Mental Capacity Law Newsletter July 2015: Issue 58

Compendium: Screen-Friendly

Introduction

Welcome to the July 2015 Newsletters: Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Newsletter: an article from Tim Spencer-Lane of the Law Commission outlining its vitally important consultation on deprivation of liberty, *Re X*, duck-spotting with Mostyn J and a significant case on medical treatment;

(2) In the Property and Affairs Newsletter: an important review of the law of 'doing the right thing' in statutory will cases, SJ Lush on wishes and feelings, and a reminder of the new LPA forms;

(3) In the Practice and Procedure Newsletter: an update on the significant changes to the Court of Protection Rules taking effect from 1 July, a useful case on the inherent jurisdiction and procedural points of analogy from cases involving children;

(4) In the Capacity outside the COP Newsletter: a stop press on ordinary residence following the Supreme Court's decision in the *Cornwall* case, the Law Society's Practice Note on meeting the needs of vulnerable clients, capacity to withdraw consent an update on the Northern Ireland Mental Capacity Bill, and the European Court of Human Rights considers life-sustaining treatment;

(5) In the Scotland Newsletter: the new Scottish Government guidance on ordinary residence and an update on the Mental Health Bill.

And remember, you can now find all our past issues, our case summaries, and much more on our dedicated sub-site here.

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For all our mental capacity resources, click here. Transcripts not available at time of writing are likely to be soon at www.mentalhealthlaw.co.uk.

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Deprivation of Liberty: the road ahead

[We are very grateful to Tim Spencer-Lane, the lawyer in charge of the project on mental capacity and deprivation of liberty at the Law Commission, for providing this article summarising the key points of the vitally important Law Commission Consultation Paper published on 7 July: we urge all readers with the slightest interest in this area to read the full report and to respond to the consultation before 2 November. We really do have a chance to get the law in this area right – and realistically only one chance in this

generation].

Mental capacity and deprivation of liberty: the Law Commission's consultation paper

The Law Commission's consultation paper on deprivation of liberty was published on 7 July ((Law Commission, *Mental Capacity and Deprivation of Liberty: A Consultation Paper* (2015), CP No 222). It puts forward a comprehensive replacement scheme for the Deprivation of Liberty safeguards (DoLS).

The DoLS have been subject to considerable criticism ever since their introduction. In March 2014 two events inflicted significant damage. First, the House of Lords post-legislative scrutiny committee on the Mental Capacity Act published a report which, amongst other matters, concluded that the DoLS were not "fit for purpose" and proposed their replacement (Report of Session 2013-14: Mental Capacity Act 2005: Post-legislative Scrutiny (2014) HL 139). A few days later, a Supreme Court judgment widened the definition of deprivation of liberty to a considerable extent (*P v Cheshire West and Chester Council* and *P v Surrey County Council* [2014] UKSC 19, [2014] AC 896). The practical implications have been significant for the public image of the DoLS, and the regime has struggled to cope with the increased number of cases.

We consider that there is a compelling case for replacing the DoLS. For instance, the DoLS are perceived to be overly technical and legalised and, more significantly, they are not meaningful for disabled people and their families or carers, and fail to secure buy-in from health and social care practitioners. Perhaps the most important consequence is likely to be that the rights of people who are deprived of liberty and those supporting them are difficult to discern.

In designing a new system we have identified a number of key principles, namely that the new scheme should be:

- aimed at delivering improved outcomes for people with health and care needs, and their families and carers;
- rooted in the Mental Capacity Act;
- straightforward and non-elaborate;
- compliant with the European Convention on Human Rights;
- supportive of the UN Disability Convention; and
- tailored according to setting

Perhaps the most frequent and consistent criticism made to us about the DoLS has concerned the nomenclature. In particular, the term "Deprivation of Liberty Safeguards" is viewed widely as unhelpful and it is suggested puts professionals off using the scheme. We have called our proposed new scheme "protective care".

Our general approach to protective care

The new scheme of protective care will apply to hospital, care home, supported living, shared lives and domestic accommodation. However, the nature of the safeguards will vary according to the particular setting.

People who lack capacity and are living in care homes, supported living and shared lives accommodation be provided with a set of safeguards (called "supportive care"). These are intended to ensure that prevention measures are in place and existing legal rights are being given effect to. There will also be additional safeguards (which we have called the "restrictive care and treatment" scheme) which would apply if a person in such settings requires more restrictive or intrusive forms of care or treatment. This will include individuals deprived of liberty, but also some whose arrangements fall short of this.

A separate scheme would apply to hospital settings and palliative care where, in contrast to long-term care, admissions ordinarily involve shorter stays and an assumption that the person will return home as soon as possible. This is a more streamlined scheme and based around the concept of deprivation of liberty.

Protective care would not be capable of being used to authorise the detention in hospital of incapacitated people who require treatment for a mental disorder. Instead, the Mental Health Act would be amended to establish a formal process and safeguards for such people.

Finally, the new scheme would allow for the authorisation of a deprivation of liberty of a person living in family or other domestic settings. This would be an administrative form of authorisation, and it would no longer be necessary to seek court authorisation in all such cases.

Supportive care

Supportive care offers a protective outer layer for the scheme. It consists of prevention measures, but also recognises the importance of minimising regulatory burdens and resource implications. Therefore, the focus is on reinforcing existing support mechanisms, more than creating new legal machinery.

The safeguards would apply to people living in, or moving into, care home, supported living or shared lives accommodation, and who may lack capacity to consent to their living arrangements. In such cases, the local authority would be required to arrange an assessment regarding the person's capacity to decide where they should be accommodated, or ensure that an appropriate assessment has taken place. There would be no requirement for an "independent assessment" in the DoLS sense. The assessment could be undertaken by anyone that the local authority thinks is appropriate, including social workers or nurses already working with the person.

In the vast majority of cases (where a local authority or the NHS is involved in the person's care) this assessment should have already taken place when the person was admitted to the accommodation or where they lose capacity while in situ. For example the assessment might have been carried out under the

Care Act 2014 in England or the National Health Service and Community Care Act 1990 in Wales. So it should be just a matter of making sure these considerations form part of the existing assessment.

People who fall within the supportive care part of our new scheme will benefit from a number of safeguards, including the appointment of an independent advocate or an "appropriate person". Amongst other matters, advocates and appropriate persons would be tasked with ensuring that the person has access to the relevant review or appeals process (for example the appeals mechanism under the Care Act, the social care complaints system in Wales, or the Court of Protection under the Mental Capacity Act). Supportive care would also require local authorities to:

- keep under review the person's health and care arrangements and whether a referral to the "restrictive care and treatment" scheme is needed; and

- ensure that the person's care plan includes a record of capacity and best interests assessments, sets out any restrictions being placed on the person, and confirms the legal arrangements under which the accommodation is being provided.

In most cases, assessments and ongoing reviews will already be happening, for instance through the Care Act in England, the community care process in Wales, and the requirements of best interests decision-making under the Mental Capacity Act. In such cases it would simply be a matter of the local authority linking with existing reviews to discharge this responsibility.

Restrictive care and treatment

The restrictive care and treatment scheme provides the direct replacement for the DoLS. But, importantly, it is not organised around deprivation of liberty. Instead it looks at whether care and treatment arrangements are becoming sufficiently intrusive or restrictive to justify enhanced formal safeguards. This will include those deprived of liberty, but will also include some whose arrangements fall short of this.

A person would be eligible if:

- they are moving into, or living in, care home, supported living or shared lives accommodation;

- some form of "restrictive care or treatment" is being proposed; and

- the person lacks capacity to consent to the provision of the "restrictive care or treatment".

The meaning of restrictive care and treatment would be determined by reference to an illustrative list. The list would include care and treatment where the person is subject to continuous supervision and control or is not free to leave. It would also cover instances where the person either is not allowed, unaccompanied, to leave the premises, or is unable, by reason of physical impairment, to leave those premises unassisted. It also refers to cases where barriers are being used, the person's actions are controlled, the person objects, or significant restrictions are being placed on diet, clothing or contact.

The restrictive care and treatment scheme would be based around a revised role for the Best Interests Assessor (known as the "Approved Mental Capacity Professional" (AMCP) under our proposals). The local authority would be required to refer cases to an AMCP. The AMCP would be required either to undertake an assessment themselves or to arrange for such an assessment to be undertaken by a person already involved in the person's care (for example, their social worker or nurse). AMCPs would be in the same position legally as Approved Mental Health Professionals. In other words, they will be acting as independent decision-makers on behalf of the local authority.

If the person met the criteria, an Approved Mental Capacity Professional would be required to ensure that:

- the decision-making processes and care arrangements continue to comply with the Care Act, Mental Capacity Act and continuing health care regulations;
- regular review meetings take place (involving the family); and
- an advocate or appropriate person, and representative have been appointed.

There would be no parallel processes or documentation as everything would be contained within the overall Care Act, Mental Capacity Act or NHS continuing health care processes. The AMCP would have the power to include conditions and make recommendations regarding the care plan.

Right to Appeal

Within this scheme there would be a right for the person (as well as the AMCP, family members, advocates and appropriate persons) to seek reviews of the care plan and apply to the First-tier Tribunal. There would be a right to appeal the decisions of the tribunal to the Upper Tribunal or the Court of Protection.

Deprivations of liberty

Restrictive care and treatment would include the deprivation of liberty of a person who lacks capacity in their best interests. Any such deprivation of liberty should first be authorised expressly by the care plan. The AMCP would need to confirm that objective medical evidence had been secured. The care plan would therefore become sufficient authority for the care provider named in the plan to deprive the person of liberty if necessary, in accordance with the terms of the plan. The duration of the authority would be set by the review date (with a limit of 12 months) and there would be a right of appeal to the tribunal. The scheme could authorise a deprivation of liberty in family and other domestic settings, as well as those living in care home, supported living or shared lives accommodation.

Hospital settings

A separate scheme would apply to authorise deprivation of liberty in hospital and palliative care settings. Under it, we propose that a person may be deprived of liberty for up to 28 days in a hospital setting based

on the report of a doctor. A responsible clinician must be appointed for any such patient, as well as an advocate and appropriate person. Further authorisations for a deprivation of liberty would require the agreement of an AMCP. The person and anyone else on their behalf may apply to the judicial body for review of the decision to deprive the person of liberty.

Mental health care and treatment

There would be a new mechanism under the Mental Health Act to enable the admission to hospital of people who lack capacity and who are not objecting to their care and treatment. The safeguards provided would include an independent advocate, a requirement for a second medical opinion for certain treatments and rights to appeal to the mental health tribunal. The Mental Capacity Act (and our new scheme) could not be used to authorise the hospital admission of incapacitated people who require treatment for mental disorder.

Conclusion

The Law Commission's consultation paper contains over 100 provisional proposals and consultation questions. Some (but not all) have been outlined in this article. It is important to emphasise that these represent our initial view about how the law should be reformed and we will be reviewing these proposals on the basis of the responses to this consultation paper.

We will be undertaking a wide consultation process in order to gather as many different views and as much information as possible. We welcome responses from all interested parties, including readers of this newsletter. Details of how to respond can be found on the inside front page of the consultation paper or contact me directly (see email below).

The next stage will be to produce and submit a report by the end of 2016 to the Lord Chancellor. Taking into account the responses we receive to this consultation paper, the report will contain our final recommendations and the reasons for them. A draft bill, giving effect to our final recommendations, will also be included.

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Re X: the Court of Appeal pronounces

Re X (Court of Protection Procedure) [2015] EWCA Civ 599 (Court of Appeal (Moore-Bick, Black and Gloster LJJ))

Article 5 ECHR – Deprivation of Liberty

The vexed question as to whether P needs to be a party to proceedings for authorisation of deprivation of liberty has now been answered, although not in the fashion that we might have expected.

In a detailed and very lengthy (45 page) judgment, the Court of Appeal has held that it did not have jurisdiction to hear the appeals brought against the decisions in *Re X Nos 1 and 2* [2014] EWCOP 25 and [2014] EWCOP 37. In essence this was because the Court of Appeal considered that the President had not in fact made any decisions against which an appeal could lie. All the members of the Court of Appeal identified, in different ways, the difficulties with the route that the President had adopted in terms of undertaking what was "*in substance a consultative exercise intended to promote the development of new rules of procedure*," which was not something that the court was entitled to undertake (paragraph 146, per Moore-Bick LJ).

Importantly, however, all three of the members of the Court of Appeal made clear, in different ways, that the President's conclusions (at least as regards Article 5) could not, in consequence, be considered authoritative (this is expressed most clearly by Gloster LJ at paragraph 127).

Further, and equally – if not more – importantly, all three members of the Court of Appeal made clear that those conclusions were flawed. Whilst, strictly, these conclusions are obiter, they were very strongly expressed, Black LJ making clear that her 50 paragraphs of analysis on this point were firmly what she would have decided had the court had jurisdiction. We therefore anticipate that very considerable weight would be placed upon them by any subsequent court considering (for instance) a challenge to the '*Re X* procedure.'

All three members of the Court of Appeal were clear that, at least as the Court of Protection is currently constituted, both fundamental principles of domestic law and the requirements of the ECHR demand that P be a party to proceedings for authorisation of deprivation of liberty:

The key paragraphs from each of the judgments are set out below.

Black LJ

1. "*it is generally considered indispensable in this country for the person whose liberty is at stake automatically to be a party to the proceedings in which the issue is to be decided. The President's conclusion that it was unnecessary for this to be so in relation to an adult without capacity appears therefore to run counter to normal domestic practice. It might, therefore, be thought to require very firm foundations if it is to be regarded as acceptable*" (paragraph 86);

2. "*Article 5 is not, of course, drafted in terms which reflect our domestic procedure and practice and nor does the jurisprudence of the ECtHR speak in those terms. It is not surprising therefore that it is not said explicitly that a person whose liberty is the subject of proceedings must be a party to those proceedings. It is necessary to consider the substance of what is said in the Article and the decisions concerning it and to determine how the required guarantees can be delivered in the procedural framework of the domestic legal system*" (paragraph 93);

3. "*What is essential is that the person concerned 'should have access to a court and the opportunity to be heard either in person or, where necessary, through some form of representation'. In so far as special procedural safeguards are required because the person is not fully capable of acting for himself, they are there to secure the right and must not impair the 'very essence' of it.*" (paragraph 94);

4. "*I can accept that, in theory, P need not always be a party to the proceedings if his participation in them can reliably be secured by other means. The question is, however, whether this can be done and, more importantly, whether the streamlined procedure contemplated by the President could be sufficiently relied upon to achieve it. In considering this, it has to be borne in mind that the President was establishing a process which was to be universal. It would be translated into action by many who were expert and efficient but, inevitably, also by some who were lacking in time or expertise or judgment.* […] I *am not suggesting bad faith on the part of those involved in the process, merely acknowledging the pressures and realities of everyday practice*" (paragraph 96);

5. "*The problem with the President's scheme, in my view, is at least twofold. First, it is heavily dependent upon P conveying a wish to be joined in the proceedings or opposition to the arrangements proposed for him, or someone else who has his interests at heart taking these points on his behalf. Secondly, it depends entirely on the reliability and completeness of the information transmitted to the court by those charged with the task. In many cases, this will be the very person/organisation seeking authorisation for P to be deprived of his liberty and the possibility of a conflict of interest is clear*" (paragraph 100);

6. Especially given the limitations with the consultation process contained in Annex C to the *Re X* forms, and the challenges of consulting with a person of impaired capacity, "[i]*t is not appropriate, in my view, for P's participation in proceedings to turn in any way upon whether he wishes to participate or indeed upon whether he expresses an objection to the form of care that is being provided or proposed. There is too high a risk of slip ups in such a scheme. Article 5 requires a greater guarantee against arbitrariness*" (paragraph 103).

7. "*I do not go so far as to say that no scheme in relation to deprivation of liberty would comply with Article 5 unless it provided for deprivation of liberty proceedings in which P was formally a party. The Schedule A1 procedure (with the initial authorisation conferred by the local authority but with provision for a challenge under section 21A) has been accepted as providing appropriate safeguards in relation to deprivation of liberty and I entirely accept that it could be extended to cover a wider category of case. Furthermore, I accept that it might be possible to take the best of that procedure and to devise a less complex process which will still protect those whose liberty is in the balance. I cannot agree with the President, however, that the streamlined scheme he devised provides the elements required for compliance with Article 5. I stress that I am only concerned, at present, with whether P must be a party to the deprivation of liberty proceedings. Given the tools presently available in our domestic procedural law, I see no alternative to that being so in every case*" (paragraph 104, emphasis added);

8. Under the President's scheme, "*which amounts to placing an additional hurdle in the way of P participating in the proceedings – instead of being a party automatically, there is an additional process to be gone through before he is joined, namely the collection/provision of material to persuade the court that he wishes/needs to be joined… P therefore in a position which is the opposite of what the Strasbourg jurisprudence requires, namely that the essence of the Article 5 right must not be impaired and there might, in fact, need to be additional assistance provided to P to ensure that it is effective*" (paragraph 107);

9. Even if the consequence were to be greater pressure on resources and delay, such were not material to a determination of whether there are adequate safeguards to satisfy Article 5. "*For the reasons I have explained, had I been in a position to determine the issue in these proceedings, I would have held that in order that deprivations of liberty are reliably subjected to thorough scrutiny, and effective procedural safeguards are provided against arbitrary detention in practice, it is presently necessary for P to be a party in the relevant proceedings*" (paragraph 108).

Gloster LJ

10. "*I am supported in this conclusion* [that the President's opinions are not authoritative] *by the views of Lord Justice Moore-Bick and Lady Justice Black, with which I agree, that in any event the President's conclusion - that a patient need not be made a party in order to ensure that the proceedings are properly constituted (even though he may be joined as a party at his request) - is* not *consistent with fundamental principles of domestic law and does not provide the degree of protection required by the Convention and the Strasbourg jurisprudence*" (paragraph 127)

Moore-Bick LJ

11. "*In order to obtain a decision which binds a person of full age and sound mind it is necessary to make him a party to the proceedings and in the light of the approach adopted in Cheshire West, it is* difficult *to see why the same should not be true of a person who lacks capacity, despite the fact that he must act by a litigation friend, when his liberty is at stake*" (paragraph 170);

12. "*The decision in Winterwerp v The Netherlands (1979) 2 E.H.R.R. 387 makes it clear that a person who lacks capacity must have access to a court and an effective opportunity to be heard, either in person or by means of representation. The fullest right to participation in proceedings is that which is enjoyed by the parties, but the streamlined procedure envisaged by the President contemplates that there will be cases in which a person lacking capacity will not be made a party because someone considers that it is unnecessary for that step to be taken. I agree with Black L.J. for the reasons she gives that a procedure under which such a person need not be made a party in order to ensure that the proceedings are properly to constituted (even though he may be joined as a party at his request) is not consistent with fundamental principles of domestic law and does not provide the degree of protection required by the Convention and the Strasbourg jurisprudence*" (paragraph 171).

It is perhaps important to note that the Court of Appeal did not express any view upon the two other

questions that were formally before it on the appeal, namely (1) whether in all cases an oral hearing is required; and (2) whether a litigation friend must act via a solicitor (unless they are themselves entitled to do so). However, given the manner in which the Court of Appeal expressed themselves in relation to the President's judgments, it can properly be said that the President's conclusions in this regard must also be seen as the expression of opinion rather than authoritative decisions (indeed, strictly, extra-judicial opinion).

Comment

The unusual saga that is *Re X* has reached a suitably unusual conclusion.

Quite where this leaves practitioners and the Court is, at present, not entirely clear. In particular, it is not entirely clear whether, given the effect of the coming into force of Rule 3A of the Court of Protection Rules (discussed in our Practice and Procedure Newsletter), it will necessarily be the case that P must, in fact, be joined as a party in every application for orders authorising a deprivation of liberty.

It might potentially, be that other directions could be made under Rule 3A(2) (for instance the appointment of a representative or an accredited legal representative upon the creation of a panel of such representatives) who can secure P's participation in such a way as to secure protection of their rights. It should perhaps be noted that the draft of Rule 3A was, in fact, before the Court of Appeal, although no reference was made to it by any of the members of the court.

We provide further guidance as to the steps that public authorities should take in our updated Guidance Note on judicial authorisation of deprivation of liberty. We can also provide advice on specific cases or issues of concern (including block listing of applications): please email Peter Campbell: peter.campbell@39essex.com.

Not quite MIG (aka duck-spotting for beginners)

Bournemouth Borough Council v PS & DS [2015] EWCOP 39 (Mostyn J)

Article 5 ECHR – Deprivation of liberty

Summary

Ben was 28 years old. He was on the autistic spectrum, had mild learning disability, and needed continuous care. Since 2011 he had been living in a two-bedroom bungalow with staff, 24 hours a day. There was constant observation and monitoring. He was assisted with personal care and encouraged to engage in a timetable of daily tasks. Due to previous risky incidents, Ben was not allowed to access the kitchen when staff were cooking; during this time he had free unsupervised access to all parts of the bungalow and garden. All kitchen utensils and medication were locked away. And when staff were not cooking, he could go into the kitchen but only with staff. He was given complete privacy to masturbate in his bedroom when

he wished.

With no sense of road or traffic awareness, one to one staff support was required at all times in the community. Sensors would alert staff if Ben sought to leave the bungalow by himself, although he had never tried. But if he did leave, staff would follow him, attempt to engage with him and monitor him in the community. If he did not want to return home, an escalation of measures would be used, which if unsuccessful ultimately would lead to consideration being given to calling the police to exercise their powers under s 136 of the Mental Health Act 1983. Past sexually inappropriate incidents in public toilets meant that staff had to be nearby when he used them.

Ben's wishes fluctuated between wishing to return to hospital, where everything was done for him, to wishing to live with his mother. Neither option was possible. Indeed, contact with his mother only took place on a monthly, supervised basis, although this was to be increased and reviewed to see whether it could be unsupervised. The issue was whether Ben was deprived of his liberty. He had been discharged as a party. But his wishes and feelings were made known by a court-appointed independent mental capacity advocate.

Mostyn J summarised the earlier decisions in *Rochdale* and *Tower Hamlets*, addressing some of the concerns expressed in our commentaries. One important aspect of the analysis concerns the freedom to leave limb of the acid test. His Lordship noted:

> *21. In the Rochdale case I decided that the protected person, a lady aged 52 who was severely mentally incapacitated, cared for round the clock in her own home, was not in a position of being detained by the state either legally, literally or philosophically. I decided on the facts at para 25 that "she is not in any realistic way being constrained from exercising the freedom to leave, in the required sense, for the essential reason that she does not have the physical or mental ability to exercise that freedom." In that regard I followed the definition of what constitutes freedom to leave as spelt out in JE v DE and Surrey County Council [2006] EWHC 3459 (Fam) [2007] 2 FLR 1150 by Munby J at para 115, which to my mind had been implicitly approved in the Supreme Court at para 40. That definition is: "leaving in the sense of removing [herself] permanently in order to live where and with whom [she] chooses".*

His Lordship observed that the "i*ntensive support and care a person requires to meet their to meet their needs plainly does engage Article 5 ECHR, but not necessarily in the way suggested by the advocates of the term-of-art definition promulgated by the Supreme Court. Rather, it engages and gives effect to the right to security mentioned in that Article*" (emphasis in original). Ultimately, whether the circumstances satisfy the acid test was likely to be determined by the "I know it when I see it" legal technique. Or, using the zoological metaphor attributed to the American Poet, James Whitcomb Riley, "*when I see a bird that walks like a duck and swims like a duck and quacks like a duck, I call that bird a duck*" (para 29).

Mostyn J held that Ben was not deprived of his liberty:

> "*33. I cannot say that I know that Ben is being detained by the state when I look at his position. Far from it. I agree with Mr Mullins that he is not. First, he is not under continuous supervision. He is afforded appreciable privacy. Second, he is free to leave. Were he to do so his carers would seek to persuade him to return but such*

persuasion would not cross the line into coercion. The deprivation of liberty line would only be crossed if and when the police exercised powers under the Mental Health Act. Were that to happen then a range of reviews and safeguards would become operative. But up to that point Ben is a free man. In my judgment, on the specific facts in play here, the acid test is not met. Ben is not living in a cage, gilded or otherwise.

…

40. I do not criticise this local authority in the slightest for bringing this case. In the light of the decision of the Supreme Court local authorities have to err on the side of caution and bring every case, however borderline, before the court. For if they do not, and a case is later found to be one of deprivation of liberty, there may be heavy damages claims (and lawyers' costs) to pay. I remain of the view that the matter needs to be urgently reconsidered by the Supreme Court."

Comment

Many may empathise with his Lordship's call for the acid test to be revisited at the highest level. But unless and until that happens, the Supreme Court's approach to duck-spotting rules. Indeed, the intensity of Ben's care regime appears to be far greater than that of MIG in the Surrey case. Why she was deprived and Ben was not is therefore difficult to reconcile. Both factual situations walk, swim and quack in a similar fashion. Similarly, according to Lord Kerr in the majority, freedom to leave did "*not depend on one's disposition to exploit one's freedom.*" Again, this is difficult to reconcile with para 25 of the *Rochdale* decision. The "plan" for returning Ben to the bungalow was far more robust than that in any of the three cases before the Supreme Court.

The case also illustrates the potential impact of the Court of Appeal's decision in *Re X* that was handed down two weeks after his Lordship's decision. It now appears that the person must be joined as a party to deprivation of liberty proceedings in every case (paras 104 and 108). As discussed in the Practice and Procedure Newsletter, it may be that a different direction can be made under Rule 3A (with effect from 1 July 2015), a rule in contemplation by his Lordship. At present, it may be that what Mostyn J did would not satisfy the Court of Appeal as being ECHR compliant. If Ben did have to be a party (which Alex for one would doubt is compelled by the observations in *Re X*), Ben's financial circumstances vividly illustrate the unfairness that would have otherwise resulted. Had he been joined as a party, owing to his savings it appears he would have had to pay his legal costs. Why the most vulnerable members of society have to pay the costs incurred in the State acting compatibly with Article 5 remains a mystery.

All of this simply indicates why the Law Commission's consultation does not come a moment too soon.

A clash of cultures?

St George's Healthcare NHS Trust v P &Q [2015] EWCOP 42 (Newton J)

Best interests – Medical treatment

Summary

P had a long history of kidney problems and had required regular dialysis. In November 2014, he suffered a cardiac arrest which caused his brain to be starved of oxygen for around 25 minutes. He sustained a severe brain injury. Around a month later, his treating clinicians applied to the court for declarations that it was in P's best interests not to escalate his care, and to withdraw elements of the life-sustaining treatment he was receiving, on the basis that P was in a vegetative state. P's family disagreed, and in due course (after the application had been made) further clinical assessment revealed that P was in a minimally conscious state. P's treating clinicians still maintained that it was not in his best interests for dialysis to be continued. The court disagreed – the prospects of recovery to independence, or even to a reliable level of functional communication, were slim. But P's wishes, although not written down or directed to the specific circumstances he found himself in, were 'highly relevant'. In particular, the court noted that:

> *(1) Prior to his injury he told his cousin that he did not agree that people should be assisted to die, and that a life was no less valuable or less worth living if a person was chronically disabled or ill. That was powerfully confirmed by his cousin in evidence.*
>
> *(2) P was a deeply religious man. He strongly believed that life was sacred given by God and could only be taken away by God.*
> *(3) As a Sunni Muslim he believed that suffering was a component of predestination and someone else should not play an assisting role in shortening life merely because of the subjective quality of that life. It is against the tenet of his faith to do anything to shorten a life.*
> *(4) He had powerful wishes and feelings which were well expressed and which should not be supplanted or substituted by anyone else's view.*

Thus, the court concluded that "*the preservation of any life would be considered by P to be of significant value. His present circumstances are a life which P would find worthwhile, even though I entirely accept many others would not adopt the same position*." As a result, the declarations and orders sought by the hospital were not granted.

Comment

This case is an interesting illustration of the impact on end-of-life decision making of the Supreme Court decision in *Aintree*. Viewing the best interests test from this particular P's perspective means respecting P's wish to be kept alive in any state, just as much as it means respecting another P's wish not to be kept alive. Futility had been thought post-*Aintree* still to be a concept that was predominantly clinical (i.e. it was a clinical rather than value judgment as to whether the procedure in question would work). This judgment might on one view be seen as encroaching further into the sphere of clinical decision-making here, although it is important to note that it became clear during the course of the case that the clinicians did not, in fact, pin their colours to the mast of 'futility,' but rather on the basis of a (good faith but incorrect) interpretation of what they thought the patient would have wanted (paragraph 35)). The case undoubtedly emphasised the importance of viewing matters through the eyes of the patient as regards the evaluation of whether the treatment was either overly burdensome and whether it would result in even a severely compromised quality of life that the patient would nonetheless regard as worthwhile. The implications of this approach, entirely in line with that in *Aintree* are significant, not just for patients, but in

respect of wider issues concerning the application of scarce resources.

In this regard, it should also be noted that the judge was critical of the Trust for having brought the application relatively shortly after patient suffered the hypoxic brain injury, and before a SMART assessment had been carried out. Newton J emphasised the case was "*yet another stark example of the absolute necessity for a structured assessment to have occurred before any application is even contemplated. I have been told in this and in other cases that misdiagnosis (of people who are said to be in a vegetative state but are in truth in a minimally conscious state) occurs in a remarkably high number of cases, the rate of misdiagnosis is said to be some 40%. That is not to say that in any way any male fides attaches to the treating clinicians. In this, as in every other case which I have heard, I have the utmost respect both as a human being and as a professional judge to the care with which they apply themselves, to these most difficult issues of which this is just such an example. Without a rigorous evidential analysis real mistakes can be made*" (emphasis in the original).

The cases in which a SMART assessment has previously been said to be required by the court are primarily cases concerning applications to withdraw ANH, where the individual has been suffering from a disorder of consciousness for some time. It is not clear that the Royal College of Physicians' Guidance on Prolonged Disorders of Consciousness requires such formal assessments to be carried out where clinicians are making decisions about escalation of treatment of a patient in intensive care within a matter of weeks after injury. Reliable diagnosis within a period of a few weeks or months may not be possible, even with the use of structured assessments, yet decisions will need to be taken as to what treatments to provide. The 'window of opportunity' for prompt decision-making in P's best interests may be further threatened if the court requires long term formal assessment in every case (see the 2013 article by J Kitzinger & C Kitzinger '*The 'window of opportunity' for death after severe brain injury: Family perspectives*' *Sociology of Health and Illness* 35(&), pp. 1095-1112).

This case therefore exemplifies the real dilemmas facing treating Trusts as to when, and on what basis, they are to bring applications relating to withholding or withdrawing life-sustaining treatment. Leave it too "late," and they are criticised for failing to afford the courts sufficient time to consider the matter carefully (see e.g. *Sandwell and West Birmingham Hospitals NHS Trust v CD* [2014] EWCOP 23); bring it too early, and they run the risk that the declaration is not granted, leaving the treating clinicians in a situation where they can feel (whether or not with reason) that their clinical judgments have been overridden by the court.

Deprivation of liberty in the hospital setting – paper now updated

The paper Alex wrote with Catherine Dobson on this thorny subject has now been thoroughly overhauled and updated and can be found here.

Doing the right thing?

Re Peter Jones [2014] EWCOP 59 (District Judge Eldergill)

Best interests – Property and Affairs – Statutory Wills

Summary

In this case, decided in November 2014, but which only appeared on Bailii very recently, District Judge Eldergill heard an application by deputies for the execution of a statutory will (P being intestate) and one by P's daughter for a substantial lifetime gift. The facts need not concern us but the District Judge usefully summarises the law relating to the making of statutory wills and in particular the thorny issue of how to approach the perceived need to ensure that P is seen to "do the right thing".

He noted that in *Re M, ITW v Z & Ors* [2009] EWHC 2525 (COP), the President did not on the basis that it was somehow the right thing to do make provision in the statutory will for a legacy for J, who was the one person to have maintained a relationship with M and who continued to visit and telephone her. In so deciding, a ''particularly compelling feature'' was that J:

> *''would be gaining a benefit which M, while she had capacity, felt that he did not need and which, it would seem, she still thinks he does not need. How can it be in her best interests to go counter to such long-held views? The only proper answer, it seems to me, would be if it could be said that giving him a legacy was either an appropriate reward for what he is now doing for M or an inducement to him to do more for her; but neither, in my judgment, can be justified in the circumstances as they exist (at para. 57).''*

Paragraphs 62-68 and 70-75 are worth setting out in full

> *62. The Act requires the decision-maker to consider the past and present wishes and feelings of the relevant person, the beliefs and values that would be likely to influence their decision if they had capacity and the other factors that he would be likely to consider if they were able to do so. In my view, where P with capacity has just made a will excluding Y and/or has recently expressed clear views that he dislikes Y, does not want to see Y and does not want Y to share in his estate, and P is then incapacitated by a stroke, in ordinary circumstances it would be inappropriate to make use of his incapacity to now make a Will in favour of Y simply because the decision-maker believes he ought to have done so.*
>
> *63. Taking such an approach would run counter to testamentary freedom and the wishes, feelings, beliefs and values provisions of the Mental Capacity Act 2005 and lead to inconsistent and arbitrary outcomes. In the example just given, if P is not struck down by a stroke then — subject to the limits imposed by the Inheritance (Provision for Family and Dependants) Act 1975 — he is fully entitled to be as unappreciative of Y''s merits and needs as he wishes and Y gets nothing. If he is struck down by a stroke a third-party decision-maker can ''correct'' his wish not to leave anything to Y (and his clear wish not to be remembered with any greater affection by Y than he felt for Y) by substituting their own view or society's view as to what P ought rightfully to have done.*

64. As Baroness Hale made clear in Aintree, the purpose of the best interests test is to consider matters from the particular individual's point of view. Occasionally there may be circumstances such as those referred to by the President or the avoidance of post-death litigation which justify departing from a person's clear past and present wishes and beliefs. However, in the ordinary case the Mental Capacity Act is not a vehicle for imposing on people views, wishes and feelings that clearly are contrary to those they held before losing capacity, do not hold now and would not hold if they regained capacity, however right those views may be, and however unworthy P''s views are according to most people's standards.

65. The onset of mental incapacity is not an opportunity for moral correction.

66. That still leaves room, of course, for the case at the other end of the spectrum where the court authorises a statutory Will which makes good the omissions of P but does not seek to correct their considered acts and decisions. For various reasons all of us never quite get round to doing many of the things we know we ought to do. Making a Will may be one of them. Most people would wish to make a Will if they knew both that they were going to be incapacitated by a stroke tomorrow and the consequences of dying intestate or leaving a defective Will. They would seek to avoid the sometimes arbitrary nature of intestacy, the consequences of dying intestate on those dear to them, the resulting inconvenience and worry for their family, the possibility of family discord and avoidable litigation arising from a failure to make clear their intentions.

67. Thus, in the absence of clear evidence to the contrary, one is entitled to assume that had P given proper thought to their pending incapacity and intestacy he or she would have wanted to put their house in order and make a Will. They would want to do the right thing and not to leave family members with such unintended consequences and problems. Hence, it seems to me, the case law emphasises that adult autonomy is not the only consideration and that in many cases and for many people it is in their best interests that they be remembered with affection by their family and as having done ''the right thing'' by a Will.

68. That is a long-winded way of saying that in the absence of evidence to the contrary most people want to do the right thing by their family and loved ones and a judge is entitled to take that view, in the absence of evidence to the contrary and any relevant legal considerations.

[…]

70. At one stage I thought that there might have been a difference of opinion or emphasis as to what is meant by the phrase ''substituted judgement''.

71. "Substituted judgement" is a principle which holds that surrogate decisions should be made by establishing as accurately as possible the decision which the incapacitated person would have made for themselves if they had capacity. Section 4 states that it is one of the things for the judge to consider.

72. The Law Commission argued that ''best interests'' on the one hand and ''substituted judgment'' on the other were not in fact mutually exclusive. It favoured a ''best interests'' criterion which contained a strong element of ''substituted judgment'' (Law Com No 231, para 3.25).

73. A main reason for rejecting a pure substituted judgement test was not that the views, beliefs and values of an incapacitated person are unimportant but that they are important (Law Com No 231, para 3.29):

> *"One of the failings of a pure 'substituted judgment' model is the unhelpful idea that a person who cannot make a decision should be treated as if his or her capacity were perfect and unimpaired, and as if present emotions need not also be considered."*
>
> *74. One must take into account and give weight to the person''s present wishes and feelings, and what they now view as important, and not just the values and beliefs which they held when they had capacity, even if more objective.*
>
> *75. Furthermore, as the Commission noted when rejecting a pure substituted judgment approach, if a person has never had capacity then 'substituted judgment' is impossible and there is no viable alternative to a best interests approach.*

In the end, the District Judge ordered the execution of a statutory will that left 75% of P's estate to his wife and 25% to his daughter with a substantial advancement by way of a lifetime gift (broadly following the suggestions made on P's behalf by the Official Solicitor).

Comment

Although a decision which, strictly, has no precedent value, we anticipate that, as with many other decisions by District Judge Eldergill, both practitioners and members of the judiciary will refer in future to the clear summary of the law at paragraphs 62-68. We suspect the ringing statement at paragraph 65 is likely also to feature in many a training session.

Paragraphs 72-75 will also, we suspect, be pored over as we grapple with what the Convention on the Rights of Persons Disabilities means when it demands that we ensure 'respect for the rights, will and preferences' in any legal procedures invoked in relation to persons said to be unable to take their own decisions (as to which see further the next case note)

Short Note: what place wishes and feelings?

In *GN v Julia Newland* [2015] EWCOP 43, Senior Judge Lush dealt with an application by one of P's sons to reconsider the appointment of a solicitor as P's deputy. The application had been dealt with on paper by an authorised court officer and GN had not been notified.

The reason why he had not been notified was that P, who was suffering from Alzheimer's disease, had expressed the view that she did not want GN to have anything to do with her financial affairs or be involved in her life.

The Senior Judge held that the decision not to notify had been correct and refused to revoke the order appointing Ms Newland deputy. The principal reason for both decisions was P's expressed wishes.

In that regard, Senior Judge Lush emphasised sections 4(4) and 4(6)(a) MCA along with Article 8 of the European Convention on Human Rights which provides that everyone has a right to respect for his or her

private and family life, home and correspondence stating that this includes the right to respect someone's refusal to let a particular relative have anything to do with them or the management of their property and financial affairs and the United Nations Convention on the Rights of Persons with Disabilities, which it ratified on 7 August 2009. Article 12.4 of the Convention which states that:

> *"States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests."*

Senior Judge Lush noted that: "*If I were to allow GN's application to manage his mother's property and affairs, I would be failing in my duty to act in CN's best interests under both domestic law and international human rights law by disregarding her rights, will and preferences and by facilitating an appointment in which there is such a clear conflict of interest*."

Short Note: reappointment of attorneys

Nugee J has just (1 July) allowed an appeal against the decision of Senior Judge Lush in *Re M* noted in our December 2014 Newsletter, and reported at [2014] EWCOP 40. The Senior Judge had severed parts of a LPA that sought to reappoint a joint attorney as sole attorney in circumstances where one of the joint attorneys was unable or unwilling to continue to act.

The Senior Judge had ruled that s.10(4) MCA did not allow that. He had suggested that the way around the problem was to execute 2 LPAs, one to take effect if the other ceased so to do because of the death etc of one of 2 joint attorneys.

Nugee J held that that was too restrictive an interpretation of the legislation and that one instrument could be used to appoint joint deputies with survivorship.

This is a pragmatic and welcome decision. A fuller note will appear when the judgment has been published.

New LPA Forms

A reminder that from 1 July 2015, there are new LPA forms for both property and affairs and welfare.

The new forms are available on the Gov UK website.

You can still use the old forms until 1 January 2016.

All change at COP Towers

The remainder of the first round of COPR rule changes came into force on 1 July: an unofficial compilation of the amendments with a commentary by Alex can be found here (and the most recent issue of the Elder Law Journal includes an article by him explaining the background and thought processes in more detail).[1] They are also accompanied by new Practice Directions, available here.

Perhaps the most important change is the introduction of a new Rule 3A. It is accompanied by a new Practice Direction 2A. Rule 3A is intended to be the response to the developments in Strasbourg case-law making clear the importance of procedural safeguards in proceedings in which an individual is either (1) to be declared to lack capacity in one or more domains; (2) to be the subject of substitute decision-making. For more detail on this, see the excellent report by Lucy Series entitled 'The participation of the relevant person in proceedings before the Court of Protection.'

In summary form, Rule 3A (which is accompanied by a substitute Part 17), requires in each case the Court to consider, either on its own initiative or on the application of any person, consider whether it should make one or more of one of a 'menu' of directions relating to P's participation. That menu includes:

1. P being a party;

2. P's participation being secured by the appointment of a representative whose primary function is to give P a 'voice' by relaying information as to P's wishes and feelings;

3. Specific provision for P to address (directly or indirectly) the judge determining the application; or

4. No direction or an alternative direction (meeting the overriding objective) if P's interests and position can properly be secured.

Rule 3A has deliberately been placed at the start of the Rules to emphasise the shift in focus from the previous iteration, where the position of P was much less expressly catered for (and, indeed, was only expressly provided for in Rule 73(4), providing that P was not to be a party unless the Court ordered otherwise).

Equally importantly, assuming that the necessary steps are taken to enable this to happen by way of the creation of a panel of such representatives, Rule 3A provides that a direction may be made appointing an accredited legal representative ('ALR') to represent P. This can be done whether or not P is a party; importantly, if P is a party, then an ALR may be appointed without a litigation friend being appointed to act for P. This innovation, drawn from Rule 11(7) of the Mental Health Tribunal Rules, is designed to supplement, not supplant, the role of litigation friends; the intention (as spelled out in the accompanying Practice Direction, 2A) is that ALRs can provide assistance where urgent orders are required and it is not

[1] This note draws upon that article; whilst Alex was a member of the Ad Hoc Rules Committee, this note is written in a personal capacity.

possible to appoint a litigation friend. They may also play an important role in 'narrow' applications such as applications under s.21A MCA 2005, thereby allowing the resources of litigation friends – whether the Official Solicitor or otherwise – to be reserved for more complex cases where, for instance, expert evidence will be required.
The provisions in Rule 3A and Part 17 relating to ALRs are unusual because, as at the time of writing, they relate to a panel which does not exist. The expectation is that the Law Society will take the lead role in accreditation (as they do in relation to Mental Health Tribunal representatives), but at the time of writing, has only taken preliminary steps in this regard.

Rule 3A was – deliberately – written in such a way that it can survive a failure to bring about a panel. It was also – equally deliberately – written in such a way that was (as much as possible) future-proof as regards case-law developments. The developments in *Re X* discussed in the Health, Welfare and Deprivation of Liberty Newsletter show that this may have been a wise course of events.

Rule 3A needs to be read both with Part 17 and the amendment to Rule 95, the latter of which clarifies that the court can admit, accept and act upon such information, whether oral or written, from P, any protected party or any person who lacks competence to give evidence, as the court considers sufficient, although not given on oath and whether or not it would be admissible in a court of law apart from this rule. This amendment picks up – belatedly – the decision of McFarlane J (as he then was) in *Enfield LBC v SA* [2010] EWHC 196 (Admin) and the 'work around' he gave there as to the admissibility of evidence from P.

Finally, it should be noted that there is (deliberately) is no specific mention in the rules of capacity to choose a representative (i.e. not an ALR); there may well be analogies here with the position considered in the context of the Mental Health Tribunal, *YA v CNWL NHS Trust & Ors* [2015] UKUT (AAC)). If P has the capacity to choose a representative, it would be very unlikely indeed that the court would wish to appoint a representative in whom P did not have trust (not least because such a representative would be most unlikely to be able to fulfil their functions of relaying P's wishes and feelings to the court).

Update to Practice Direction: Committal for Contempt – Open Court

Practice Guidance was issued by the Lord Chief Justice on 24 June to "answer[…] various questions which have arisen on the application and interpretation of the Practice Direction: Committal for Contempt - Open Court, dated 26 March 2015 (the Committal PD)." Of most immediate relevance is the useful pro forma for judgments made upon committal to The guidance also confirmed that the operation of the Practice Direction will be subject to review in October 2015.

Short Note: the power of the inherent jurisdiction

In *O v P* [2015] EWHC 935 (Fam), a case from earlier this year which only recently came to our attention, Baker J considered an application in wardship proceedings, or alternatively under the court's inherent jurisdiction, which would have the effect of amending an existing injunction previously made in the wardship proceedings and extending its duration beyond the ward's 18th birthday in circumstances where there was a real risk posed to her and her mother by her father, who had previously abducted her from the

country, and also twice been convicted of offences of incitement to solicit the murder of her mother. The ward and her mother were now in Australia.

The mother sought an extension of the protective orders made in the wardship proceedings. This was resisted by the father.

Baker J held that he had "no doubt" that the court has the power to grant the orders sought on behalf of the applicant and that an order should be made in this case. His reasons were set out at paragraph 27 as follows, and merit reproduction in full:

> "*(1) In my judgment, an order made during the currency of wardship proceedings may be extended following the 18th birthday of the child or young person. The dicta of Thorpe LJ in Re F* [(Adult: Court's Jurisdiction) [2001] Fam 38]*, are of general application. Where a court has ruled that a young person is at risk of harm, and has granted an injunction to protect her from that risk, it must have the power, as part of the protective measures available in wardship and under the inherent jurisdiction generally, to extend that protection beyond the young person's 18th birthday. The origins of wardship lie in the parens patriae role of the Crown. In the exercise of parental responsibility generally, decisions are often taken for the benefit of young people that extend into adulthood. In most cases, parents – and the court – stand back to allow young people to make decisions for themselves. In some cases, however, young people need continuing help and protection beyond their 18th birthdays. In such circumstances, parents continue to exercise responsibility, and this court under its inherent jurisdiction, must be prepared to do so if required.*
>
> *(2) This principle is reflected in the dicta of Munby J in Re SA* [[2006] EWHC 2942 (Fam)] *quoted above. Although dealing with a different set of circumstances – the need to protect a young woman from the risk of an unsuitable arranged marriage – the learned judge was careful to stress that there is probably no theoretical limit to the jurisdiction and (citing Singer J in Re SK* [[2004] EWHC 3202 (Fam)]*, supra) observed that the jurisdiction must evolve in accordance with social needs and social values. In my judgment, the jurisdiction extends to protect vulnerable young people whether or not they lack capacity. Since the decision in Re SA, society has increasingly recognised that there are many young people who for one reason or another are in need of protection beyond their 18th birthday. Cases of sexual exploitation are but one example. There are, of course, statutory remedies available in many cases, but the inherent jurisdiction is also available to provide protection where appropriate. As Munby J observed in Re SA at paragraph 2 in the passage already quoted,*
>
> > *'A young woman who remains just as vulnerable now she is an adult as she did when she was still a child should not suddenly be deprived with the protection which the court has hitherto felt it necessary to afford her and which I believe is still very much required in her best interests.'*
>
> *I respectfully agree.*
>
> *(3) The European Convention of Human Rights, implemented by the Human Rights Act 1998, has only reinforced that obligation. The court is a public authority and, when exercising its jurisdiction in wardship and under the inherent jurisdiction, must have regard to Articles 2, 6, and 8 when making orders that are needed to protect young people falling within its jurisdiction.*

(4) When, as here, the court has jurisdiction at the start of wardship proceedings on the grounds that the child is habitually resident in England and Wales, that jurisdiction continues until the conclusion of the proceedings, notwithstanding the fact that the ward has become habitually resident elsewhere. That is sufficient to provide jurisdiction in this case for the making of the orders sought by the applicant. In addition, the court may have jurisdiction on the grounds that the ward is a British national. In either case, the question is, as Baroness Hale observed in Re A whether it is appropriate to exercise the jurisdiction in the particular circumstances of the case.

(5) It follows that I reject Mr P's submission that Australia is the only forum for determining an application for protective relief. He further submits that Australia is the appropriate forum on the grounds that all parties are living there. On this point, however, I accept the submission of Mr Lyon that to require either S or the mother to make an application in Australia exposes both of them to the very risks which this court's orders have been designed and intended to avoid.

(6) Having regard to the history, and the evidence I heard during the last hearing as quoted from my 2014 judgment, I am in no doubt that this mother, and indirectly S, remain at very great risk from the man who has twice been convicted of offences involving the incitement to murder the mother, the second conviction relating to an offence committed while he was in prison in Australia and the mother was on the other side of the world in the United Kingdom. The revelation in the course of the hearing in 2014 that the father had obtained photographs that indicated he may be aware of the location of the address of the mother and S has been confirmed by his skeleton argument for this hearing. Although to date the direct threat has been towards the mother, it is in my judgment plain that S remains at risk of emotional harm as a result of that threat. I completely reject the father's reassertion of the argument, made repeatedly in proceedings in this court and in Australia, that he has been motivated solely by a wish to protect S.

28.In my judgment, it is imperative that this court makes the order within the wardship jurisdiction, or alternatively under its inherent jurisdiction to protect vulnerable adults, extending the protection provided hitherto beyond S's 18th birthday. In the circumstances of this case, it is essential that, in order to ensure the protection is extended for S, the mother is also kept within the ambit of the injunction.

The precise order made by Baker J was reproduced at the end of the judgment, and serves both as a useful template and a reminder of the power of the High Court under its inherent jurisdiction to protect those with capacity but vulnerable and in need of the assistance of the court.

Short note: Relief from Sanctions

The appeal in *Re H (Children)* [2015] EWCA Civ 583 raised the following question: "*When considering an application to extend the time for appealing in a family case relating to children, what regard, if any, should be had by the judge to the overall merits of the proposed appeal?*"

The position in civil appeals generally was set out in R (on the application of Hysaj) v Secretary of State for the Home Department [2014] EWCA Civ 1633. In that case, Moore-Bick LJ stated:

"If applications for extensions of time are allowed to develop into disputes about the merits of the substantive appeal, they will occupy a great deal of time and lead to the parties incurring substantial costs. In most cases

> *the merits of the appeal will have little to do with whether it is appropriate to grant an extension of time. Only in those cases where the court can see without much investigation that the grounds of appeal are either very strong or very weak will the merits have a significant part to play when it comes to balancing the various factors that have to be considered at stage three of the process. In most cases the court should decline to embark on an investigation of the merits and firmly discourage argument directed to them. Here too a robust exercise of the jurisdiction in relation to costs is appropriate in order to discourage those who would otherwise seek to impress the court with the strength of their cases."*

The Court of Appeal in the present case considered that it was not necessary on the facts of the case before it to deviate from the general civil law test (set out in *Hysaj*) because it was clear (indeed it was conceded by the respondent) that the grounds of appeal were 'very strong' (in this case unanswerable) and therefore the circuit judge who had heard the appeal at first instance had erred in underestimating the strength of the appeal leading him to attribute no weight real weight to the underlying merits in his relief from sanction analysis.

We suggest that exactly the same principles will apply in relation to applications for extension of time under the (revised) provisions relating to appeals, and from, the Court of Protection.

Short note: HMCTS funding of representation

The Court of Appeal has pronounced in *Re K and H (Children)* [2015] EWCA 543 upon the vexed issue of when HMCTS can be forced to fund representation for litigants in persons in family proceedings, a question of equal relevance before the Court of Protection.
At the heart of this case is a fact finding hearing to determine whether a father had abused a 15 year old girl, Y (the daughter of his partner from a previous relationship). The judge determined that a fact finding hearing was necessary but that it would be inappropriate for the father to cross-examine Y. The judge decided that a legal representative should be appointed for the father (who did not qualify for legal aid as he failed the means test requirements) and that the costs of the legal representative should be paid for by HMCTS.

The Lord Chancellor appealed against the decision with the permission of the judge.

The Court of Appeal concluded that the judge did not have power to order HMCTS to bear the costs of a legal representative for a party outwith the detailed statutory scheme (effectively overruling the decisions of Sir James Munby in *Q v Q* [2014] EWFC 31 and *In re D* [2014] EWFC 39).

The Court of Appeal considered that the father's Article 6 and his and other parties Article 8 rights could be sufficiently safeguarded by the judge conducting the cross examination in such a case. The court also suggested other case management options such as (i) questioning by a justices' clerk; (ii) the appointment of a guardian for the father's children who could question Y.

However, the court did acknowledge that there may be some complex cases where the absence of a legal representative could lead to the proceedings not being compliant with Articles 6 and 8 of the Convention.

The Master of the Rolls therefore suggested that consideration should be given to the enactment of a statutory provision for (i) the appointment of a legal representative to conduct the cross examination and (ii) the payment out of central funds of such sums as appear to be reasonably necessary to cover the cost of the legal representative.

Life-long anonymity orders

In the case of *Birmingham City Council v Riaz & Ors* [2015] EWHC 1857 (Fam), the sequel to the inherent jurisdiction case noted briefly in our February 2015 newsletter, Keehan J confirmed that the High Court has the power under its inherent jurisdiction in a suitable case to make a lifelong Reporting Restriction Order ('RRO'). The case before Keehan J revolved around whether a young woman who had been the victim of Child Sexual Exploitation ('CSE') could be made the subject of a life-long RRO so as to protect her once she turned 18. No party before Keehan J ultimately contested that the power existed. Having conducted the balancing exercise required between the competing Article 8 ECHR rights of the woman and the Article 10 rights of the press and broadcast media, Keehan J concluded that, whilst there was considerable public interest in the press being able to report upon cases of CSE, there was no public interest in identifying the woman in question as a victim of CSE:

> *"42. AB is entitled to respect for her private life. What could be more private and personal than the fact that she has been the victim of CSE? I am satisfied that the fact she has been the victim of CSE is entirely a private and personal matter for AB. If, once she has attained her majority or thereafter, she wishes to make it known that she is a victim of CSE, that must be a matter for her and her alone.*
>
> *45. I have earnestly reflected on this difficult issue of whether I should grant a RRO to afford AB lifelong anonymity. I have taken account of the high priority accorded by Parliament and the courts to the protection of victims and especially to young people.*
>
> *46. I have carefully balanced the competing Article 8 and Article 10 rights. On the basis that I find no public interest in identifying AB as a victim of CSE and I find that there are compelling reasons why AB's history of being a victim of CSE should remain confidential and private to her, I am completely satisfied that the balance falls decisively in favour of granting the lifelong RRO sought by the local authority.*
>
> *47. I further consider that there is a high public interest in supporting the victims of CSE to come forward and report their abuse to the authorities and to co-operate with them. Whilst the issue of lifelong RROs in possible future CSE injunction cases will have to be determined on their own merits, there is a very real risk, in my judgment, that my refusal to grant a RRO in this case, might deter other young victims of CSE from coming forward to the authorities. In principle I propose to make a RRO in favour of AB for her lifetime."*

We suggest exactly the same principles would apply in the event that the Court of Protection is invited to grant a similar injunction.

Short Note: settling can be a prolonged process

In *Re R (A Child)* [2015] EWCA Civ 674, the Court of Appeal confirmed that a person can remain habitually

resident somewhere for many years after they have ceased to have a permanent abode there. In the case before it, the Court of Appeal applied the now well-established principles applicable in family cases under both EU and Hague instruments in a situation where a woman had ceased to have permanent residence in the UK in 2006, and had moved around a number of countries (in particular spending 16 months in Morocco) until March 2013.

The Court of Appeal held that – although viewed at high level surprising – the judge had been correct to find that: (1) the mother had failed to settle or integrate into Moroccan life; (2) there had been domestic violence; (3) the parents had lived apart for significant periods in Morocco; (4) that the mother had really only ever integrated into the UK, where she had spent over 10 years at school and university and in work; and (5) her return to Morocco had been an extended stay while she sought a temporary harbour. In consequence, given the degree of dependence of her young daughter, her habitual residence was effectively determined by that of her mother, and therefore remained in the United Kingdom at the material time.

Questions of settlement and integration are equally relevant in the context of cases before the Court of Protection, and it is suggested that the instant case supports the propositions both that:

(1) Adults with impaired capacity removed wrongfully from England and Wales will only lose their habitual residence here (and hence the Court of Protection will only lose its jurisdiction over them) after an extended period of time, especially where they have not been integrated into the second jurisdiction;

(2) Conversely, adults with impaired capacity either placed into or outside England and Wales by statutory authorities will also – as a general rule – remain habitually resident in the jurisdiction of that statutory authority even if the placement lasts a considerable period of time (a proposition accepted, obiter, by Baker J in *Health Services Executive of Ireland v PA & Ors* [2015] EWCOP 38 at paragraph 53).

Short Note: privilege and paying for care

In a case that passed up by at the time, but is the subject of a very interesting article by Sheree Green in the most recent edition of the Elder Law Journal, the Chancery Division has recently clarified the obligations of solicitors where questions of 'sharp practice' arise in relation to dispersal of assets.

In *LBB Brent v Estate of Mr Owen Kane & Ors* [2014] EWHC 4564 (Ch), the Claimant local authority sought disclosure of documents to which legal professional privilege would normally attach on the grounds that the exemption did not apply because there was evidence of iniquity or sharp practice.

The local authority had provided residential care to Mr Owen Kane for 6 years prior to his death and considered that his two sons had deliberately engaged in a series of transactions (including disposing of his property) with a view to avoiding paying for his care. The local authority therefore sought disclosure of information held by a firm of solicitors, including legal advice about the transactions relevant to the dispute.

The judge considered the case law and concluded that there was a clear exception to the principle of legal professional privilege where there was prima facie evidence of iniquity (*Barclays Bank v Eustice* [1995] 1 WLR 1238*, BBGP Managing General Partner Ltd v Babcock & Brown Partners* [2011] Ch 296*, JSC BTA Bank v Mukhtar Ablyazov and others* [2014] EWHC 2788).

The judge held (and the claimant accepted) that there had to be prima facie evidence of iniquity for privilege to be defeated (*C v C [*2008] 1 FLR 115).

The judge was satisfied that there was prima facie evidence of sharp practice in the present case and that consequently legal professional privilege did not apply. Disclosure was ordered.

This case is a useful reminder that even legal advice can be subject to an order for disclosure where there is prima facie evidence of iniquity/sharp practice.

Stop Press: ordinary residence and the Supreme Court

In a decision handed down this morning (8 July) [2015] UKSC 46, the Supreme Court has allowed Cornwall's appeal in the important appeal in relation to ordinary residence. We will cover this in more detail in the next issue (and its implications for the Scottish Government on ordinary residence discussed in this month's Scotland Newsletter). In the interim, we note the detailed discussion given by Lord Carnwath for the majority at paragraphs 33ff of the judgment, in which – for present purposes most materially:

1. Confirmed that there are not, in fact, two separate Vale tests, but "*they were complementary, common-sense approaches to the application of the Shah test to a person unable to make decisions for herself; that is, to the single question whether her period of actual residence with her parents was sufficiently 'settled' to amount to ordinary residence*" (paragraph 47);

2. Doubted whether authorities on 'habitual residence' were of assistance in relation to considerations of 'ordinary residence (paragraph 48);

3. Confirmed that the residence of the subject, and the nature of that residence, provides the essential criterion for responsibility for community care provision. "*In so far as Vale is relied on to substitute an alternative test, based on 'the seat of (his) decision-making', or otherwise on his relationship with his parents and their home, it depends on a misunderstanding of that judgment. The seat of the decision-making power in relation to a mentally disabled adult is the authority making the placement (subject to any contrary determination by the Court of Protection), not the parents. For the same reason, the weight put by the decision-maker on the so-called Vale tests 1 and 2, both in the guidance and in the decision-determination, was in my view misplaced.*" (paragraph 51).

Our initial reaction to this judgment is that it is of considerable assistance in putting to bed the canard that incapacitated adults are big children who necessarily take their ordinary residence from that of their parents. However, complex questions are likely to arise as to how and when their ordinary residence will change where their move has not been made pursuant a placement by a statutory but informally (see, by analogy, although we accept only limited analogy in light of Lord Carnwath's observations at point 2 above, the discussion of informal decision-making by Sir James Munby P in the context of changes of habitual residence in *JO v GO* [2013] EWHC 3992 (COP)).

Updated capacity assessment guide

Our capacity assessment guide has now been updated and can be found here.

Law Society Practice Note: Meeting the Needs of Vulnerable Clients

This Practice Note for solicitors was published by the Law Society on 2 July 2015 and can be found on the Law Society's website here. It is supplemented by an easy read guide for clients, which helps them to

access solicitors.

The Practice Note and guidance have been produced by the Law Society in response to a 2013 report by the Norah Fry Research Centre and the University of Bristol. The report showed a clear need for guidance to the profession on how to work with others to gain a better understanding of the issues that people with learning disabilities face, the types of help they might require and on good practice in communicating with and advising those with learning disabilities.

Both the Practice Note and the easy read guidance aim to assist solicitors to meet the needs of vulnerable clients. This includes clients with a range of physical and mental health problems including learning disabilities. The Practice Note is intended to be read by all solicitors, practice managers and legal support staff who advise or deal with vulnerable clients, their families, carers, or other third parties.

It is divided into a number of parts and provides practical advice on how to:

- identify vulnerable clients;
- identify their needs at an early stage and respond appropriately;
- communicate with vulnerable clients more effectively;
- address issues vulnerable clients may have in relation to mental capacity,
- work with third parties who can assist the vulnerable adults, such as a litigation friend, attorney or deputy; and
- help the vulnerable person achieve the best possible legal outcomes.

It contains helpful guidance on assessing capacity and the relevant legal test of capacity (for example capacity to instruct a solicitor, conduct proceedings, make a gift or a will) and identifying undue influence and steps to be taken to if undue influence is suspected.

The final section of the Practice Notes contains a number of case scenarios that demonstrate the range of circumstances in which practitioners may encounter these issues in their practices together with some suggested ways of dealing with them. It ends with a list of useful links to other relevant information and organisations.

Beverley Taylor

Capacity to withdraw consent

Mrs Julie Connolly v Croydon Health Services NHS Trust [2015] EWCOP 39 (Queen's Bench Division (HHJ Collender QC))

Mental capacity – Medical treatment

Summary

Mrs Connolly ('Mrs C') brought a clinical negligence action against the Defendant NHS Trust for damages for personal injuries and consequential loss following a diagnostic procedure, an angiogram. The Claimant asserted that she had consented to the procedure on the basis that it was a low risk investigative procedure. In fact complications had arisen resulting in the necessity of an angioplasty. The Claimant argued that she had withdrawn consent during the course of the procedure and that in the circumstances it was negligent of the Defendant's employees to continue with it.

Mrs C. was 52 years of age at the time of the procedure and had for a long time suffered from a range of medical conditions and had for long been anxious about her health. In 2009, she complained to her GP of symptoms that were consistent with, or suggestive of, angina pectoris. An echocardiogram was performed which was normal. It was suggested that the claimant undergo an angiogram. The claimant was provided with a consent form preparatory to carrying out the procedure. She was also sent an information sheet explaining the procedure in detail, and describing risks involved with the procedure. Mrs C. duly signed the consent form.

A local anaesthetic was given to Mrs C. in her right arm to permit access for a catheter via her radial artery. Mrs C. suffered from a spasm and pain, the catheter was withdrawn and another attempt was made but was unsuccessful. Another attempt was then made via the femoral artery. During this period analgesic was given to Mrs C. At an early stage during the course of the procedure, a condition was detected in Mrs C. (an occluded left descending artery LAD), which is a serious and life threatening condition. As a result of this the procedure had to be turned into an angioplasty and access via the femoral route was undertaken. In the course of the procedure, the claimant complained of pain in her right arm and of severe pain across her back, chest and jaw and it was noticed that there had been a dissection of the left main stem artery. Mrs C was transferred to King's College Hospital where two further stents were inserted into her arterial system. It was unclear whether the dissection had been caused at the time of the angiogram procedure via the radial route or only after the femoral route was begun.

Mrs C. brought a case against the staff at the defendant hospital for damages for personal injuries and consequential loss arising from the performance of the angiogram. The claimant asserted that she had not provided valid consent for the angiogram as she was provided with misleading information before the procedure started. Secondly, that she withdrew such consent as she had given before access via the femoral route was undertaken and it was only after this time that she sustained a dissection of the LAD. The defendant disputed the case and asserted, amongst other things, that at the material time, the Mrs C did not have capacity to withdraw consent. Further that an event that threatened her life occurred before withdrawal of her consent such that the staff f the hospital were entitled to ignore any suggestion from her that she wished them to halt the procedure.

Dismissing the claim, the judge found that claimant's consent had not been vitiated by inadequate or misleading information. He further found that the dissection and excruciating pain suffered by the claimant were suffered by her before access to her arterial system was gained via the femoral route and that the Claimant had failed to satisfy the court than she had the capacity to withdraw consent during the course of the procedure or that she had in fact done so.

Comment

This case is another in a line of cases on consent to treatment and is well worth reading for its summary of the case law to date. In this case the judge considers the situation when the patient has consented to one procedure, but during the course of the procedure it becomes necessary to carry out a further procedure for which the patient has not consented or in so far as she has consented for which she argues she has withdrawn her consent.

The judge highlights the relevant issues for his consideration on withdrawal of consent at paragraph 47

> "[…] *had the patient capacity at the material time to withdraw consent and the extent to which, if at all a medical emergency confronting a medical practitioner may entitle them to continue with a procedure in the face of objection from a patient?*"

The judge found that because analgesic drugs and sedation had been administered to her she did not have capacity to withdraw her consent to treatment during the procedure. He also found that once the emergency arose it was clearly reasonable for the clinician to proceed with the procedure because "*the consequences of the hospital staff halting the procedure would have been the death of Mrs C*" [paragraph 126].

NHS guidance on the withdrawal of consent is contained in the Reference Guide to Consent for Examination or Treatment (2009) published by the Department of Health, at paragraph 45:

> *'A person with capacity is entitled to withdraw consent at any time, including during the performance of a procedure. Where a person does object during treatment, it is good practice for the practitioner, if at all possible, to stop the procedure, establish the person's concerns and explain the consequences of not completing the procedure. At times, an apparent objection may in fact be a cry of pain rather than withdrawal of consent, and appropriate reassurance may enable the practitioner to continue with the person's consent. **If stopping the procedure at that point would genuinely put the life of the person at risk, the practitioner may be entitled to continue until that risk no longer applies**'* (emphasis added)

It is therefore clear that where an emergency arises in a clinical setting a doctor may be entitled to continue to treat the patient despite an apparent withdrawal of consent if the person's life is at risk.

Beverley Taylor

Civil liability and mental health

Dunnage v Randall UK Insurance Ltd [2015] EWCA Civ 673 (Court of Appeal (Arden, Rafferty and Vos LJJ)

Other proceedings – civil

Summary

Vince poured petrol over himself. His nephew, the Claimant, struggled unsuccessfully to prevent him igniting it. Both were engulfed in flames. Vince died; the Claimant jumped to safety from a balcony but was seriously burned. Post-mortem, Vince was diagnosed as having suffered florid paranoid schizophrenia, with delusion beliefs that had dispossessed him of his own mind. A claim in negligence was brought against Vince's estate and insurer for damages. The insurance policy excluded cover for any acts by him that were wilful or malicious. The main issue was whether the standard required by his duty of care was objective or whether personal characteristics of the defendant could be taken into account.

The Court of Appeal unanimously held that no distinction should be drawn between physical and mental illness. For adults, whether a duty of care was breached was determined by the objective standards of a reasonable person. Unless a defendant can establish that his condition entirely eliminated responsibility – such as a fatal coronary thrombosis at the wheel, killing a pedestrian – he remained vulnerable to liability if he did not meet the objective standard of care (paras 114-115, 126). In that event, the defendant has done nothing to cause the injury and would thereby escape liability (paras 132-133). On the facts, Vince failed to exercise reasonable care. But the injury was accidental because he "had clearly lost control of his ability to make choices". Indeed, the lighter may have sparked accidently during the struggle. He did not intend to cause injury, was not acting wilfully or maliciously and was therefore liable to pay damages:

> "*153. The objective standard of care reflects the policy of the law. It is not a question of the law discriminating unfairly against people with physical or mental illness. The law takes the view as a matter of policy that everyone should owe the same duty of care for the protection of innocent victims. It would after all, in many cases, be open to a person who knows he has reduced abilities to take account of those abilities in what he does … There will be hard cases, as this case may be one, where a person does not know what action to take to avoid injury to others. However, his liability is no doubt treated in law as the price for being able to move freely within society despite his schizophrenia.*"

Comment

This decision vividly illustrates the differing approaches of criminal and civil law to the concept of human responsibility. Had Vince attempted to kill his nephew, he may have been found not guilty by reason of insanity, with its subjective considerations. The law of negligence, by contrast, judges him objectively, despite his "absence of volition" being between 95% and 100%. Clearly there are different public policies at stake. Varying the standard according to their level of ability may introduce legal uncertainty. But holding the severely disabled to an objective standard – a standard that might for them be impossible to achieve – seems somewhat artificial. Moreover, to suggest that civil liability was Vince's price for freedom is hardly CRPD-friendly, to put it mildly.

The Northern Ireland Mental Capacity Bill

Alex gave evidence with Caroline Bielanska, Phil Fennell, Julian Hughes, Wayne Martin and George Szmukler to the Ad Hoc Committee of the Northern Ireland Assembly considering the Mental Capacity Bill

introduced there on 8 June. As Alex has written about previously, what is being undertaken in Northern Ireland is a truly ambitious piece of legislation which will, at one bound, catapult Northern Ireland far beyond England and Wales in terms of mental capacity legislation. It will also put Northern Ireland ahead of any other jurisdiction in the world in terms of trying to work through mental health legislation which is strongly (if not exclusively) capacity-based.

We would urge anyone with the slightest interest in mental capacity or mental health law to take the time to look at the Bill. We would, further, urge us all to see how the Bill unfolds and to keep our fingers crossed that the Assembly are in a position to conduct the necessary scrutiny so as to complete all the relevant legislative steps prior to the expiry of its mandate in March 2016 (and to keep reminding anyone who will listen that the passage of such legislation is only just the beginning…).

As some of you may know, Alex was involved in the Essex Autonomy Project work assessing the compatibility of the MCA with the CRPD. Alex is now part of the core research team expanding that work to cover the 3 jurisdictions of the United Kingdom. As part of the early stages of that work, Wayne Martin from the EAP and I applied the wet towels and came up with a number of suggested amendments to the Bill. They are designed both to build upon our combined experiences in different arenas trying to bring P into the heart of decision-making and to improve compliance with the CRPD. These can be found here, and we would very much welcome suggestions or comments thereupon. For those of you who may think this is all about a far-away piece of legislation about which we know little or nothing – think again. Why should not wording such as this feature if and when we come (as we must) to revisit the MCA 2005?

Short note: the European Court considers withdrawal of life-sustaining treatment

In *Lambert v France* [2015] ECHR 545, the Grand Chamber of the European Court of Human Rights considered the withdrawal of life-sustaining treatment from a man in a vegetative state. The man's family disagreed about whether withdrawal was in his best interests, and some of his relatives applied to the court for declarations that withdrawal would violate his rights under Articles 2, 3 and 8 ECHR.

The Grand Chamber conducted a comparative review of the law in the area, noting that

> "*72. According to the information available to the Court concerning 39 of the 47 Council of Europe member States, no consensus exists in practice in favour of authorising the withdrawal of treatment designed only to prolong life artificially. In the majority of countries, treatment may be withdrawn subject to certain conditions. In other countries the legislation prohibits withdrawal or is silent on the subject.*
>
> *73. In those countries which permit it, this possibility is provided for either in legislation or in non-binding instruments, most often in a code of medical ethics. In Italy, in the absence of a legal framework, the withdrawal of treatment has been recognised in the courts' case-law.*
>
> *74. Although the detailed arrangements for the withdrawal of treatment vary from one country to another, there is consensus as to the paramount importance of the patient's wishes in the decision-making process. As*

the principle of consent to medical care is one of the aspects of the right to respect for private life, States have put in place different procedures to ensure that consent is expressed or to verify its existence.

75. All the legislation allowing treatment to be withdrawn makes provision for patients to issue advance directives. In the absence of such directives, the decision lies with a third party, whether it be the doctor treating the patient, persons close to the patient or his or her legal representative, or even the courts. In all cases, the involvement of those close to the patient is possible, although the legislation does not choose between them in the event of disagreement. However, some countries operate a hierarchy among persons close to the patient and give priority to the spouse's wishes.

76. In addition to the requirement to seek the patient's consent, the withdrawal of treatment is also subject to other conditions. Depending on the country, the patient must be dying or be suffering from a condition with serious and irreversible medical consequences, the treatment must no longer be in the patient's best interests, it must be futile, or withdrawal must be preceded by an observation phase of sufficient duration and by a review of the patient's condition."

The Grand Chamber, noting that it had never ruled upon precisely the issues that the case gave rise to, concluded that:

- There was an important distinction between the intentional taking of life, and 'therapeutic abstention'. Withdrawal of life-sustaining treatment was not the intentional taking of life, and so the State's negative obligation to refrain from taking life under Article 2 ECHR was not engaged.

- In respect of the positive obligation to protect life under Article 2 ECHR, States had to be afforded a margin of appreciation, not just as to whether or not to permit the withdrawal of artificial life-sustaining treatment and the detailed arrangements governing such withdrawal, but also as regards the means of striking a balance between the protection of patients' right to life and the protection of their right to respect for their private life and their personal autonomy.

- In a case such as this, reference should be made, in examining a possible violation of Article 2, to Article 8 of the Convention and to the right to respect for private life and the notion of personal autonomy which it encompasses. The French Courts had been justified in concluding that Mr Lambert would not have consented to continued ANH.

- The arrangements in France did not violate the positive obligations imposed by Article 2. The legislative framework was clear and had been meticulously applied in the case.

- The same analysis subsumed the complaints under Article 8, which were similarly dismissed.

The decision is perhaps not entirely surprising, but reaffirms that the approach in England and Wales is in line with the European consensus. It also confirms the stark difference in law identified in *Bland* (whatever its difference in clinical reality and/or as perceived by families on the ground) between the – lawful – withdrawal of life-sustaining treatment and the – unlawful – intentional taking of life.

Finally, the decision is of importance for emphasising the centrality of the previously expressed wishes of the patient in making any decision about the withdrawal of life-sustaining treatment, thereby (in our domestic context) reinforcing the message of *Aintree* that the decision that must be made is the one that is right for that patient. As noted in this month's Health, Welfare and Deprivation of Liberty Newsletter, it may well be that the result of such an analysis is not necessarily comfortable for the treating clinicians.

Assess Right

We think readers will be interested in this useful new website designed to assist people involving in carrying out or participating in capacity assessments. Created by NHS Aylesbury Vale CCG and NHS Chiltern CCG, it is a clear and straightforward tool which will assist in ensuring compliance by practitioners with the MCA and Code of Practice, and in helping families to understand how the process should work.

Mental Capacity Act: using the key principles in care planning

A SCIE commissioned short film (featuring a cameo by Alex) is now available, looking at the five key principles of the MCA and how these can be applied to the care planning process. It shows, through interviews with self-advocates, and health, legal and social care professionals, how the proper application of the MCA is needed to ensure that care planning is person-centred and empowering. The film stresses the importance of planning for the least restrictive option in any situation, and always acting in the best interests of people who lack capacity, and not in organisational interests. It talks about how advance decisions about future treatment can be really helpful.

New guidance – old flaw?

On 1st June 2015 Scottish Government issued new "Guidance on the recovery of expenditure on accommodation and services under section 86 of the Social Work (Scotland) Act 1968", Circular No CCD3/2015, replacing the previous guidance in Scottish Government Circular No CCD3/2010. Scottish Government failed to consult as would hitherto have been customary in such matters.

Apart from the concerns identified below, the guidance brings helpful clarity to situations where people in need of provision of accommodation and/or services under the Social Work (Scotland) Act 1968 cross borders between local authorities. As "Case Study 3" in the guidance shows, complexities can be situations where a person in area A has an accident resulting in permanently impaired mobility in area B and is placed in residential care in area C. The answer in that case is that local authority C charges the cost to local authority B, because local authority B arranged the placement, and then local authority B charges to local authority A because the lady's ordinary residence remains in area A. There is perhaps some concern that this assumes full and prompt co-operation among the three local authorities. Those of us in practice are aware that this does not always happen. That accordingly leaves open the question as to whether, if local authority B discharged their duty to meet needs arising in their area regardless of the person's ordinary residence, and in consequence arranged the placement in area C, in advance of any engagement by area A, then does responsibility rest with local authority B as the placing authority, or local authority A as the authority of ordinary residence? The guidance could be interpreted as suggesting either.

A greater concern is the suggested timescale for dispute resolution, and the lack of access to that process for people actually affected by such delay. The guidance suggests (paragraph 47) that: "Where a local authority corresponds with another authority, a timescale of one month is the suggested period within which the latter should issue a response". It then suggests (paragraph 48) that: "Where agreement cannot be reached within 4 months of the dispute commencing the authorities may wish to consider requesting a determination of ordinary residence [by Scottish Ministers] under section 86(2)". No information is given as to the period within which Scottish Ministers would resolve the dispute. Practitioners who have been involved in cross-border dispute situations between local authorities, or simply where local authorities have failed to respond, are aware of circumstances where real disadvantage and detriment can be caused to vulnerable people, and serious anxiety to their families, by prolonged failure to resolve. It is disappointing that they would still require to seek remedies outside the dispute resolution process outlined in the new guidance.

The most surprising aspect of the new guidance is that it still follows the previous guidance in offering a unique interpretation of relevant English case authority on the question of when ordinary residence moves when a person lacking sufficient capacity to decide the matter herself or himself in fact moves from one local authority area to another. As with the old guidance, the new guidance acknowledges (paragraph 16) that: "There is no statutory definition of the term 'ordinarily resident' in the 1968 Act, nor have the Scottish courts been asked, as at the date of this Circular taking effect [1st June 2015], to interpret its meaning". It then proceeds in paragraphs 17 and 18 to refer to English authorities, including the dictum of Lord Scarman in *Shah v London Borough of Barnet* [1983] 1 All E.R. 226: "unless … it can be shown that the

statutory framework or the legal context in which the words are used requires a different meaning I unhesitatingly subscribe to the view that 'ordinarily resident' refers to a man's abode in a particular place or country which he has adopted voluntarily and for settled purposes as part of the regular order of his life for the time being, whether of short or long duration" (emphasis in guidance).

In a case on habitual residence of a child, the Supreme Court observed in *Re LC (Children)* [2014] UKSC 1 (Supreme Court) that where Lord Scarman had observed in the Shah case that proof of ordinary (or, the Supreme Court said, 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"*, the Supreme Court was of the opinion that: *"insofar as Lord Scarman's observation [in Shah] 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"*.

Then last year in "the Cornwall case" - *R (Cornwall Council) v SoS for Health & Ors* [2014] EWCA Civ 12 – the Court of Appeal in England, dealing with a dispute about in which Council area an adult was ordinarily resident, confirmed that: *"Shah should be abandoned as the appropriate test to apply when considering the ordinary residence of young children, because they cannot sensibly be said voluntarily to choose where they live nor to have a subjective settled purpose with respect to it. Precisely the same difficulties arise with respect to those who are severely mentally disabled as Vale itself recognised. Shah provides no real assistance in those cases either." (Lord Justice Elias, para 74)*.

Even more peculiarly, the new guidance quotes in Annex A what are known as the two "Vale tests" for determining the ordinary residence of individuals who lack capacity. Vale test 1 is in the following terms: *"Where a person was so mentally handicapped that she was totally dependent on a parent or guardian, her ordinary residence was that of the parent or guardian: Mr Justice Taylor proceeds to expand on this to state that it was clear from Lord Scarman's speech in Shah that the mind of the claimant was important in two respects in determining ordinary residence: the residence must be voluntarily adopted and there must be a degree of settled purpose. In this case however, the applicant was not capable of deciding where to live and it is unreal to speak of settled purpose: the decision as to where she should live was at all times her parents' decision".* Vale test 2 is: *"The Alternative Approach involves considering a person's ordinary residence as if they had capacity. All the facts of the person's case should be considered including physical presence in a particular place and the nature and purpose of that presence as outlined in Shah without requiring the person themselves to have adopted the residence voluntarily".*

Startlingly, having quoted this authority and having acknowledged that in the absence of any Scottish authority it is necessary to look to English authority, the Scottish guidance persists in following Vale test 1 and disregarding Vale test 2, notwithstanding that equivalent English guidance, which is Department of Health: "Ordinary Residence: Guidance on the Identification of the Ordinary Residence of People in need of Community Care Services, England" (October 2013 – being an update of earlier guidance), refers to both tests as alternatives. The new Scottish guidance, like its predecessor, offers no basis or authority in law for this different "interpretation". It merely states that "the approach in England differs in that it encourages a broader view than that in Scotland". One fears that Scottish Ministers continue to face the potential alternatives of judicial review for failing to follow their own guidance, or judicial review for failing to apply

the law upon which their guidance is stated to be based; and people affected will still be caught in that situation, including in cross-border situations where, under the Care Act 2014, the "responsible person" (in the case of Scotland, the Scottish Ministers) for the country in which the claiming authority is based determines the matter. We are still at risk of situations where a person who has moved from England to Scotland is deemed in accordance with English guidance to no longer have ordinary residence in an English local authority area, and under Scottish guidance not to have acquired ordinary residence in a Scottish local authority area.

The difficulties are compounded in that the view with which Scottish Ministers persist will clearly result in differences between ordinary residence, on the one hand, and habitual residence both under the Adults with Incapacity (Scotland) Act 2000 and under the Hague Convention on International Protection of Adults (Hague Convention 35, of 13th January 2000) in the case of persons with impairments of relevant capacity. That will increase unnecessarily the number of cases where the deemed local authority of ordinary residence will be in a different area from the court having jurisdiction on grounds of habitual residence.

A further potential complication is that under the Carers Bill at present before the Scottish Parliament, it is proposed that assessments of carers' needs should be carried out by the local authority of the carers' ordinary residence, even where that is different from the ordinary residence of the person cared for (presumably, in the meantime, meaning ordinary residence as asserted – without authority – by Scottish Ministers).

The Cornwall case was appealed to the Supreme Court. Annex A concludes with a note that the guidance will be reviewed and, if necessary, amended following that decision. As noted in the Stop Press in the Capacity outside the Court of Protection Guidance, the decision of the Supreme Court was handed down just as this Newsletter went to press. We will be returning to this subject in the next Newsletter.

Adrian D Ward

Mental Health (Scotland) Bill

Introduction

Further to the February 2015 update on this Bill, Stage 3 the legislative process took place on 24th June 2015. The following is therefore a brief summary[2] of the most notable of its finalised provisions[3].

As mentioned before, the Bill amends the Mental Health (Care and Treatment)(Scotland) Act 2003 (2003 Act) and the Criminal Procedure (Scotland) Act 1995. It also introduces a victim notification scheme in relation to mentally disordered offenders extending the existing victim notification scheme under the Criminal Justice (Scotland) Act 2003.

Certain original provisions are now missing, and these are, in the view of the author, to be welcomed. The

[2] The Bill as passed contains several 'tidying up' provisions which will not be mentioned here.
[3] Subject, of course, to any potential challenge to legislative competence (ss 33 and 35 Scotland Act 1998) and Royal Assent.

proposal to extend the existing automatic 5 working day extension between the end of a short term detention certificate and the Mental Health Tribunal hearing to 10 working days was removed. Additionally, the reduction of the period within which an appeal can be made against a decision to transfer to hospital (state or otherwise) from 12 weeks to 28 days was also removed.

However, mental health officers (MHOs) will still have increased duties, as previously indicated. In its End of Stage 1 Report, the Health and Sport Committee, as lead committee, sought further assurances from the Scottish Government regarding resourcing and a strategic review of MHO provision to improve the recruitment, training and retention[4]. The Scottish Government responded by saying that in its assessment the proposed legislative changes will have a limited impact on MHOs. However, noting concerns regarding the capacity of the MHOs workforce generally it is exploring this with key stakeholders, including local authorities and mental health officers, to see how it can be addressed[5].

Orders regarding level of security (ss 9D-11A, Bill as passed)

The right for patients to be able to challenge their conditions of detention on grounds of excessive security will be extended to medium secure units only. As mentioned earlier, there could conceivably be occasions where an individual in a low secure setting may be subject to inappropriately relative high levels of security although the necessity for their detention remains. This has important Article 8 (right to private and family life) ECHR (and corresponding Articles 17 and 23 CRPD) implications. However, the Scottish Government was not prepared to concede this.

The awaited regulations to accompany the provisions in s 268 and make the right to appeal against detention in conditions of excessive security in non-state hospitals real have also now been drafted and it is intended that these will come into force after the summer recess[6].

There are, however, certain obstacles to a patient's ability to make the challenge. The Bill amends the 2003 Act to require that before such a challenge, from both the State Hospital and non-state hospitals[7], a medical practitioner must report (with reasons) that in their opinion the patient does not require to be detained under such a level of security[8]. This may help to reduce unmeritorious challenges but it nevertheless is an impediment to a patient's ability to obtain a fair hearing and fully exercise their right with potential ECHR, and CRPD, implications[9]. Another impediment of a similar nature appears in the draft regulations relating to medium secure settings. These provide[10] that a patient's detention will be at a level of security that is excessive when the security at the hospital is greater than is necessary to safely manage (a) the risk that the patient may pose to (i) the patient's own safety; and (ii) the safety of any other person;

[4] Scottish Parliament Committee on Health and Sport, *Stage 1 Report on Mental Health (Scotland) Bill*, 3rd Report, Session 4 (2015) ("Report"), paras 72-73. http://www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/86251.aspx
[5] Scottish Government Response to Stage 1 Report, pp 2-3.
[6] See also A Ward, *LS v Scottish Ministers (judicial Review)*, in the June 2015 newsletter on this issue.
[7] ss 264 and 268, 2003 Act respectively.
[8] ss 9D(2) and (3) Bill as passed.
[9] Articles 6, 8 and 14 ECHR. See also Articles 5, 12, 13 and 17 CRPD.
[10] Reg. 5, draft Mental Health (Detention in Conditions of Excessive Security) (Scotland) Regulations 2015.

and (b) any risk to the patient's safety that other persons may pose. This last criterion could therefore be arguably used to justify retention of the patient at a higher level of security than is required even though it is beyond that patient's control and not therapeutically appropriate with Articles 3, 8 and 14 ECHR, and also Article 5 ECHR[11], consequences.

Nurses' holding power (s 14, Bill as passed)

Nurses will be able to detain patients pending medical examination for a period not exceeding three hours. Currently, they can detain a patient for up to two hours but this can be extended by up to an hour to allow the medical examination to take place[12].

Absconding patients from other jurisdictions (s 25, Bill as passed)

There were concerns that the amendments might potentially permit treatment that the absconding patient would not have been subjected to in the jurisdiction from where they came. This has now been ameliorated to some extent by the fact that the final Bill specifically provides that neurosurgery and ECT will not be authorised.

Deaths of psychiatric patients (s 27B Bill as passed)

It is debatable whether the current arrangements for investigation into the deaths of psychiatric patients, which currently do not command mandatory investigations under legislation, is compatible with the operational duty imposed on states by Article 2 ECHR[13]. Unfortunately, this does not appear to have been satisfactorily addressed in the Inquiries into Deaths (Scotland) Bill currently before the Scottish Parliament.

The Mental Health Bill as passed admittedly now contains a provision requiring the Scottish Government to carry out a review of existing arrangements for investigating deaths of compulsory and voluntary psychiatric patients within 3 years of the material section coming into force. It must then report its findings to the Scottish Parliament. This is a step in the right direction but a painfully slow process.

Extension of assessment order period (s 29, Bill as passed)

A court will be able to extend an assessment order for 14 days (it is currently 7 days). As previously mentioned[14], this has implications in terms of timeous determination of a patient's case under Articles 5 and 6 ECHR.

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[11] *Aerts v Belgium* (25357/94) (1998) ECHR 64; *Hadzic and Suljic v Bosnia Herzegovina* (39446/06)(2011)ECHR 911.
[12] s 299, 2003 Act.
[13] See H Patrick, J Stavert and J Malcolm "The right to life, and to proper inquiries on death: A human rights perspective on the investigation of deaths of psychiatric patients in Scotland" (2012) 1 *Juridical Review* 51 and J Stavert, "Deaths of Psychiatric Patients, Article 2 ECHR & Proper Investigation: a case for reform in Scotland?" (2012) 419 *Scolag Legal Journal* 206.
[14] See Mental Capacity Law Newsletters, Scotland, September 2014 and February 2015.

Patient/ service user support

a) Named persons (ss18A-20A Bill as passed)

The 2003 Act will be amended so that no named person will be appointed for anyone aged 16 years and over unless they specifically appoint such a named person in a written and witnessed statement. Similarly, a named person must specifically consent to act in a written and witnessed statement. What now needs to be worked on is clarifying and raising awareness as to the role of named persons as this has been found to be lacking in many cases[15]. The Mental Welfare Commission has already recommended that the Scottish Government revises the 2003 Act Code of Practice and its guidance for named to this end[16].

b) Advance statements (s 21 Bill as passed)

The End of Stage 1 Report had recommended that in addition to the central register of advance statements to be held by the Mental Welfare Commission the Scottish Government consider placing a statutory duty on health boards and local authorities to promote them[17]. This is important in terms of recognition of the need to reinforce the requirement for patient participation under the 2003 Act, under Article 8 ECHR and in terms of moving towards the April 2014 UN Committee on the Rights of Persons with Disabilities *General Comment on Article 12 CRPD: the right to equal recognition before the law.*

The Bill as passed includes a provision requiring health board to publicise any support it offers for making or withdrawing an advance statement and sending a copy of such advance statement or withdrawal to a health board. Moreover, the Mental Welfare Commission may require the health board to provide information on its compliance with such duty. Whilst this falls short of a duty to actually promote advance statements it is nevertheless a positive step forward.

c) Independent advocacy (s 21A Bill as passed)

As stated in the February 2015 issue, the provision of independent advocacy, despite the statutory obligation on health boards and local authorities across to secure its availability[18], is inadequate. Moreover, research indicates that at any one time in Scotland around 1.2 million people (representing 21% of the population) have a right to independent advocacy[19].

Reinforcement of this provision would thus maintain and enhance the person- and rights- centred spirit of the Act in terms of promoting autonomy and equal partnership in shared decision-making. It would also to some extent address the requirements of the UN Committee on the Rights of Persons with Disabilities

[15] See, for example, the McManus Review, p14 and Mental Welfare Commission for Scotland, Experience of Named Persons, 2014, pp 4-5 and 21.
[16] *Ibid*, pp 4-5.
[17] Paras 157-158, Report.
[18] S 259 2003 Act.
[19] See Scottish Independent Advocacy Alliance, *Mental Health (Scotland) Bill: SIAA Briefing for the Health and Sport Committee*, November 2014, p2.

General Comment on Article 12 CRPD.

The Bill as passed provides that the Mental Welfare Commission can request information on local authority and health board actual and intended compliance of this duty from local authorities and health boards[20].

Victim Notification Scheme (ss 43-45, Bill as passed)

Section 16 of the Criminal Justice Act provides that victims can receive information regarding, for example, the first time the prisoner is entitled to be considered for temporary release, escapes, is transferred to a prison outside Scotland, releases on licence/parole, dies or when the custodial sentences ends. The EU Directive 2012/29/EU contains a right for victims to receive information (Article 6) and makes no distinction between offenders and mentally disordered offenders.

The Bill as passed permits victims to receive certain information about a mentally disordered offender who is in hospital receiving treatment for mental disorder under a hospital direction or transfer for treatment direction (s 43 Bill as passed). It also permits victims (and their next of kin) have the right to receive certain information about a mentally disordered offender (aged 16 years and over) on a compulsion order and restriction order (s 44 Bill as passed). Victims also have the right to make representations in certain circumstances when disposals or measures are being considered regarding a mentally disordered offender (s 45 Bill as passed).

There has been concern, reflected in the End of Stage 1 Report[21], about the ministerial power in s 48 to amend the provision, under delegated legislation, and that this might subsequently be used to extend the provisions to persons subject to compulsion orders. This would therefore potentially apply to persons who have only committed a minor offences and it is questionable whether this would be a reasonable and proportionate measure in terms of Articles 8 and 14 ECHR.

In its response the Scottish Government[22] stated that if the scheme is extended beyond those on a Restriction Order it would be done in such a way that will not put mentally disordered offenders in a disadvantaged position relative to other offenders. It also stated that a Short Life Working Group was currently considering how to implement these provisions in the Bill.

Conclusion

The Bill was not intended by the Scottish Government to represent a 'root and branch' review of the 2003 Act. This was disappointing to those who would have liked to have used this opportunity to undertake a wider review and amendment of the legislation. However, as indicated above, whilst certain concerns remain about some of the amendments several of those that were challenged have been removed. Time

[20] Actual evidence of compliance can be requested for a period of at least 2 years specified by the Commission and information on intended compliance can be requested for a period of at least 2 years.
[21] Para 194.
[22] Scottish Government response to End of Stage 1 report, pp 11-12.

will no doubt tell the extent to which the amendments will operate in practice.

Jill Stavert

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Conferences at which editors/contributors are speaking

International Academy of Law and Mental Health Congress

Jill is presenting a paper at this conference on 12-17 July in Vienna, entitled 'Meeting the Challenges of the General Comment on Article 12 CRPD: Scottish Incapacity and Mental Health Legislation.'

Deprivation of Liberty Safeguards

Tor will speaking at POhWER's conference on 17 July in Central London on DOLS, including discussion of the Law Commission's Consultation Paper. For further details, and to book, see here.

The Law Society of Scotland Update Conference on Mental Health and Incapacity

Jill is speaking on deprivation of liberty at this conference in Glasgow on 4 September. For further details, and to book, see here.

The Mental Capacity Act 2005 – Ten Years On

Alex will be speaking on '(Re)presenting P' at this major conference hosted by the University of Liverpool on 9 and 10 September. For further details and to book, see here.

Jordan's Court of Protection Conference

Alex will be speaking at Jordan's Annual Court of Protection Conference on 13 October 2015. For further details, and to book, see here.

Court of Protection Practitioners' Association National Conference

Alex will be speaking at COPPA's national conference on 24 September 2015. For further details, and to book, see here.

Advertising conferences and training events

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

Seventh Annual Review of the Mental Capacity Act 2005

Neil and Alex will both be speaking (along with Fenella Morris QC) at this annual fixture in York on 15 October, now under the auspices of Switalskis solicitors. For further details, and to book, see here.

Taking Stock

Neil will be speaking on 16 October at this (further) annual fixture, arranged by Cardiff Law School, at the Royal Northern College of Music. For further details, and to book, see here.

Other conferences of interest

Our friends Empowerment Matters are hosting an IMCA conference on 12 November at the Smart Aston Court Hotel in Derby, entitled 'Interesting Times – developments for IMCAs in practice and law.' For more details and to book, see here.

Chambers Details

Our next Newsletter will be out in early August. Please email us with any judgments or other news items which you think should be included. If you do not wish to receive this Newsletter in the future please contact marketing@39essex.com.

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

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