *X and Y v Netherlands* (1985) 8 EHRR 235 at para 23, *Storck v Germany* (2005) 43 EHRR 96 at para 89, and *A Local Authority v A (by her Guardian ad Litem, Judith Bennett-Hernandez), B A Local Authority v C (by her litigation friend the Official Solicitor), D, E* [2010] EWHC 978 (Fam) at para 84.

³⁴ Scottish Law Commission, *Discussion Paper on Adults with Incapacity*, 2012, paras 6.13-6.14.

³⁵ *Ibid*, para 6.14.

³⁶ *Shtukaturov v. Russia* (2012) 54 EHRR 27, paras 89-90 and 93-95. In advocating a functional capacity assessment approach, the European Court of Human Rights is adhering to principles set down by the World Health Organisation.

³⁷ *Herczegfalvy v Austria* (1992) 15 EHRR 437 at para 82.



their will may reach the “minimum level of severity” threshold required to engage Article 3³⁸ although whether this threshold is reached depends on whether the treatment is in accordance with “the recognised rules of medical science”³⁹ and on the circumstances of each case.⁴⁰ Moreover, excessive or unwarranted medication may violate Articles 3 and 8⁴¹ and the sedative effects of drug treatment could be construed as a deprivation of liberty engaging Article 5. This is reinforced by Articles 17 (right to personal integrity), 15 (freedom from torture, cruel, inhuman or degrading treatment) and 12 (equal treatment before the law) of the UN Convention on the Rights of Persons with Disabilities (CRPD). The UK has international law obligations to ensure that CRPD rights are protected and promoted. In addition, the European Court of Human Rights must take, and has started to take, into account the provisions of this treaty in its jurisprudence.⁴²

Relevant Scottish legislation

Adults with Incapacity (Scotland) Act 2000 ('the 2000 Act')

In terms of non-consensual treatment, an adult certified as lacking capacity in terms of the 2000

Act⁴³ can be administered medical treatment provided it is specifically provided for in that certificate.⁴⁴ This does not permit the use of force or detention in such administration except in the case of emergency and only then for as long as is necessary in the circumstances.⁴⁵ Certain treatments are, however, subject to additional special safeguards, for instance a second opinion from an independent medical practitioner⁴⁶ and, as the Mental Welfare Commission points out in its guidance,⁴⁷ this applies to treatment to reduce sex drive.

Before any intervention under the 2000 Act is permitted, various principles must be taken into account. These include the fact that the intervention must only take place where, to ensure that it is a proportionate measure, it will benefit the adult⁴⁸ and it is the least restrictive option in the circumstances.⁴⁹ Moreover, ensuring that the adult’s autonomy is respected, the past and present wishes of the adult and others such as carers, guardians and attorneys and the encouraging of autonomous decision making where possible must be taken into account.⁵⁰

The 2000 Act may authorise medical treatment for physical or mental conditions. However, if the adult refuses treatment for a mental disorder then it is generally considered to be more appropriate, and protective of their rights, to consider use of the 2003 Act.⁵¹

Mental Health (Care and Treatment)(Scotland) Act 2003 ('the 2003 Act')

⁴³ s.1(6). S

⁴⁴ S.47

⁴⁵ S.47(7)(a).

⁴⁶ S.47(2A).

⁴⁷ *Covert Medication*, p5.

⁴⁸ S.1(2).

⁴⁹ S.1(3).

⁵⁰ Ss1(4)-(5).

⁵¹ See, for example, *Covert Medication*, *op cit*, p6.

³⁸ *Herczegfalvy v Austria* (1992) 15 EHRR 437 at para 82. See also App No 41153/06 *Dybeku v Albania* 18 Dec 2007 at para 47 and No 33834/03 *Rivière v France* 11 Jul 2006 at paras 72 and 63.

³⁹ *Herczegfalvy* at para 82.

⁴⁰ *Pretty v United Kingdom* (2002) 35 EHRR 1 at para 52. See *Kudla v Poland* (2002) 35 EHRR 11 at para 92. See also *Tyrer v United Kingdom* (1979-1980) 2 EHRR 1 at para 30 and *Soering v United Kingdom* (1989) 11 EHRR 439

⁴¹ See, for example, *Grare v France* (1992) 15 EHRR CD100.

⁴² For example, *Stanev v Bulgaria* (Application no. 36760/06) (2012) ECHR 46, *ZH v Hungary* (Application 28973/11), judgment of 8 November 2012 and *Plesó v. Hungary* (Application no. 41242/08) Court (Second Section) judgment 2 October 2012.



Part 16 of the 2003 Act provides that under certain circumstances an individual may be subjected to non-consensual treatment. One of the criteria for civil compulsory measures being adopted under the Act is that the individual's ability to take decisions about the treatment is significantly impaired as a result of their mental disorder. The Act does not define this but it is likely that similar factors to those for assessing incapacity in 2000 Act will be taken into account and it must be demonstrated that the person is capable or incapable of making a valid treatment choice in relation to a specific intervention/ treatment. The fact that they may not have had insight about the original treatment does not mean that do not have insight about other interventions.

Where a person is capable of giving consent then they must do so. If they are not, or refuse to give consent, then they can be treated compulsorily under the Act provided its criteria are met.⁵² During the first two months of compulsion, any drug treatment may be given (provided the registered medical officer gives reasons for this where the individual refuses to consent to it). After the two months then treatment can only be given where either the individual is capable of giving valid consent and does or following an independent second medical opinion has been provided supporting this. It should be noted that drug therapy to reduce sex drive requires an independent second opinion from the beginning of compulsion.

Again, as with the 2000 Act, before functions are discharged under the Act, its principles and certain considerations, which also support proportionality and respect for patient autonomy, must be regarded. In terms of

principles, the range of available options should be considered, the least restrictive option, only adopting that which will be of maximum benefit to the individual and non-discrimination, as well as regarding the patient's wishes, the views of named persons, carers, guardians and attorneys and encouraging patient participation in care and treatment decisions are all statutorily enshrined.⁵³ Moreover, before there can be compulsory measures adopted the presence of mental disorder, treatability, risk, significantly impaired decision making ability about the treatment because of the mental disorder and the necessity for such involuntary treatment must be considered.⁵⁴

The principles mentioned above apply to person aged 18 years and over but the considerations for compulsory treatment are the same. For children or young persons under 18 years of age then, in addition to these considerations, any functions must be discharged in a "manner that best secures the welfare of the patient."⁵⁵

In Scotland, children under the age of 16 years can consent to medical treatment provided they understand what it is and what it involves including the risks involved.⁵⁶ Responsibility lies with the medical practitioner as to whether this is the case with each individual child. Where a child is unable to give valid consent then those with parental responsibility can make the decision for them although use of the 2003 Act should be considered where treatment is proposed for a mental disorder.

Mental Welfare Commission for Scotland, *Covert Medication: A Good Practice Guide*

As already mentioned, the Mental Welfare Commission's guidance is very clear about the

⁵³ Ss1(3).

⁵⁴ S.64(5).

⁵⁵ S.2(4).

⁵⁶ S.2(4) Age of Legal Capacity (Scotland) Act 1991.

⁵² Namely the presence of mental disorder, treatability, risk, significantly impaired decision making ability and necessity (s.64(5)).



importance of adherence to ECHR rights and to provisions and principles of existing legislation when considering the use of covert medication.

The guidance provides a checklist⁵⁷ – a “Covert Medication Care Pathway” – for situations when covert medication is being considered. It recommends that necessity, capacity, the application of legal principles and procedures (including relevant human rights, particularly Article 8 ECHR), benefit (to the patient), minimum restriction of freedom, the individual’s past and present feelings, consultation of others who may have knowledge of the individual’s preferences (e.g. guardians, attorneys, relatives and friends etc.) and encouraging the individual to use existing skills and develop new skills are all taken into account.⁵⁸ From a practical and safety perspective it emphasises the need to ensure that the proposed medication can actually be safely disguised without causing harm to the patient, that those administering the medication are fully aware of how to correctly administer it, adequate recording and review of administration of the medication, and the need to assess whether any additional treatment that is required really needs to be covertly administered.⁵⁹

The guidance also makes it clear that family carers, as well as medical staff and professional carers, must heed the guidance although, admittedly, monitoring the former in this respect presents the greater challenge.

Conclusion

In light of the legislative silence on covert medication the guidance is most welcome. The 2000 and 2003 Acts and obligations imposed upon the State by the ECHR do provide a structure within which the consideration and

administration of medication in this way must operate. However, two matters require additional mention.

The first is the role of advance statements. Notwithstanding that the wishes expressed in these documents may, on occasion, be overridden in psychiatric treatment situations, these should be otherwise respected. Their advantages and importance are undeniable when it comes to individual autonomy and providing a clear expression of a person’s treatment preferences.

Secondly, it seems likely that the guidance may have to be revisited once the full implications of Article 12 CRPD are ascertained in light of current radical interpretations of the Convention that strongly promote supported decision making (and the abolition of guardianship) and of laws providing for the compulsory treatment of mental disorder.⁶⁰

Jill Stavert

Colin McKay appointed as new Chief Executive Officer of the Mental Welfare Commission for Scotland

We hope that our readers will join us in congratulating Colin McKay upon his appointment as CEO of the Mental Welfare Commission for Scotland, the first lawyer to hold the post, after a long and distinguished career during which, amongst other things, he was a key member of the campaign that led to the creation of the Adults with Incapacity (Scotland) Act 2000, secretary to the Millan Committee in its review of Scottish mental health law, and managed the Government team that took forward the Mental Health (Care and Treatment)(Scotland) Act 2003.

⁶⁰ See *Substituted decision makers and the interaction between the Adults with Incapacity (Scotland) Act 2000 and Mental Health (Care and Treatment) (Scotland) Act 2003* also in this edition.

⁵⁷ See Appendix 1 for a downloadable checklist form.

⁵⁸ pp6-9.

⁵⁹ Pp9-10.



Conferences at which editors/contributors are speaking

- Neil will be speaking, along with others including Jenni Richards QC, at an afternoon seminar hosted by Langleys Solicitors at the University of York's Law School on 13 March 2014 entitled "A Deprivation of Liberty? Post Cheshire West and P & Q." Full details are available [here](#).
- Alex and Tor will be speaking at the Community Care Conference "Implementing The Mental Capacity Act and Deprivation of Liberties Safeguards," on 19 March 2014. Full details are available [here](#).
- Alex and Adrian will be speaking at (and Jill will be acting as a session facilitator at) 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. Full details are available [here](#).
- Neil is speaking on *Cheshire West* and developments in the DOLS field at the Best Interest Assessor's Conference 2014 on 31 March 2014 at Lincoln's Inn. Full details are available [here](#).
- Adrian will be speaking on hot topics in the incapacity field at the Solicitors' Group Wills, Trust & Tax conference in Edinburgh on 7 May 2014. Full details are available [here](#).
- Adrian will be speaking at the annual private law conference convened by the Royal Faculty of Procurators in Glasgow on 29 May 2014. Full details are available [here](#).
- Adrian is also involved in the planning and

delivery of judicial training in adult incapacity law for the Judicial Institute for Scotland.

Other conferences of interest

"Reducing Legal Risk in an Ageing Britain"

The ageing population is one of the factors driving an increase in disputes over capacity and decision making. Together with Nottingham University Hospitals NHS Trust, Browne Jacobson Solicitors are hosting a one day conference on the legal issues and liabilities arising from care of the elderly, on 11 March 2014 in Nottingham. The conference is aimed at private sector providers of health and social care as well as Local Authorities and the NHS, with leading national speakers including the NHS Litigation Authority, CQC, Department of Health, HM Coroner, academics, counsel and practitioners. For more details and to register online, please click [here](#).

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.

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