

## Court of Protection: Health, Welfare and Deprivation of Liberty

### 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](http://www.mentalhealthlaw.co.uk).

## 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 LJ))

*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.

## 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 “intensive 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](#).

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### Conferences at which editors/contributors are speaking

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#### 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](#).

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Victoria Butler-Cole  
Neil Allen  
Annabel Lee  
Anna Bicarregui  
Simon Edwards (P&A)

#### Guest contributor

Beverley Taylor

#### Scottish contributors

Adrian Ward  
Jill Stavert

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#### 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](#).



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

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



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