Mental Capacity Law Newsletter August 2016: Issue 68

Compendium

Welcome to the August 2016 Newsletters. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Newsletter: covert medication and deprivation and further findings in relation to state imputability;

(2) In the Property and Affairs Newsletter: statutory wills and charitable giving and OPG guidance on professional deputy costs;

(3) In the Practice and Procedure Newsletter: an update on Case Management, s.49 and Transparency pilots and habitual residence strikes again;

(4) In the Capacity outside the COP Newsletter: assistance wanted with questionnaires on powers of attorneys/advance decisions and mediation and relevant law reform developments around the world;

(5) In the Scotland Newsletter: the first AWI appeal determined by the Sheriff Appeal Court and Scottish observations on habitual vs ordinary residence.

With this Newsletter, we also roll out the next iteration of our capacity assessment guide, including a re-ordering of the stages of the test and summaries of (ir)relevant information for the most important decisions. You can find it on our dedicated sub-site here, along with all our past issues, our case summaries, and much more. And you can find 'one-pagers' of the key cases on the SCIE website.

We are now taking our usual summer break, but will return in early October with all the mental capacity news that is fit to print.

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Covert medication and deprivation of liberty

AG v BMBC & Anor [2016] EWCOP 37 (District Judge Bellamy)

Medical treatment – deprivation of liberty

Summary

In this case, District Judge Bellamy has given some rare, and useful, clarification as to the seriousness of the consideration that must be given to the use of covert medication, especially in the context of DOLS authorisation.

During the course of a s.21A application challenging a DOLS authorisation in place in respect of a 92 year old woman, AG, it became clear that part of AG's care plan at the home involved the covert administration

of strong sedative medication in the form of promethazine and then diazepam. There were no conditions relating to this medication contained in the care plan.

Following directions made as to the provision of information as to how this medication had come to be administered, the District Judge was able to draw the following conclusions (although not making formal findings of fact):

> *"(a) Proper consideration does not appear to have been given to the initial covert use of promethazine between November 2014 and February 2015;*
>
> *(b) The use of covert medication was not subject to proper reviews or safeguards.*
>
> *(c) The decision to administer diazepam covertly in February 2015 (as prescribed by the GP) appears not to have been communicated to the supervisory body or to the RPR so that an opportunity to request a review of the standard authorisation at that time was lost;*
>
> *(d) There does not appear to have been a review or provision for review of the fundamental decision to administer medication covertly notwithstanding the covert medication policy disclosed [it would appear to be that of NICE] makes it clear that this is only to be considered in exceptional circumstances.*
>
> *(e) The best interest decision making process appears not to have involved any family member or RPR on behalf of AG nor her allocated social worker.*

Fortunately (one might think) no harm appeared to have been caused to AG by the covert use of either promethazine or diazepam.

District Judge Bellamy noted that:

> *25. Although it is not an issue for me to determine I accept that treatment without consent (covert medication in this case) is an interference with the right to respect for private life under Article 8 of the ECHR and such treatment must be administered in accordance with a law that guarantees proper safeguards against arbitrariness. Treatment without consent is also potentially a restriction contributing to the objective factors creating a DOL within the meaning of Article 5 of the Convention. Medication without consent and covert medication are aspects of continuous supervision and control that are relevant to the existence of a DOL. It must therefore attract the application of Section 1(6) of the Act and a consideration of the principle of less restriction and how that is to be achieved.*
>
> > *'1(6) Before the act is done, or the decision made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.'*
>
> *Such intervention must be proportionate to the circumstances of the case and accord with the principle of minimum intervention consistent with best interests.*

By way of general observation, District Judge Bellamy noted that:

> *29. All parties agreed that covert medicines should only be used in exceptional circumstances and when such a means of administration is judged to be necessary and in accordance with the Act. The guidelines published by NICE (National Institution for Healthcare and Excellence) [available here] provide that medication should not be administered covertly until after a best interest meeting has been held, unless in urgent circumstances. Care homes are to ensure that if a decision is taken to covertly administer medicine to an adult care home resident, then a management plan should also be agreed and recorded after a best interest meeting. The meeting should be between healthcare professionals and family members. The decision to covertly administer diazepam as compared to promethazine, was not communicated to the supervisory body. The care home as managing authority has a duty to keep a patient's case under review and if any of the qualifying requirements appear to be reviewable then it must request a review. The supervisory body in this case BMBC may be almost entirely dependent upon the managing authority (the care home) to notify it of any change or proposed change to care/treatment.*

District Judge Bellamy further held that:

> *37. It is clear that the managing authority has a duty to monitor for any change in a person's circumstances on an ongoing basis. This obligation exists no matter how long or short the stipulated duration of the authorisation granted. The code is clear, there must be a care plan setting out clear roles and responsibilities for monitoring and addressing the issue of when a review is necessary.*
>
> *38. Covert medication is a serious interference with a person's autonomy and right to self-determination under Article 8. It is likely to be a contributory factor giving rise to the existing DOL. Safeguards by way of review are essential.*
>
> *39. The reference to a change in the relevant person's case is broad and must sensibly apply to each of the steps in the best interests assessment on a case-by-case basis. A clear omission of information relating to additional restrictions or interference with autonomy is a relevant change in the circumstances known to the best interest assessor that should trigger an immediate review under part 8. This would also apply to new circumstances arising after the DOL is granted and that were not known about or did not exist at the time.*
>
> *40. The use of medication without consent or covertly whether for physical health or for mental health must always call for close scrutiny.*
>
> […]
>
> *43. The following may assist by way of future guidance:-*
>
> *(a) Where there is a covert medication policy in place or indeed anything similar there must be full consultation with healthcare professionals and family.*
>
> *(b) The existence of such treatment must be clearly identified within the assessment and authorisation.*
>
> *(c) If the standard authorisation is to be for a period of longer than six months there should be a clear*

provision for regular, possibly monthly, reviews of the care and support plan.

(d) There should at regular intervals be review involving family and healthcare professionals, all the more so if the standard authorisation is to be for the maximum twelve month period.

(e) Each case must be determined on its facts but I cannot see that it would be sensible for there to be an absolute policy that, in circumstances similar to this, standard authorisation should be limited to six months. It may be perfectly practical and proportionate provided there is a provision for reviews (or conditions attached) for the standard authorisation to be for the maximum period.

(f) Where appointed an RPR should be fully involved in those discussions and review so that if appropriate an application for part 8 review can be made.

(g) Any change of medication or treatment regime should also trigger a review where such medication is covertly administered.

(h) Such matters can be achieved by placing appropriate conditions to which the standard authorisation is subject and would of course accord with chapter 8 of the deprivation of liberty safeguard's code of practice. […].

District Judge Bellamy also endorsed the written guidance proposed by the supervisory body, which included the following:

(i) if a person lacks capacity and is unable to understand the risks to their health if they do not take their prescribed mediation and the person is refusing to take the medication then it should only be administered covertly in exceptional circumstances;

(ii) before the medication is administered covertly there must be a best interest decision which includes the relevant health professionals and the person's family members;

(iii) if it is agreed that the administration of covert medication is in their best interests then this must be recorded and placed in the person's medical records/care home records and there must be an agreed management plan including details of how it is to be reviewed; and

(iv) all of the above documentation must be easily accessible on any viewing of the person's records within the care/nursing home.

(v) If there is no agreement then there should be an immediate application to Court.

Comment

Although not a decision with binding precedent value, being a decision of a District Judge, this decision is extremely useful for highlighting (1) the very widespread use of covert sedative medication in

circumstances such as those of AG (which are not uncommon); and (2) the seriousness with which such administration should be accompanied, but is all too often not. It is undoubtedly a serious interference with Article 8 ECHR. As the European Court of Human Rights has repeatedly made clear (for instance in *Shtukaturov v Russia* [2008] ECHR 223 at paragraph 89) "*whilst Article 8 of the Convention contains no explicit procedural requirements, 'the decision-making process involved in measures of interference must be fair and such as to ensure due respect of the interests safeguarded by Article 8*.'" The greater the interference, the more rigorous the decision-making process (see also in this regard, by analogy, *X v Finland* [2012] ECHR 1371 at paragraphs 220-221).

Given that the use of covert sedation is also, as District Judge Bellamy noted, often associated with the exercise of supervision and control giving rise to a deprivation of liberty, it is clearly important that, where the results do give rise to such a deprivation, they are monitored and controlled by reference to the provisions of DOLS.

We would, however, emphasise that the administration of any covert medication is a step which must be taken with considerable care and forethought. Indeed, a failure to comply with the principles of MCA 2005 and the steps required by s.4 would, we suggest, both mean that it would not be possible to justify the resulting interference with the Article 8 ECHR rights and (by analogy with *Winspear*) mean that those involved in the administration of the medication would have no defence under s.5 MCA 2005 to a claim brought on the basis of those rights.

State imputability, families and deputies

Re R [2016] EWCOP 33 (Senior Judge Lush)

Article 5 – deprivation of liberty – state imputability

Summary

In a judgment from a case heard prior to the decision in *Re SRK* but delivered afterwards (without referring to it) Senior Judge Lush has also weighed into the debates about state imputability in the context of Article 5.

In, *Re R* Senior Judge Lush had cause to consider the situation of Robert, a young man with intellectual disabilities, epilepsy and autism. He was non-verbal and frequently self-harmed, and required a high level of support from others to manage his activities of daily living. His mother, father and brother were his deputies (both for property and affairs and personal welfare). In January 2015, at a meeting convened by his social worker from LB Haringey, and attended by his family and members of the staff from his college, it was agreed that the best option for Robert, when he left college, would be a supported living placement. Haringey agreed to fund the family's proposed choice of supported living placement, together with day care, and transport between the two.

In December 2015, Haringey applied to the Court of Protection for a determination as to whether Robert was deprived of his liberty (and if necessary) authorisation. Haringey contended that Robert was not being deprived of his liberty and was free to leave his current placement whenever he wished; and, in the event that there was any deprivation of his liberty, it was his family's responsibility, as his court-appointed deputies, because they chose his current placement.

Senior Judge Lush held that Robert's care arrangements satisfied the acid test for deprivation of liberty because: he was obliged to live in a particular place subject to constant monitoring and control; he had 1:1 support during the day and 1:2 support at night; all aspects of his care arrangements were controlled and supervised by the care staff; he was only allowed to leave the building with close supervision; he was not free to leave the building without permission; if he did attempt to leave without permission, he would be restrained by the care provider's staff, naturally as an act of humanity; and the fact that his living arrangements were as comfortable as they possibly can be made no difference. He held that it was irrelevant that Robert was content and acquiesced with these arrangements. He also distinguished the decisions of Bodey J in the case of Mrs L and Mostyn J in *PS* on the basis that "[Mrs L] *was living in her own home and had no supervision and control for large parts of the day. For broadly the same reasons, Robert's circumstances are also different from Ben's* [in PS]*, who had appreciable privacy and was free to leave.*"

He also found (at paragraph 58) that:

(a) Haringey was actively involved in every stage of the care planning process. It actually admitted that, 'Haringey provided the financial support and specialist knowledge and commissioning ability to enable Robert to access the choice of providers and services that his parents have decided jointly with professional input are in his best interests.'

(b) Haringey convened the meeting on 23 January 2015, at which it was decided that the best option for Robert would be supported living.

(c) It provided specialist knowledge by drawing up a list of the organisations that support people with autism to live in the community.

(d) It supplied a copy of that list to Robert's deputies and invited them to decide which package of support they thought would be most suitable for him.

(e) Whatever choice Robert's deputies had made would have been subject to further approval by Haringey.

(f) Haringey carefully matched Robert with his two housemates to ensure that the three of them would be compatible with one another.

(g) Haringey funds Robert's supported living placement and his day care and the transport costs between the two locations.

(h) The providers of the placement and the day care service are accountable to Haringey.

(i) The supported living placement and the day care service are subject to review by Haringey.

Further:

59. For the purposes of section 4 of the Mental Capacity Act 2005 Haringey was ultimately "the person making the determination" as to what was in Robert's best interests and, because it was practicable and appropriate to consult them, pursuant to subsection 4(7), Haringey took into account the views of 'any deputy appointed for the person by the court.'

The deputies' views, however, did not automatically determine the outcome and were merely a factor that Haringey was required to take into account as part of the overall decision-making process.

Because he found that the state (in the form of Haringey) was directly responsible for the deprivation of liberty, Senior Judge Lush did not then go on to consider issues of indirect state responsibility.

Comment

It is hardly surprising that Senior Judge Lush had little truck with Haringey's attempt to disavow responsibility for what was clearly an objective confinement of Robert to which he could not consent. However, for our part, we would have focused solely upon the fact that, discharging public law obligations, they were commissioning and funding the arrangements under which Robert was (beneficently) confined. It seems to us that this is where Haringey's real responsibility for the deprivation of liberty lay.

Indeed, we would respectfully suggest that the reference to s.4 MCA 2005 is something of a red herring here. On its face, if (as appears clear) Haringey was in discharge of its public law obligations willing to fund a range of placements, between which Robert's deputies were able to choose on his behalf, then for purposes of the MCA (but not Article 5 ECHR), it seems to us that the decision-makers in this case were indeed the deputies. Senior Judge Lush's decision may reflect the pragmatic reality that the public authority will be seen to be in the MCA driving seat in these situations, but it does not sit easily with the fact that only deputies, attorneys and the Court of Protection are able formally to make decisions on a person's behalf, and in respect of all other – informal – decisions the MCA does not afford any particular status to one person or body (see *G v E* at paragraph 51). Alex will be exploring the issue of informal decision-making, the place of public authorities and the proper approach to s.5 MCA 2005 in an article forthcoming in the Elder Law Journal.

We would also suggest that when read together with the decision in *Re SRK* this decision reinforces the point that arguments as to direct versus indirect state responsibility are rather beside the point in these situations. Even if Haringey had been found not to be directly responsible, it seems to us inconceivable that it would not have been found to be have been on notice of the confinement and following Re SRK and *Re A and C* [2010] EWHC 978 (Fam) to have been under the obligation imposed by the positive limb of

Article 5 ECHR to have investigated the circumstances and, if the confinement could not be brought to an end (as by definition here it could not have been given that Haringey were in agreement with it) sought the necessary authority from the Court of Protection. We should note that, whereas in Re SRK, it would appear that the obligation to seek the authorisation of the Court of Protection lay with the deputy administering the personal injury settlement, there could have been no doubt that it would have lain with Haringey here as it was funding the arrangements.

Deprivation of liberty, dogs and a deputy's dereliction of duty

Mrs P v Rochdale Borough Council and others [2016] EWCOP B1 (District Judge Matharu)

Article 5 ECHR – DOLS authorisations – Article 8 – contact – P's wishes – deputies – property and financial affairs

Summary

Mrs P's deprivation of liberty was authorised in a nursing home. By the time of the final hearing in the MCA section 21A proceedings, place of residence was not in dispute. The focus was upon whether the care arrangements amounting to a deprivation of her liberty were in her best interests. And these were "*inextricably linked*" with the appointment of a deputy that was managing her property and finances.

She had experienced two strokes and was a coeliac sufferer requiring gluten-free food. The only living being with whom she shared any love or devotion was her dog, Bobby. Her "*face lights up*" when she saw other dogs. But the deputy considered "*it would seem irresponsible in the extreme to suggest that a dog visits a care home for elderly and frail people*". She owned her own home and had a number of pensions and investments in bonds. The court was particularly troubled about how Mrs P, and the things that she needed, were (not) being provided for by her deputy:

> *27 … What is known is that her wishes and feelings before her second stroke were very clear. She enjoyed a good quality of life, she loved her dog, likes to be made to feel glamourous. Now she is wearing ill-fitting clothes, and financially unable to pay to have her feminine needs attended to, such as having her hair and nails done.*

The deputy failed to provide money for new clothes. Nor did he purchase the more varied food that was requested and refused a request by Mrs P's legal representative to bring Bobby to see her. These were "*all matters which are affecting the quality of her life. They are extremely important to and for her*."

District Judge Matharu decided to replace the deputy with a panel deputy because he was not acting in her best interests and appeared to be working against the litigation friend, not with them. Moreover:

> *27. It may seem to those not well rehearsed in the needs of a person who owns a pet, in this case a person who no longer has capacity to make decisions about various matters, what the importance of a pet is in their*

life. The deputy only has to read any single reference in reports, assessments or statements of Mrs P of how important Bobby is to her. Her Social Worker says in her witness statement to the court that:

> *I would recommend that of single most importance in her life is her dog and having some form of contact with her dog in the future if possible.*
>
> *By comparison, the comments of Temperley Taylor solicitors in the e mail of 13th July are "brutal" and insensitive. When enquiries were made of them, they appeared to reject such questioning or consider themselves challenged in some inappropriate way. That is not the case. The questions being put to them were a line of reasonable enquiry by the Litigation Friend as to Mrs P's best interests.*

28. I have had regard to the financial information at C67-8. In around October 2015 the money in her NatWest account was around £7000. Now there is a nil balance. That is all the court is told. "Troubling" is the term that I would use and this is an understatement.

29. When I consider the Act and Code of Practice, the authorities show I should deal with as many matters as possible. I am making this order today because the deputy having been served with the application was aware of its content and implications. I have used every endeavour to resolve matters in the least restrictive way possible to Mrs P. However, this is the only way to deal with matters. I commend counsel for bringing it to court in this way. The Deputyship cannot continue to operate in "a prism" of its own.

Comment

We mention this decision for three reasons. The first concerns human well-being. The importance of animals to those with (or, for that matter, without) dementia or other conditions cannot be underestimated. Indeed, some go so far as to describe it as "*dog therapy*" or "*animal-assisted therapy*." In this case, Bobby was given away when Mrs P moved into residential care. Experience suggests that, especially in a "gilded cage", the comfort of a pet can make people happier and reduce so-called "*behaviour that challenges*."

Secondly, it is worth noting that the deputy had failed to engage with the court on the basis that they were not a party to the welfare proceedings. District Judge Matharu corrected the error of the deputy's ways:

> *24. Let me make this clear. Under Rule 74 of the Court of Protection Rules, any order made binds this firm because "any person who has been served with or notified of an application form" shall be bound as if they were a party. Temperley Taylor LLP knew there was a hearing date. They were served with the application and informed of it. The Deputy has a solicitor at court today so is represented and will be bound by the order I make.*

The final reason is jurisdictional. The application to remove the financial deputy was made within MCA section 21A proceedings. It is axiomatic that access to money can affect someone's liberty. And being able to consider financial deputyship within section 21A proceedings, avoiding a jurisdictional fixation, is – we suggest – eminently sensible.

Short Note: objections, RPRs and Article 5(4)

The long-awaited judgment from Baker J as to when it is necessary for RPRs to bring challenges (themselves or in the name of P) against authorisations has now been delivered orally. We will report upon the judgment and upon its consequences fully when it is published.

Statutory wills and charitable gifting

K v LM [2015] EWCOP 91 (District Judge Mort)

Statutory wills

Summary

In this case P was seriously assaulted by her birth mother when very young. She eventually received a large CICA award. Her care needs were met by the income from that award and NHS continuing health care payments. P's remaining capital exceeded £2m and was not being eroded. P's adoptive parents, it seems, were much involved in P's care. Her other family was a sibling who had 2 daughters.

P's deputy made an application for a statutory will proposing 25% each to her parents, 25% to her sibling and 25% to the 2 children of her sibling with an accrual clause to prevent anyone else benefitting.

The Official Solicitor was appointed P's litigation friend. P's family did not attend the hearing but made written representations.

Everyone agreed that there should be a statutory will. The issue was as regards any charitable gift.

The Official Solicitor proposed 20% to charity on the grounds that the funds were from the community and in those circumstances P would have wanted some part to go back to the community.

P's family accepted that a charitable gift was appropriate but suggested 5%. P's deputy, the applicant, supported that, pointing out that IHT would return a substantial amount to the community anyway.

In an email, P's adoptive mother stated that she had felt "*massively insulted*". P's wishes as to charitable giving were impossible to ascertain, and her adoptive mother declined to suggest any charities that P might wish to name, commenting in the same email that "*the only way of getting this kind of information from her will be to plant the idea in her mind – thus it will not be 'her' choice/wishes*."

In the result, the District Judge decided that the Official Solicitor's approach was right, directing a gift of 20% to charities principally a charity of the local NHS trust.

Comment

There is little in the judgment (which was published at the request of the Official Solicitor) that tells us why the judge decided that 20% was more in P's best interests than 5%. A Court of Protection Visitor had tried to ascertain P's views but with limited success. The judge clearly had section 4(7)(b) MCA in mind (requiring the court to take account of the views of those engaged in caring for P). The judge must have had in mind

the fact that one of those carers had felt "massively insulted" but still found it in P's best interest to prefer the views of the Official Solicitor rather than that carer.

We must confess to a degree of unease as to why such an outcome could be said to be in P's best interests. For those who want to reflect further upon when and whether it is really right to apply a best interests criterion in the making of statutory will applications where (as here) it appears to be impossible to discern the person's wishes and feelings, we commend the article by Rosie Harding entitled "The Rise of Statutory Wills and the Limits of Best Interests Decision-Making in Inheritance" (2015) Modern Law Review 78: 945–970.

Professional deputy costs

The Office of the Public Guardian and the Senior Courts Costs Office have issued good practice guidance in relation to the new costs supervision and assessment regime. It is essential reading for all professional deputies.

Highlights are reminders that professional deputies will be required to submit estimates for their costs for the following year when submitting their annual breakdown of costs; that costs must be reasonable and proportionate to the value of the estate with work being done by the appropriate level of fee earner; that a professional deputy has an obligation to consider if it is P's best interests for them to continue in the role rather than ask a family member to take over; being open and transparent with family members with costs information and, whilst respecting P's confidentiality, considering whether it is in P's best interest for family members to have information about their charges.

The guidance has a section which gives an overview of the SCCO's approach regarding the assessment of general management costs.

Case Management Pilot starts 1 September

The Case Management Pilot will start on 1 September, to run until 31 August 2017 (alongside the s.49 Pilot and the extended Transparency Pilot, both discussed further below).[1]

The Case Management Pilot can be found here. It introduces three distinct pathways for COP proceedings: 1) a Property and Affairs pathway, 2) a Health and Welfare pathway, and 3) a hybrid pathway for cases that have elements of both. The expectations of practitioners will be different depending upon which pathway is engaged. Common to each, though, is an expectation of much greater 'front-loading' and cooperation to narrow the issues.

The Case Management Pilot is accompanied by a revised set of Rules which foreshadow a re-numbering of the Rules that is anticipated as part of the second tranche of rules changes (moving to the same model as in the CPR and FPR). For ease of reference, all the Rules that will apply for purposes of the Pilot are set out in an annex – with suitably highlighted amendments – to the Pilot practice direction. They are also found collected together on the Court of Protection Handbook website here. There are six Pilot Parts:

- Pilot Part 1: the overriding objective, including the participation of P, heightened duties upon the court and upon parties, and new duties upon both legal representatives and litigants in person;
- Pilot Part 2: interpretation and general provisions;
- Pilot Part 3: managing the case;
- Pilot Part 4: hearings;
- Pilot Part 5: court documents;
- Pilot Part 15: experts.

As these parts cover the majority of relevant matters that arise during the life of an application, the intention is that practitioners (and the judiciary) will have to do the minimum of cross-referencing to the current iteration of the Rules during the life of the Pilot. However, an unfortunate consequence of the fact that for reasons beyond the control of the ad hoc Rules Committee the renumbering of the Rules cannot take place at present is that there will be parallel Rules for the life of the Pilot depending on whether cases are within or outside the Pilot. This means, for instance, that Rule 3A representatives are actually Pilot Rule 1.2A representatives in cases on the Case Management Pilot.

[1] What follows is an updated version of the note that appeared in our March 2016 newsletter. Alex as a member of the ad hoc Rules Committee has been involved in developing the Pilot. As before, this note does not, represent an official comment upon behalf of the Rules Committee.

Before highlighting the key points of the three pathways, it is important to note the types of applications which the Pilot will not affect, which include: uncontested applications, applications for statutory wills and gifts, applications relating to serious medical treatment and deprivation of liberty applications (both *Re X* applications and s.21A applications). However, even for such cases, we strongly suggest that it is prudent to proceed in any case on the basis of any stricter obligation/test that would apply if the case were on the Pilot. If the Case Management Pilot achieves its aim of changing the culture of the Court of Protection, then it is likely that the judiciary will seek to follow its spirit even where its letter does not apply.

It should also be noted that the intention is that the Case Management Pilot sits alongside and does not displace the Transparency Pilot, so the expectation will be that all of the hearings noted below, with the express exception of the Dispute Resolution Hearing provided for in the property and affairs pathway, will be listed according to the Transparency Pilot rules as regards public/media attendance.

Personal welfare pathway

The personal welfare pathway starts pre-issue, with a set of requirements designed to ensure that only those applications which actually require resolution by court proceedings come to court, and those which do, do so in circumstances where the issues are clearly delineated from the outset. The Pilot Practice Direction then specifies in some detail what must be included with or accompany the application upon issue including – importantly – a statement as to how it is proposed P will be involved in the case.

The next stage is for matters to be considered by a judge on the papers both for gatekeeping purposes (i.e. allocating to the correct level of judiciary) and the making of initial directions including, importantly, listing a Case Management Conference within 28 days (unless the matter is urgent). The judge can also direct that there be an advocates' meeting before the CMC.

The CMC will be the first attended hearing and a vital step in the proceedings because of the obligations placed upon the court (not just the parties) to ensure that the issues are narrowed and directions set for the proportionate resolution of those that are in dispute. Importantly, one of the matters that the court will do is to allocate a judge to the matter – judicial continuity being recognised as crucial to the success of the pilot. It is also important to note that this Pilot is running alongside the s.49 pilot discussed further below, and also includes a tightening of the rules in relation to experts (where the Pilot applies) so as to limit permission to circumstances where their evidence (1) is necessary to assist the court to resolve the issues in the proceedings; and (2) cannot otherwise be provided.

The intention is that in the ordinary run of the events there would then only be (at most) two more hearings, a Final Management Hearing and the Final Hearing. Ahead of the Final Management Hearing, whose purpose is to determine whether the case can be resolved by consent and, if not to ensure proper preparation for trial, an advocates' meeting is to be listed at least 5 days in advance for purposes of – inter alia – preparing a draft order for the court to consider at the FMH. Matters that are likely to be covered at the FMH will include such things as the trial timetable and a witness template, as well as the contents of

the trial bundle: in line with the injunction given by the Court of Appeal in *Re MN*, the expectation is that the trial bundle for the Final Hearing will not generally exceed 350 pages, and must not include more than one copy of the same document.

It is important to note that, unlike the Public Law Outline, there is no fixed timeframe within which proceedings must be concluded, the only fixed date being the listing of the Case Management Conference. The intention, however, is that the process set down in the Pilot is will mean dramatically shorter resolution of welfare applications.

Property and Affairs pathway

The property and affairs pathway does not start pre-issue because it is recognised that it is often only upon issue that it becomes clear that a property and affairs application is contentious. It therefore compromises four stages.

The first stage is when the application becomes contested, i.e. when the court is notified in the COP5 that the application is contested or a respondent wishes to seek a different order.

The case management stage takes place on the papers, and includes either: (1) listing for a Dispute Resolution Hearing; or (2) transfer to a suitable regional court for listing of the DRH and future case management. If the respondent has not given sufficiently clear reasons for opposing/seeking a different order, the judge will also at that stage require such reasons to be given.

The Dispute Resolution Hearing is a major innovation, and represents – in essence – judicial mediation in a form familiar to family practitioners. A DRH, which will normally take place before a District Judge, is to enable the court to determine whether the case can be resolved and avoid unnecessary litigation, and to that end the content of the hearing is not to be disclosed and everything said therein is not admissible (save in relation to a trial for contempt). The court is expressly required to give its view as to the likely outcome of the proceedings as part of the DRH. The aim is for the court to be able to endorse a consent order at the end of the DRH; if not, the court will list for directions of the management of the hearing and a Final Hearing.

The last stage – the Final Hearing – will take place in accordance with directions made at the DRH (there being no Final Management Hearing as with the welfare pathway).

As with the welfare pathway, there is no fixed timeframe for the determination of the application. Nor, in this instance, is there a specific timeframe for listing of the first attended hearing – the DRH. This recognises that there is merit to flexibility because there will be some cases in which allowing longer for a DRH is more likely to bring about a quicker resolution overall; conversely, in some cases, the sooner that judicial banging of heads takes place the better.

Mixed welfare pathway

If an application comprises elements of both welfare and property and affairs, prospective parties are directed at the pre-issue stage to identify which pathway is most effective and to comply with the requirements of that pathway so far as possible. At point of issue, they must file a list of issues to allow the court to identify which pathway or mixture of elements is most appropriate.

The court will then, on the papers, either allocate the case to one of the two pathways set out above, or give directions as to the elements of each pathway are to apply and the particular procedure the case will follows.

Urgent applications

In all cases there is express provision for urgent applications, requiring the parties in particular to specify why the matter is urgent and any particular deadline by which the issue(s) need to be resolved as well, as well as directing compliance (insofar as possible) with any necessary pre-issue steps.

Expert evidence

An important change that is introduced by the Case Management Pilot is a revised Part 15 on expert evidence. Crucially, the test for permission has been revised in COPR Pr121 to make it more stringent. The court's duty is now to restrict expert evidence to that which is necessary to assist the court to resolve the issues in the proceedings, and by COPR Pr 121(2) the court may only give permission to file or adduce expert evidence if it is satisfied that it is both necessary and cannot otherwise be provided. Further, the court must now in deciding whether to give permission to file or adduce expert evidence have specific regard by COPR Pr123(2A) to (a) the issues to which the expert evidence would relate; (b) the questions which the expert would answer; (c) the impact which giving permission would be likely to have on the timetable, duration and conduct of the proceedings; (d) any failure to comply with any direction of the court about expert evidence; and (e) the cost of the expert evidence. Additionally, by para 4.5(m), the Case Management Pilot Practice Direction provides that for cases on the welfare pathway, the court must at the case management hearing actively consider whether a section 49 report (or a report from a Rule 3A/PR r1.2 representative) could achieve a better result than the use of an expert.

Section 49 pilot

The s.49 Pilot also starts on 1 September, to run until 31 August 2017. The Practice Direction applies both to orders made under s.49 MCA by the COP of its own motion and – more importantly – to orders sought by parties. The Practice Direction is accompanied by a draft order. It recognises, in essence, that s.49 reports are an extremely important part of the COP's armoury when it comes to information gathering, but that they must be deployed:

(1) Carefully, so as to ensure that they are targeted to public bodies actually able to provide useful information;

(2) With suitable thought and preparation on the basis that, to be effective, they are best approached as if they were expert reports.

An important innovation is the requirement, where possible, for a party seeking a s.49 report from a NHS body or local authority to have made contact prior to the application being heard by the court to identify an appropriate person ("a senior officer") able to receive the order, and to have discussed with the body the reasonableness and time scales for providing the report. Although it does not prescribe when a court will and will not order one, the Practice Direction set out (at paragraph 3) common factors that the court may consider when deciding whether to order a s.49 report, including:

- where P objects to the substantive application or wishes to be heard by the court and does not qualify for legal aid;
- where it has not been possible to appoint a litigation friend or [under the new numbering] rule 1.2 representative, including where the court has made a direction under rule 1.2(5);
- where a party is a litigant in person and does not qualify for legal aid;
- where the public body has recent knowledge of P; or it is reasonably expected that they have recent knowledge of P; or should have knowledge due to their statutory responsibilities under housing, social and/or health care legislation;
- the role of the public body is likely to be relevant to the decisions which the court will be asked to make;
- the application relates to an attorney or deputy and involves the exercise of the functions of the Public Guardian; and
- evidence before the court does not adequately confirm the position regarding P's capacity or where it is borderline; or if information is required to inform any best interests decision to be made in relation to P by the court.

An unofficial version of the template s.49 order in Word form is to be found here.

Transparency Pilot extended and model order varied

The Transparency Pilot has been extended to run until 31 August 2017. We hope in due course that a formal report as to the reasoning will be published, but for present purposes practitioners – and indeed the

judiciary – should note the following changes to the Pilot Order (which is available here, including in unofficial Word form):

- An addition to paragraph 5A (i.e. those bound by the order) to make express that it binds "all persons who are provided with or by any means obtain documents and information arising from this application;"

- An addition to paragraph 6 (concerning anonymisation of the transcript of hearings/judgments/orders), making clear that a confidential schedule should be provided with the necessary identification (and a copy of the order) to any person who needs to know the identity of P and/or others anonymised, for instance for purposes of complying with an order for disclosure of documents/information relating to P;

- A considerable simplification of the requirements relating to anonymisation of documents. Because – so far – very few hearings have been attended by anyone other than the parties, the initially cautious approach, which required all core documents to be anonymised, has been relaxed. There is now no requirement that this is to be done; rather the court, by new paragraph 7, may at any time give such directions as it thinks fit (including directions relating to anonymisation, payment, use, copying, return and the means by which a copy of a document or information may be provided) concerning the provision of information or copies of documents put before the court and the terms on which they are to be provided to any person who attends an attended hearing (and who is not already allowed to be given a copy of a document under PD13A – i.e. for such purposes as receiving advice or making complaints to relevant bodies).

Tor had previously prepared an unofficial easy read version of the Pilot Order, and we understand that an updated version to reflect the provisions of the amended Order will be forthcoming.

It should be noted, finally, that the PD extending the Transparency Pilot did so in such a fashion that it is now easier to update the Pilot Order, and practitioners should therefore make sure to ensure that they are using the current version, which will always be found here.

Shameless plug: LAG Court of Protection Handbook 2nd edition

All the above, and much more, will be covered in detail in the second edition of the LAG Court of Protection Handbook upon which Alex is beavering away at the moment with his co-authors with a view to publication in October. For more details and to pre-order, see here.

Habitual residence, integration and deprivation of liberty

Re DB; Re EC [2016] EWCOP 30 (Baker J)

International jurisdiction of the Court of Protection – Other

Summary [2]

This decision concerns the habitual residence of two people placed by Scottish authorities in hospital in England. For a Scottish perspective on the judgment, see the article by Adrian Ward in the August 2016 Scotland Newsletter.

DB and EC both had significant learning disabilities and required intensive care packages which engaged Article 5. Both had been born and raised in Scotland, initially placed in a specialist hospital in England and detained under s.3 MHA 1983 but subsequently made subject to a standard authorisation under Schedule A1 MCA 2005. Both applied under s.21A MCA 2005 to challenge their detention in the hospital. The parties did not dispute that the court had jurisdiction to determine a s.21A challenge regardless of whether the subject of the proceedings was habitually resident in England or Wales. The issue for the court was whether it could determine the best interests of the men as regards their care and residence if they were habitually resident in Scotland. The English and Scottish authorities agreed that both men had acquired habitual residence in England. The Official Solicitor for both men argued that they were habitually resident in Scotland. The judge, Baker J, noted that the meaning of habitual residence under the MCA 2005 was the same as under family law statutes and instruments, and that applying the guidance provided by the courts in those areas, both men were habitually resident in England for the following reasons:

- They had been present in England for a substantial period of time (7.5 years in one case and 6 in the other);

- Although ultimately the plan was for both men to return to Scotland, their placement in England was understood to be indefinite, and would last until they were ready to return and a suitable placement was available;

- Although the men's lives had not been characterised by the degree of social or family integration enjoyed by most people, neither was able to integrate in a family or social environment anywhere in a conventional way as a result of their disabilities, and they had in fact achieved a degree of integration at the hospital.

Comment

This decision is a useful illustration of the application of the established principles in family law to habitual residence disputes involving adults. Of particular significant is the court's conclusion that a person with significant learning disabilities could achieve a degree of integration in a hospital setting, having regard to the difficulties such a person would have in social integration in any setting, whether or not of an institutional nature.

[2] Alex now being instructed in this case, he has not contributed to this note.

Another interesting aspect of the case is the agreement by the parties concerned that the Court of Protection had jurisdiction to determine a s.21A application even if the person subject to the standard authorisation was not habitually resident in England or Wales. The authors are aware of previous unreported cases in which it has been asserted that by virtue of paragraph 7 of Schedule 3 to the MCA 2005, the court does not have such jurisdiction. In this case, the need to determine the habitual residence of DC and EB arose because, as part of the s.21A challenges, the court would be invited to determine substantive issues of capacity and best interests and make orders under ss.15 and 16 MCA 2005, and the court and the parties proceeded on the basis that such orders could only be made in respect of a person habitually resident in England or Wales by virtue of para 7 of Schedule 3.

The judgment does not examine whether there is an inconsistency between the court having jurisdiction under s.21A in respect of all people subject to standard authorisations, whether or not they are habitually resident in England and Wales, but its jurisdiction otherwise being limited by habitual residence. It remains the case therefore that there is no judicial explanation as to whether DOLS authorisations can in fact be granted in respect of people who are not habitually resident in England and Wales, and if so, why Schedule 3 does not prevent authorisations in respect of such people being challenged under s.21A.

Review of Recommendation CM/Rec(2009)11 – help wanted

Joan Goulbourn at the Ministry of Justice has enlisted our help in ensuring that as complete a set of answers as possible can be given to the review of Recommendation 2009(11) of the Committee of Ministers to member states on principles concerning continuing powers of attorney and advance directives for incapacity. A detailed questionnaire (prepared by our very own Adrian Ward, who is charged with conducting the review) can be found here, together with explanatory notes here. Please can questionnaires, complete either in whole or in part, be returned to Joan (Joan.Goulbourn@justice.gsi.gov.uk) by 9 September.

Mediation in the Court of Protection: consultation

Charlotte May, a specialist mediator and adult social care solicitor is conducting research in to mediation in the Court of Protection, and is after participants willing to complete a survey as to mediations which have (and have not) worked in the Court of Protection. Details of the research can be found here (note that questionnaires will now be sent out in September 2016). There is at present, a real dearth of hard evidence as to the ways in which mediation can work in the court, and we would urge anyone with experience to engage in this consultation to help develop a body of such material.

Weighing balance sheets in the scales

Re A (A Child) [2016] EWCA Civ 759 (Court of Appeal (McFarlane and King LJJ)

Best interests – medical treatment

Summary

This appeal arose following an application made by an NHS Trust to withdraw life-sustaining treatment, in particular, to remove respiratory support by a ventilator from a patient with the inevitable consequence that the patient would quickly die thereafter.

The case concerned a little boy (A), aged 2 years 8 months, who suffered a road traffic accident. A suffered grave injuries including a spinal cord injury and hypoxic brain injury. He was tetraplegic and could not feel anything below the neck. He could not see and, whilst the circuit of his hearing was intact, he was unable to process this into functional hearing. He did not respond to any command, noise or sight. He had no spontaneous respiratory effort, no limb movement, no response to painful stimuli, no cough reflex and weak gag responses.

A's mother could not accept the medical evidence as to A's current level of responsiveness. She believed that he responded to music, that when he curled his hands it was a sign of pleasure rather than a reflex movement and that there might be some functional vision. She believed A responded to her voice. All the

doctors said that the mother was mistaken in her belief.

A remained in pediatric intensive care since the day of his accident and received 24 hour one to one nursing care. His life expectancy was uncertain by limited. A had suffered three episodes of ventilator associated pneumonia and multiple urinary tract infections. It was common ground that A would have repeated episodes of pneumonia and, at some stage, his pneumonia would be so severe that he would not be able to be ventilated and will die.

Given the extent of A's injuries and his poor prognosis, his treating clinicians had discussed with A's family the possibility of the withdrawal of life sustaining treatment. A's father agreed to the withdrawal of life support because he felt that A was suffering from intensive care intervention. A's mother did not agree to the proposed course of action and wished the continuation of full intensive care. It was against this backdrop that the NHS Trust made an application to court for a declaration that it would be lawful and in A's best interests to remove his respiratory support.

When the matter came to trial, the three doctors who were called to give evidence, and the children's guardian, were each of the view that A's best interests could only be served by discontinuing life sustaining treatment. If the declarations were not made, it would be desirable to move A to a neurorehabilitation unit for long-term care. This in itself would require surgery to allow A to be ventilated through a tracheostomy tube as his current form of ventilation through a mechanical ventilator could not be used outside an intensive care unit. In addition, a gastrostomy PEG would have to be inserted to allow A to be fed directly into his stomach. The medical team considered that such invastive procedures to be wholly contrary to A's best interests and, in the event, given A's clinical presentation in the last few weeks, it would seem that any attempt to transfer A to a rehabilitation unit was out of the question.

The judge at first instance, Parker J, granted the declarations sought by the NHS Trust and declared that it was lawful and in A's best interests to remove his respiratory support by extubating him and, if he becomes unstable, not to reintroduce his respiratory support again but instead generally to furnish pain relief or sedation and nursing to ensure that A suffers the least distress and pain in the manner of his dying. The mother appealed to the Court of Appeal on three grounds:

1. The judge was wrong to make a finding that A was in pain and/or misunderstood the evidence in respect of pain;

2. The judge failed to carry out a proper, detailed and careful balancing exercise in respect of whether continued treatment was in A's best interests;

3. The judge failed to have regard to the obligation to protect life.

The Court of Appeal dismissed the mother's appeal on all three grounds.

In relation to the judge's findings on pain, the Court of Appeal recognised that this was an area of medical

disagreement. Two of the doctors believed that A's physical manifestations observed by the treatment were clinical responses to pain or discomfort. One of the doctors considered that those parts of A's brain that process pain were demonstrably injured on the MRI scan, and not working on an EEG, which led the doctor to believe that A did not feel pain and was not in distress. The judge, having seen and heard all the evidence, had to choose between what was undoubtedly a "reasonable range of professional opinion." It could not be said that the judge was plainly wrong in preferring the interpretation of the two doctors who had observed commonplace signs associated with pain and discomfort.

In any event, the Court of Appeal found that even if the judge had been wrong about A's ability to feel pain and discomfort, the judge had correctly directed herself as to the law and weighed up with care all the relevant factors to inform A's best interests in the widest sense. It could not be said that the judge had been wrong in agreeing with all of the experts and A's children's guardian that it the time had come to withdraw A's life-sustaining treatment.

Comment

This is a very unusual appeal in that it directly challenged the findings of a trial judge as to the specific condition of and sensations experienced by the subject of a medical treatment application.
We report it because, notwithstanding that it related to a child, A, the Court of Appeal drew heavily from the case law established under the Mental Capacity Act 2005 when considering and assessing A's best interests. In particular, central to the Court of Appeal's approach was the Supreme Court decision in *Aintree Hospital NHS Foundation Trust v James* [2013] UKSC 67. The Court formulated the test to be applied as *"what is in the best interests of the child at the particular time in question, having regard to his welfare in the widest sense, not just medical, but social and psychological?"* The Court of Appeal highlighted a real danger of failing to stand back and consider A's welfare in its widest sense. In this particular case, almost all of the evidence related to the issue of "pain" and disproportionate emphasis had been placed on this one item which, although relevant, did not go to the heart of the decision.

Importantly for practitioners, the Court of Appeal cautioned against applying a too rigid and mechanistic approach when using a balance sheet. King LJ was "*well aware of their value*." However, endorsing concerns expressed by McFarlane LJ in *Re F (A Child) (International Relocation Cases)* [2015] EWCA Civ 882, she noted that:

> *The courts have long recognised that in disputes in respect of serious medical treatment the matter should be brought before the court. See for example NHS Trust v SR Radiology and Chemotherapy [2013] 1 FLR 1297. At the end of the day, as was emphasised by Baroness Hale in the Aintree case, the test to be applied by the courts in such cases is simply this: what is in the best interests of the child at the particular time in question, having regard to his welfare in the widest sense, not just medical, but social and psychological? Too heavy a focus on a balance sheet may, as was recognised by McFarlane LJ, lead to a loss of attribution of weight.*

That message applies more widely to best interests' decision-making generally, not just in highly sensitive medical treatment cases. As McFarlane LJ emphasised in *Re F* (and Hayden J has made clear is also the case

under the MCA), "[i]*f a balance sheet is used it should be a route to judgment and not a substitution for the judgment itself*."

Short note: s.117 and deputies

In the course of a judgment [2016] EWHC 1954 (Ch) refusing a strike out application in respect of a restitutionary claim (a judgment which says a number of interesting things about whether such claims can be brought in the context of s.117 MHA 1983 where the claim is not for repayment of monies charged but where it is said that an aftercare plan should have been in place so that monies would never have been paid by the claimant), Newey J reminded us, in passing, of the need for deputies to be careful to ensure that they make requests for aftercare under s.117 wherever such can (and should) be made. The claimant's deputy in the instant case had paid well over £500,000 on his behalf in care home fees and then upon carers in circumstances where the claimant is now contending that such sums should always have been paid by the relevant local authority and NHS CCG. Newey J indicated that he considered that the claimant would have an uphill struggle with his restitutionary claim, such that the consequences of what was contended (by the claimant) to be his deputy's "mistake of law" may not easily be untangled.

Money and mental health: consultation

The new Money and Mental Health Policy Institute upon which we reported in April 2016 has now published a major consultation entitled *In Control – a consultation on* regulating *spending in periods of poor mental health*. The report examines some of the psychological drivers of increased spending and explore a range of possible solutions, along with a series of questions to which the institute invites those with expertise in financial services, retail and mental health to respond. The deadline for responding is 10 October.

Inside the Ethics Committee

For those of you who missed it, the editors other than Tor strongly recommend that you listen to the edition of *Inside the Ethics Committee* on withdrawal of CANH which was broadcast on 4 August, on which Tor featured, and which featured a powerful (and challenging) discussion of the role of the Court of Protection in such cases. It can be found here.

Mental capacity law reform in New Zealand

Both readers from New Zealand and readers from England and Wales would be well advised to read the report recently published by Alison Douglass for the New Zealand Law Foundation. The report, available here, entitled *Mental Capacity: Updating New Zealand's Law and Practice*, is an admirably comprehensive and detailed review both of the current law in New Zealand and – by comparison – that in England and Wales – and a detailed set of proposals for reform.

Separately, a mental capacity toolkit has been published to assist doctors and other healthcare professionals in assessing capacity, which includes an extremely useful checklist. Whilst it is New Zealand-specific as regards the legal framework, the outline is equally applicable by way of good practice to capacity assessments being carried out in England and Wales. A particularly interesting aspect is the emphasis upon the cultural component, which takes a specific form in New Zealand but – in principle – is equally relevant to assessments carried out in other jurisdictions.

Vulnerable adult law reform in Singapore

Once again proving that Singapore is a useful comparative resource for those in England and Wales willing/able to look further afield, we note (with thanks to Terence Seah of Virtus Law for bringing it to our attention) that the Singaporean government is consulting upon a draft Vulnerable Adults Bill. The consultation documents can be found here, and the deadline for response is 23 August. The Bill has certain features similar to those in the Scottish Adult Support and Protection Act 2007. If translated into the English context, it would represent – at least in part – a codification of the High Court's inherent jurisdiction, something which Alex, at least, would wish the Law Commission to consider as part of its 13th programme of law reform on which it is consulting at present.

JM (Appellant) v Aberdeenshire Council (Respondent)

On 8th July 2016 the Sheriff Appeal Court issued its first decision ([2016] SAC (Civ) 5 XO5/16) in an appeal under the Adults with Incapacity (Scotland) Act 2000, an appeal by JM against a decision of Sheriff Summers in Aberdeen appointing the Chief Social Work Officer of Aberdeenshire Council to be welfare guardian to JM's brother JC. JC was described as having been diagnosed "with severe mental retardation and learning disability"; as requiring 24-hour support; and having "limited understanding and communication levels".

In April 1992 a guardianship order was granted in favour of the Council in respect of JC. It was renewed until December 2001. Although not narrated in the decision, that will have been guardianship with the fixed and limited powers provided for in the Mental Health (Scotland) Act 1984 to determine residence; to require attendance for medical treatment, occupation, education or training; and to require access to be given to any medical practitioner, mental health officer or other specified person. In May 2015 (when JC was aged 57) the Council applied for welfare guardianship under the 2000 Act. JM opposed that application and by Minute sought appointment of herself as guardian. The sheriff at first instance appointed the Chief Social Work Officer to be guardian for three years, and dismissed JM's Minute. JM appealed that decision. It appears that she was represented by a solicitor at first instance, but conducted the appeal herself. Accordingly, "for the appellant's benefit" the Appeal Court restated the law as to the limited role of an appellate court "as expressed most recently in a number of Supreme Court cases" by quoting Lord Reed in *Henderson v Foxworth Investments Limited* 2014 SC (UKSC) 203 (at para [67]) as follows:

> *t follows that, in the absence of some other identifiable error, such as (without attempting an exhaustive account) a material error of law, or the making of a critical finding in fact which has no basis in the evidence, or a demonstrable misunderstanding of relevant evidence, or a demonstrable failure to consider relevant evidence, an appellate court will interfere with the findings in fact made by a trial judge only if it is satisfied that his decision cannot be reasonably explained or justified.*

This report comments upon only the first and the last of JM's five grounds of appeal.

The first was that the same mental health officer should not have prepared both the report for the appellant's application, and the report for her own application, on grounds of conflict of interest. The Appeal Court pointed out that the decision whether or not to appoint a guardian rested with the sheriff, not the mental health officer, and that the purpose of the statutory reports was to assist the sheriff in that task. The mental health officer could be expected to act in an independent manner from the local authority which sought appointment. The Appeal Court quoted with approval an unreported decision in Kilmarnock Sheriff Court dated 29th May 2009 in *JM v LM* criticising the provision of reports from two different mental health officers in a contest for appointment. In that case, the sheriff had commented:

> *I have to say that I thought it was unfortunate that the same mental health officer who prepared the suitability report in respect of the Applicant did not carry out the suitability report in respect of the Minuter. I*

> *was advised during the course of the proof by the two mental health officers who gave evidence, that they perceived a conflict of interest and did not consider it appropriate for the same mental health officer to carry out the suitability reports. Neither myself, nor Miss Kelly, the Safeguarder, quite understood this position and I think it would have been preferable if the same mental health officer had prepared both reports.*

In a clear and authoritative passage relevant to any future such contests, the Appeal Court concluded:

> *We do not know whether it is the practice in some jurisdictions for mental health officers always to decline to prepare a second report in such circumstances. But if there is such a practice we would discourage it. We readily acknowledge that there might be cases, probably rare, where the individual circumstances require a different approach, but we do not consider it to be either necessary or desirable as a matter of common practice.*

JM's last ground of appeal was that JC's views "had not been heard and, insofar as she [i.e. JM] had expressed them, had been ignored". It is perhaps surprising that the Appeal Court considered it satisfactory that the mental health officer, in both reports, recorded an attempt to meet JC and obtain his wishes and feelings about the order sought and the powers requested; that the interview was ended at an early stage to avoid distressing JC; and that it was "not possible to ascertain [JC's] view on this application". That sits uneasily with the description of JC as having "limited understanding and communication levels". Evidently, though limited, they existed. It also sits uneasily with the absolute obligation in section 1(4)(a) of the 2000 Act to ascertain the wishes and feelings of the adult by any possible means, and with the importance of the will and preferences of the adult (and thus of ascertaining them) in terms of Article 12 of the UN Convention on the Rights of Persons with Disabilities ("CRPD"). Those provisions are not referred to in the decision of the Appeal Court, nor is the apparent failure of the sheriff to have complied with the mandatory requirement upon him to consider whether a safeguarder should be appointed, with the possibility also of appointing some other person to represent the interests of the adult (2000 Act section 3(4)).

The decision of the Appeal Court is open to criticism in that it appears to proceed on the erroneous basis that the relevant test in such matters is the best interests of the adult. For example, the Appeal Court describes that in his Judgment "the sheriff explains why he decided that the grant of the respondent's application was in JC's best interests". That is not the statutory test with which the sheriff was required to comply. A best interests test was rejected by the Scottish Law Commission for the purposes of the 2000 Act in favour of the principles now appearing in section 1 of the 2000 Act (see paragraph 2.50 of the Commission's Report No 151 on Incapable Adults), a position now reinforced by the views of the UN Committee on the Rights of Persons with Disabilities as to the proper interpretation of Article 12 of CRPD.

A further point for some concern in the appeal decision is the reference, quoted above, to "severe mental retardation and learning disability". This implies that these are two different things. This commentator had always understood "mental retardation", "mental handicap" and "learning disability" to be synonymous, only the last of these being acceptable terminology in recent years.
Though mildly expressed, there is one further general point in this decision to be noted by any practitioner conducting an appeal before the Sheriff Appeal Court. The decision narrates that JM felt unwell at the

hearing but, rather than seeking adjournment, agreed that the Appeal Court should rely on a note which she had written and produced "which set out clearly the points she wished to make". What might be viewed as courtesy and assistance by the court to a party litigant should not, however, be seen as absolving a practitioner appearing before any court from the obligations of courtesy, and to provide assistance, to the court. Perhaps at least some of the points attracting critical comment in this report might not have arisen if that courtesy and assistance had been provided. However, such points were not made in the judgment of the Appeal Court, which on this aspect was limited to a single sentence: "Perhaps more surprisingly the solicitor for the respondent also advised that he was content to rely upon his written submissions which were brief to the point of being skeletal".

Adrian D Ward

Habitual residence, integration and deprivation of liberty

"DB and EC are two men born and raised in Scotland. Each has a profound learning disability and complex behavioural problems. They have both been receiving treatment in the same specialist hospital in England for several years. Proceedings in respect of each man have now been started in the Court of Protection. A preliminary issue has arisen as to whether each man has acquired habitual residence in England so as to vest jurisdiction in the Court." That is the first paragraph of the judgment of Mr Justice Baker in the conjoined (English) cases of *Re DB* and *Re EC* [2016] EWCOP 30 in which he concluded that both men had acquired habitual residence in England, for reasons reported and discussed in the principal coverage of this case in the Practice and Procedure section of this Newsletter.

Until the end of last century, that issue was unlikely to have arisen. Scotland had facilities, latterly at the Royal Scottish National Hospital at Larbert, to meet needs such as those described in the Judgment in respect of DB and EC. DB is described as having a severe learning disability, autism and epilepsy. He had a long history of highly aggressive behaviour with no apparent triggers. At one point he required a staff ratio of 4:1. The total cost of his care was £296,000 per annum. His needs were described as being "multi-layered and of a complexity only seen in a very small percentage of people with a learning disability".

EC was described as having severe learning disability, cyclic mood disorder, and autistic spectrum disorder with associated challenging behaviours. The cost of EC's care is not quoted. It would appear that the ordinary residence of DB and EC was deemed to have remained in Scotland, so that in each case care continued to be funded jointly by the relevant Scottish local authorities and health boards.

The specialist care given to each in England had been successful to the extent that after periods there of 7½ years and 6 years respectively, return to Scotland was in contemplation. Although the complexity of their needs indeed is limited to a very small proportion of people with learning disability, it is a proportion which will always exist, and for so long as specialist facilities to meet such needs do not exist in Scotland, such cases raising questions of whether habitual residence has remained in Scotland, or transferred to a specialist facility elsewhere, will continue to arise. Mr Justice Baker commented that: "Although it is undesirable that an excessive amount of time in litigation should be spent in analysing this issue, it is

essential for any court to satisfy itself that it has jurisdiction and to that end it must analyse properly the nature of the residence of the adult concerned in order to establish whether it has become habitual." That is clearly correct. Habitual residence is the primary ground of jurisdiction under the Adults with Incapacity (Scotland) Act 2000, the Mental Capacity Act 2005, and Hague Convention 35 on the International Protection of Adults. However, an obvious question arises as to whether within the United Kingdom the law in this regard should not be simplified. Perhaps one should refer to the position within the British Isles, given the extent to which specialist treatment for Irish patients is also frequently provided in England.

We have reported frequently, and with concern, upon difficulties in establishing ordinary residence, and the admitted differences of approach in that regard between England & Wales and Scotland. It is difficult to justify different approaches in each jurisdiction. Is it not perhaps also difficult to justify situations in which people such as DB and EC may have ordinary residence in one place and habitual residence somewhere else? Both DB and EC had families entirely in Scotland, with the costs of their care met by relevant Scottish local authorities and health boards. As Mr Justice Baker pointed out, "[t]he individual circumstances of both DB and EC mean that neither is able to integrate in a family or social environment anywhere in a conventional way. Wherever he resides, the life of each of them would be focused on his residential unit." That aspect, incidentally, identifies the extent to which the entirely commendable process of running down large institutions such as the Royal Scottish National Hospital had previously been, and transferring residence to placements "in the community", ran into fallacy for those for whom the only possible "community" is their care placement.

Even though such assimilation of ordinary residence and habitual residence cannot be achieved, there can surely be no good reason why within the United Kingdom (and perhaps within the British Isles) there should not be a "rule of thumb" for determining habitual residence in cases of no substantial controversy, such as a standard period of two or three years of residence in a different jurisdiction following which habitual residence would be deemed to have transferred to that jurisdiction.

Adrian D Ward

Scottish Government Consultation

'Following the conclusion of the Scottish Government consultation on the Scottish Law Commission's report on Adults with Incapacity, all publishable responses are available here, together with analysis of the responses available here.

Over the next couple of months we understand Scottish Government officials are meeting with a range of stakeholders and service users to discuss the findings from the consultation and to consider the way ahead.'

Adrian D Ward

Mental Welfare Commission for Scotland: Advice Note: Adults with Incapacity – Sexual Relationships and the Criminal Law

In July 2016, building on its previous related guidance *Consenting Adults?*, the Mental Welfare Commission published an advice note in response to concerns raised about the position under criminal law of staff supporting adults with learning disabilities in the context of such adults entering into non-exploitative sexual relationships.

In Scotland, concerns over the extremely complex issue about the extent to which it is permissible, or indeed required, to interfere in the sex lives of persons with learning disabilities was brought into sharp relief by the 2014 *LY*[3] ruling[4]. LY, a women with a learning disability, was subject to local authority guardianship specifically as a result of a former abusive and exploitative sexual relationship. However, she had subsequently entered into a non-abusive and non-exploitative sexual relationship and the local authority was seeking directions from the sheriff court as to whether or not it could authorise such relationship. The sheriff decided that as the application was made on the basis that LY lacked capacity to consent to sexual relations he could not give directions that would condone the criminal offence of rape.[5] He did, however, suggest that consideration be given to revisiting LY's ability to consent to sexual relations and a potential application for variation of the guardianship order.

The Commission's advice note acknowledges the very difficult balancing act that needs to take place when it comes to weighing up issues of autonomy and protection in these situations. It notes the need to give effect to, on the one hand, the right to respect for the adult's private and family identified in Article 8 ECHR and the right to equal recognition before the law identified in Article 12 UNCRPD and, on the other hand, the adult's right to freedom from exploitation, abuse and abuse identified in Article 16 UNCRPD. It acknowledges the problems involved and, consequently, is only able to give broad guidance in terms stating that guardianship powers that are used to protect an adult should be as specifically framed as possible and clearly justify when they may in practice be used to restrict the person from entering into a sexual relationship. Moreover, it states that every case must be considered on an individual basis bearing in mind the principles of the Adults with Incapacity (Scotland) Act 2000, with advocacy involvement and possibly involving requesting the court to appoint a curator *ad litem* or safeguarder.

In relation to the assessment of capacity to consent to sexual relations the Commission notes, in the absence of relevant Scottish jurisprudence, the English and Welsh Court of Appeal ruling in *IM v LM*[6] that the test for capacity (a) is whether the person is able to consent to sexual relationships in general and not whether a person can consent to sex with a particular person; and (b) should not be overly demanding and require a disproportionate level understanding on persons with capacity issues to on others. Importantly -

[3] *Application for directions by West Lothian Council in respect of Y*, 2014 SLT (Sh Ct) 93.
[4] There is a dearth of case law in Scotland relating to such issues.
[5] S 1 Sexual Offences (Scotland) Act 2009, taken together with s 17 of the same Act, provides that sexual intercourse without consent or a reasonable belief of consent constitutes rape.
[6] [2014] EWCA Civ 37.

and in line with the requirements of the Adults with Incapacity (Scotland) Act 2000 and Article 12 UNCRPD that people will be given support to assist them in taking decisions - the Commission also notes that capacity assessments should be based on the person's ability to take a decision with support. At the same time, however, it acknowledges that where there is evidence of a risk of exploitation, and the person cannot protect themselves against this, carefully justified guardianship may be appropriate.

Finally, the advice note sets out various non-prescriptive factors that the Lord Advocate has stated the Crown and Procurator Fiscal Service would consider in deciding whether or not to prosecute in the case of persons with capacity issues and sexual relations.

Jill Stavert

Mental Welfare Commission for Scotland reports of NHS wards in Scotland

On 20 July the Mental Welfare Commission published reports relating to recent visits to various NHS wards across Scotland.

The visits considered standards, care, treatment, support and participation, including physical health care, the use of mental health and incapacity legislation, activity and occupation and the physical environment. The good and the less good are noted and several recommendations are made.

The announced visits were to:

- Knapdale Ward, a twelve bed mixed sex dementia ward at Mid Argyll Community Hospital and Integrated Care Centre, Lochgilphead, where no recommendations were made.

- A six bed purpose built IPCU in Wishaw General Hospital (which takes both male and female patients) where one recommendation was made.

- A twelve bed IPCU at the Royal Edinburgh Hospital (with single bedrooms for women and men) where two recommendations were made.

- Three inpatient rehabilitation wards (Craiglea, North Wing and Myreside) at the Royal Edinburgh Hospital (catering for people with mental illness and complex care needs) where three recommendations were made.

- Two fifteen bed wards (one male (Parkside North) and one female (Parkside South) with a patient group whose ages range from mid-50s to mid-80s and who have spent most of their adult life in institutional care) where four recommendations were made.

The only unannounced visit was to an eighteen bed medium stay mixed sex rehabilitation ward, providing a rehabilitation service for adults, at Gartnavel Royal Hospital, Glasgow. On this occasion eleven recommendations were made.

The individual reports, which are available on the Commission's website, should be consulted for full and specific information. Although each and every recommendation certainly does not apply to all the wards visited by the Commission they highlight, in general terms, important issues such as the need for greater focus on recovery and rehabilitation and its reflection in care plans, patient participation and tailored support, the physical health needs of persons with mental disorder, ensuring the appropriate use of mental health and incapacity legislation, consent to treatment authorisation, the use of and processes surrounding medication, ward conditions and the use of restrictions. Interestingly, although mixed sex wards can be contentious and there were a number of these here, this did not appear to raise any particular issues on these occasions.

Jill Stavert

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Conferences at which editors/contributors are speaking

4th World Congress on Adult Guardianship

Adrian will be giving a keynote speech at this conference in Erkner, Germany, from 14 to 17 September. For more details, see here.

Autism-Europe International Conference

Alex will be taking part in a panel discussion on deprivation of liberty at Autism-Europe's 11th international congress in Edinburgh on 16-18 September. For more details, see here.

ESCRC seminar series on safeguarding

Alex is a member of the core research team for an-ESRC funded seminar series entitled 'Safeguarding Adults and Legal Literacy,' investigating the impact of the Care Act. The third (free) seminar in the series will be on 'Safeguarding and devolution – UK perspectives' (22 September). For more details, see here.

Deprivation of Liberty in the Community

Alex will be doing a day-long seminar on deprivation of liberty in the community in central London for Edge Training on 7 October. For more details, and to book, see here.

Switalskis' Annual Review of the Mental Capacity Act

Neil and Annabel will be speaking at the Annual Review of the Mental Capacity Act in York on 13 October 2016. For more details, and to book, see here.

Taking Stock

Both Neil and Alex will be speaking at the 2016 Annual 'Taking Stock' Conference on 21 October in Manchester, which this year has the theme 'The five guiding principles of the Mental Health Act.' For more 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.

Alzheimer Europe Conference

Adrian will be speaking at the 26th Annual Conference of Alzheimer Europe which takes place in Copenhagen, Denmark from 31 October–2 November 2016, which has the theme Excellence in dementia research and care. For more details, see here.

Jordans Court of Protection Conference

Simon will be speaking on the law and practice relating to property and affairs deputies at the Jordans annual COP Practice and Procedure conference on 3 November. For more details and to book see here.

Other conferences of interest

Financially Safe and Secure?

Action on Elder Abuse (AEA) Northern Ireland is delivering its first national conference on 30 September, supported by the Commissioner for Older People for Northern Ireland (COPNI) and sponsored by Ulster Bank, to explore the nature and extent of financial abuse of older people and focus on working collaboratively to address what has been described as the 'crime of the 21st Century'. For full details and to book see here.

Chambers Details

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

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THE QUEEN'S AWARDS FOR ENTERPRISE INTERNATIONAL TRADE 2013

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Alex is recommended as a 'star junior' in Chambers & Partners 2016 for his Court of Protection work. He has been in cases involving the MCA 2005 at all levels up to and including the Supreme Court. He also writes extensively, has numerous academic affiliations and is the creator of the website www.mentalcapacitylawandpolicy.org.uk. He is on secondment for 2016 to the Law Commission working on the replacement for DOLS. To view full CV click here.

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Victoria regularly appears in the Court of Protection, instructed by the Official Solicitor, family members, and statutory bodies, in welfare, financial and medical cases. Together with Alex, she co-edits the Court of Protection Law Reports for Jordans. She is a contributing editor to Clayton and Tomlinson 'The Law of Human Rights', a contributor to 'Assessment of Mental Capacity' (Law Society/BMA 2009), and a contributor to Heywood and Massey Court of Protection Practice (Sweet and Maxwell). To view full CV click here.

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

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Annabel appears frequently in the Court of Protection. Recently, she appeared in a High Court medical treatment case representing the family of a young man in a coma with a rare brain condition. She has also been instructed by local authorities, care homes and individuals in COP proceedings concerning a range of personal welfare and financial matters. Annabel also practices in the related field of human rights. To view full CV click here.

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

Simon Edwards: simon.edwards@39essex.com

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 consultant at 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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