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MENTAL CAPACITY REPORT: COMPENDIUM

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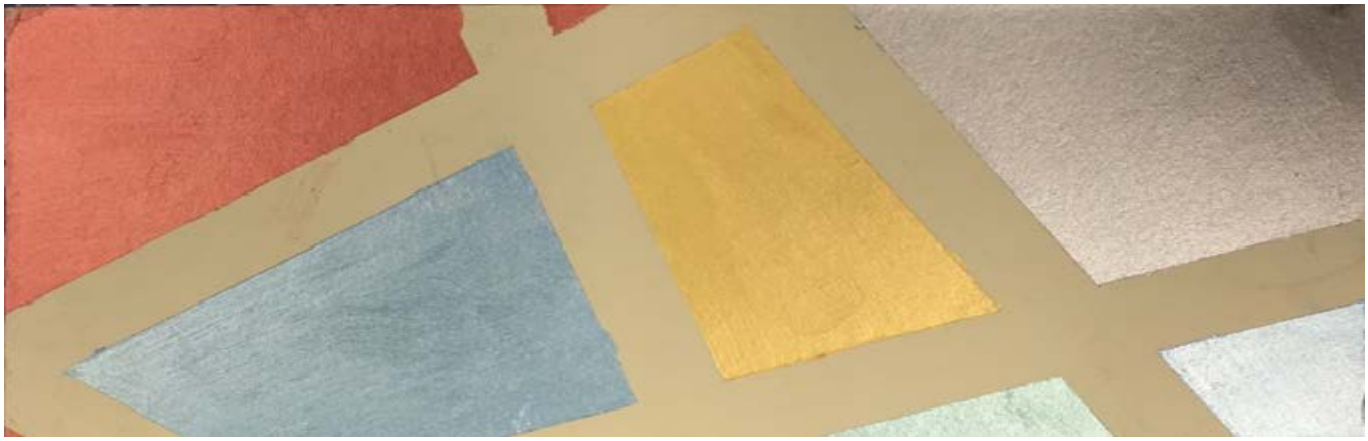

Welcome to the February 2017 Mental Capacity Report. You will note a new look, and also a new title, which reflects the fact that over the years we have evolved to carry material that goes considerably wider and deeper than in a conventional Newsletter. We have also retitled the individual sections of the Report (which you can continue to get in compendium and screen-friendly forms).

Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: positive obligations under Article 5, deprivation of liberty in the intensive care setting, and best interests in the context of childbirth and anorexia;

(2) In the Property and Affairs Report: common mistakes in making LPAs;

(3) In the Practice and Procedure Report: costs in medical treatment; an important case on time-limits in HRA cases, frustrating the Court of Protection and the end of era marked for the Court of Protection Practice;

(4) In the Wider Context Report: a new MCA/DOLS resource, capacity and the MHT, restraint in the mental health setting, mental health patients in general hospitals and truth and lying in dementia;

(5) In the Scotland Report: solicitors claiming an interest and the *nobile officium* comes to the rescue.

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You can find all our past issues, our case summaries, and much more on our dedicated sub-site here. 'One-pagers' of cases of most relevance to social work professionals will also appear on the SCIE website.

The picture at the top, "*Colourful*," is by Geoffrey Files, a young man with autism. We are very grateful to him, his family, and The Autism Trust to permission to use his artwork.

HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

Briggs update

By way of update to our report upon the decision of Charles J in *Briggs v Briggs (2)* [2016] EWCOP 53, the Official Solicitor ultimately decided not to appeal. Mr Briggs died in a hospice on 22 January.

Positively Article 5

Secretary of State for Justice v Staffordshire CC & Ors [2016] EWCA Civ 1317 (Court of Appeal) (Sir Terence Etherton MR, Elias and Beatson LJJ)

Article 5 – Deprivation of Liberty

Summary

The Court of Appeal has dismissed the Secretary of State's appeal against the decision of Charles J in *Re SRK* [2016] EWCOP 27. By way of refresher, Charles J found in that case that the state was indirectly responsible for "private" deprivations of liberty arising out of arrangements made by deputies administering personal injury payments. The Secretary of State for Justice ('SSJ') appealed the decision on two grounds.

1. The combination of the existing civil and criminal law and the obligations of public bodies to safeguard vulnerable individuals were sufficient to satisfy the positive obligation of the State under Article 5 where the day to day care of a person, who was objectively deprived of liberty but lacked capacity for the purposes of the MCA to consent to that loss of liberty, was being provided entirely privately rather than by the State. In particular, the SSJ contended that Charles J was wrong to conclude that, in such a situation, the State's positive obligation under Article 5(1) ECHR can only be discharged if a welfare order is made by the CoP under s.16 MCA authorising the deprivation of liberty pursuant to s.4A(3) MCA;

2. Responsibility for a "private" deprivation of liberty could not be attributed to the State where, as in SRK's case, there was no reason for the local authority or any other public body to have any suspicions about abuse, that there was some deficiency in the care provided to the person, that something has been done that was not in their best interests or that the deprivation of their liberty was greater than it could and should have been.

Sir Terence Etherton MR, giving the sole reasoned judgment, had little hesitation in dismissing both of these grounds of appeal.

State's Article 5 obligations

The only live question on the appeal was whether SRK's deprivation of liberty was imputable to the state under the third limb identified in *Storck*: i.e. by way of its failure to discharge its positive obligation

to protect him from deprivation of liberty contrary to Article 5(1).

The Master of Rolls held that the SSJ had been correct to identify that the State's positive obligation under Article 5(1) is to take reasonable steps to prevent arbitrary deprivation of liberty, and that Charles J had adequately expressed that test in his own language. As Charles J had noted in his judgment, *Storck* does not help on whether, in any particular case, the proper or the defective performance of a regime that has been put in place pursuant to the positive requirement of Article 5(1) would amount to a violation of that positive obligation. In other words, the Master of the Rolls held (at para 63) "*Storck* does not identify what has to be in place to meet the minimum requirement of Article 5(1)."

The Master of the Rolls accepted that the ECrtHR in *Storck* left open the possibility that a regime short of the requirement of a Court order and court supervision might be adequate for the State to meet its positive obligations under Article 5(1). It was the SSJ's case, he noted, that "notwithstanding the absence of a requirement for a welfare order from the CoP, the United Kingdom's existing domestic regime of law, supervision and regulation in respect of incapacitated persons who are being treated and supported entirely in private accommodation by private providers is sufficient compliance with the State's positive obligation under Article 5(1), at least where the public authorities have no reason to believe that there has been any abuse or mistreatment" (para 65). The SSJ relied particularly on the functions of the Care Quality Commission, the functions of the Public Guardian, the professional responsibilities of doctors and other health professionals, the safeguarding obligations of local authorities, and (in the words of the SSJ's skeleton argument) "the general framework of the criminal justice system and civil law."

However, Sir Terence Etherton MR held, Charles J had been both entitled, and right, to dismiss that argument:

> *74. The critical point, as Ms Nageena Khalique QC, for the Council, emphasised, is that, although local authorities and the CQC have responsibilities for the quality of care and the protection of persons in SRK's position, they will only act if someone has drawn the matter to their attention and there is nothing to trigger a periodic assessment. The same is true of doctors and other health professionals. Save where there are already proceedings in the CoP (when the functions of the Public Guardian will be engaged), the current domestic regime depends on people reporting something is wrong, and even then it will only be a notification of grounds for concern at that specific moment in time. That may be particularly problematic in cases where no parents or other family members are involved in the care and treatment. It does not meet the obligation of the State under Article 5(1) to take reasonable steps to prevent arbitrary deprivation of liberty.*
>
> *75. For the same reasons, as was stated by the ECrtHR in* Storck*, criminal and civil law sanctions which operate retrospectively after arbitrary deprivation of liberty has occurred, are insufficient to discharge the State's positive obligation under Article 5(1).*

Sir Terence Etherton MR therefore held that:

> *78. The Judge was fully entitled, and right, to conclude in the circumstances in paragraphs [143] and [146] that, absent the making of a welfare order by the CoP, there are insufficient procedural safeguards against arbitrary detention in a purely private care regime.*
>
> *79. The fact that, as the Judge acknowledged in paragraph [147], in the present and in many other such cases, a further independent check by the CoP will add nothing, other than unnecessary expense and diversion of resources, does not detract from the legitimacy of his conclusion since, as he observed in paragraph [148], there are other cases where the person lacking capacity will not have supporting family members or friends, and deputies and local authorities may not act to the highest requisite standards. No doubt, as the Judge observed in paragraph [148(v)], the practical burden of such applications would be reduced, in a case such that of SRK, by a streamlined paper application for the making of the initial welfare order and paper reviews.*

The relevance of abuse

Sir Terence Etherton MR was equally dismissive of the second ground of appeal:

> *83. Turning to the second substantive part of Ms Kamm's submissions, I do not accept the SoS's argument that, since each case of an alleged breach of Article 5(1) is fact dependant, there was no breach by the State of its positive obligation under Article 5(1) in the present case because SRK's care regime was in his best interests and was the least restrictive available option, and there was nothing to suggest the contrary to the Council or that there was any abuse. That is an argument that, even where there is objective and subjective deprivation of liberty of an individual, of which the State is aware, there can be no breach of Article 5(1) if the individual is being cared for, supported and treated entirely privately and happens to be receiving a proper standard of care in accordance with the requirements of the MCA at the particular time the State becomes aware of the deprivation of liberty. There is nothing in the jurisprudence to support such an argument. It runs counter to the interpretation and application of the spirit of Article 5(1) in, for example, HL and Cheshire West, in which the focus was entirely on the State's duty to prevent arbitrary deprivation of liberty and not on the quality of care and treatment actually being provided or, indeed, on whether the best and least restrictive treatment would not have involved deprivation of liberty of the individuals in those cases.*

By way of concluding observation (without express reference to the Law Commission's work, but surely with this in mind), the Master of the Rolls noted:

> *83. Finally, it is important to note that, while an application to the CoP is necessary in the present state of law and practice for the State to discharge its positive obligation under Article 5(1), such a step might not be essential if a different legislative and practical regime were to provide for proactive investigation by a suitable independent body and periodic reviews. It would, as Ms Kamm said, be for the Government to fill the gap as it had done in the case of the Bournewood gap.*

Comment

It is difficult to see how the Court of Appeal could have reached any other conclusion than that reached by Sir Terence Etherton MR, although it is notable that he did not seem to have reached it with the same degree of reluctance as did Charles J.

The ratio of the decision of the Court of Appeal would appear to apply to "private" arrangements made by any court appointed deputy (whether or not they are administering a personal injury payout). Trickier is the question of whether or not they apply to "private" arrangements made by an attorney as an attorney, unlike a deputy, is not appointed by the state. However, Charles J had at first instance referred to the potential for an attorney paid personal injury damages as one of those who should be required to know that the regime of care and treatment creates a deprivation of liberty within Article 5(1), and Sir Terence Etherton MR made no comment upon this (see para 60).

More broadly, in the circumstances, it seems that there is now really very little distinction between "public" and "private" deprivations of liberty: wherever the state is or, ought, to be aware of a person being confined under arrangements to which they cannot consent, then they will need to take steps to ensure that confinement is authorised. Absent legislative change to enable administrative procedures to be used, it will be necessary to obtain authority from the Court of Protection under the *Re X* procedure.

It is in this regard unfortunate that the Court of Appeal did not take the opportunity to confirm whether it is, in fact, the responsibility of the deputy (or – by analogy – attorney) to seek such an order in such cases. What, of course, is particularly problematic with any approach which requires steps to be taken on behalf of the person concerned is that they will inevitably cost money, money which (in most cases) will have to come from their estate. In cases such as SRK's, it is possible to factor this into any personal injury award, but in other cases it does come dangerously close to suggesting that people should pay for the privilege of having their detention authorised to comply with the State's obligations.

The Secretary of State for Justice is not seeking to appeal this decision. Until and unless the Supreme Court or Strasbourg determines that "deprivation of liberty" has a narrower meaning than that given at present (as to which, see the discussion of the *Ferreira* case below), it remains the case, therefore, that the tentacles of the state will – inevitably – have to extend ever further into private settings in the name of protecting Article 5 rights. Alex, at least, has his own thoughts as to how we might find a principled way to define deprivation of liberty in a way which returns to its core meaning of coercion, but those are for another day.

Deprivation of liberty in ICU

R (Ferreira) v HM Senior Coroner for Inner South London and others [2017] EWCA Civ 31 (Court of Appeal (Arden and McFarlane LJJ, Cranston J))

Article 5 – deprivation of liberty

Summary[1]

Maria Ferreira died in an intensive care unit after she dislodged a tube with her mittened hand. An inquest was to be held but whether a jury was required depended upon whether she died in "state detention" under ss 7 and 48 of the Coroners and Justice Act 2009. A key issue, therefore, was whether "state detention" equated to "deprivation of liberty" under Article 5(1) ECHR and the relevance of the Supreme Court's decision in *Cheshire West*.

The Court of Appeal concluded Ms Ferreira was not in state detention for three alternative reasons: (1) *Cheshire West* did not apply; (2) if it did apply, she was free to leave; and (3) unlike MCA s 64(5), the CJA 2009 does not expressly require consideration of Article 5 and ICU is not state detention.

(*1) Cheshire West distinguished*

Arden LJ (giving the sole reasoned judgment of the court) accepted that there was a substantial overlap between "state detention" and "deprivation of liberty", although it need not bear the exact same meaning. The primary answer to the issue was to be found in Article 5 (para 78) and, accordingly, she was:

> *10… not deprived of her liberty at the date of her death because she was being treated for a physical illness and her treatment was that which it appeared to all intents would have been administered to a person who did not have her mental impairment. She was physically restricted in her movements by her physical infirmities and by the treatment she received (which for example included sedation) but the root cause of any loss of liberty was her physical condition, not any restrictions imposed by the hospital."* (emphasis added)

It seems that, where a person's deprivation of liberty could not be justified under the exceptions in Article 5, regard could be had to the purpose of the liberty interference (para 81). Moreover, relying upon *Nielsen v Denmark* (involving a 12 year old in a psychiatric hospital) and *HM v Switzerland* (elderly person in residential care):

> *85… This case shows, where the detention was not capable of coming within any of the exceptions to Article 5(1), justification is not treated separately from the question whether the person is deprived*

[1] Note, both Tor and Alex being involved in this case and permission being sought by the Appellant to appeal to the Supreme Court, this note has been prepared by Neil Allen.

> *of her liberty. Moreover, the reason for his detention was relevant, and thus the fact that a person is deprived of his liberty in his own interests may prevent the deprivation of liberty from being a relevant deprivation of liberty for the purposes of Article 5.*

The court went on to hold that there is in general no deprivation of liberty where the person is receiving life-saving medical treatment:

> *88… The Strasbourg Court in Austin has specifically excepted from Article 5(1) the category of interference described as "commonly occurring restrictions on movement". In my judgment, any deprivation of liberty resulting from the administration of life-saving treatment to a person falls within this category. It is as I see it "commonly occurring" because it is a well-known consequence of a person's condition, when such treatment is required, that decisions may have to be made which interfere with or even remove the liberty she would have been able to exercise for herself before the condition emerged. Plainly the "commonly occurring restrictions on movement", which include ordinary experiences such as "travel by public transport or on the motorway, or attendance at a football match", can apply to a person of unsound mind as well as to a person of sound mind.*
>
> *89. On this basis, any deprivation of liberty resulting from the administration of life-saving treatment to a person falls outside Article 5(1) (as it was said in Austin) "so long as [it is] rendered unavoidable as a result of circumstances beyond the control of the authorities and is necessary to avert a real risk of serious injury or damage, and [is] kept to the minimum required for that purpose". In my judgment, what these qualifications mean is in essence that the acute condition of the patient must not have been the result of action which the state wrongly chose to inflict on him and that the administration of the treatment cannot in general include treatment that could not properly be given to a person of sound mind in her condition according to the medical evidence.*

An example of physical treatment falling the other side of the line and amounting to a deprivation of liberty requiring authorisation was *NHS Trust I v G* [2015] 1 WLR 1984. Here, a woman of unsound mind was to be prevented from leaving the delivery suite and might be compelled to submit to invasive treatment (a Caesarean section). This treatment would be materially different from that given to someone of sound mind: "*By contrast, I do not consider that authorisation would be required because some immaterial difference in treatment is necessitated by the fact that the patient is of unsound mind or because the patient has some physical abnormality*" (para 90).

The Supreme Court's decision in *Cheshire West* was distinguished "*since it is directed to a different situation, namely that of living arrangements for persons of unsound mind*" (para 91). And policy did not require the acid test to apply to urgent medical care:

> *93… There is in general no need in the case of physical illness for a person of unsound mind to have the benefit of safeguards against the deprivation of liberty where the treatment is given in good faith and is materially the same treatment as would be given to a person of sound mind with the same physical illness. The treatment is neither arbitrary nor the consequence of her impairment…*
>
> *95. In addition, in my judgment, Article 5(1)(e) is directed to the treatment of persons of unsound mind*

because of their mental impairment. The purpose of Article 5(1)(e) is to protect persons of unsound mind. This does not apply where a person of unsound mind is receiving materially the same medical treatment as a person of sound mind. Article 5(1)(e) is thus not concerned with the treatment of the physical illness of a person of unsound mind. That is a matter for Article 8. Where life-saving treatment is given to a person of sound mind, the correct analysis in my judgment is that the person must have given consent or the treating doctors must be able to show that their actions were justified by necessity or under section 5 of the MCA. If this cannot be shown, then there has to be some method of substituted decision-making, such as obtaining an order from the Court of Protection." (emphasis added)

(2) If acid test was applicable, Ms Ferreira was free to leave

If distinguishing *Cheshire West* turned out to be wrong, the court held that Ms Ferreira was under continuous supervision and control but was not deprived because she was free to leave. Contrary to the Law Society guidance, the court held that the focus is on the patient's wish to leave, not that of her relatives to remove her (para 96). The issue was unlikely to arise in practice where a patient with an acute condition was in ICU. If it did, clinicians would likely try to persuade the patient from leaving, but not prevent it. The evidence suggested that clinicians would go so far as to seek urgent advice from the legal team. The court goes on to say:

98. Moreover, as I read it, the two-part acid test formulated by Lady Hale in Cheshire West in my judgment was designed to apply only where the second element – lack of freedom to leave – was the consequence of state action, particularly state action consisting of the continuous supervision and control constituting the first element of the test.

99. In the case of a patient in intensive care, the true cause of their not being free to leave is their underlying illness, which was the reason why they were taken into intensive care. The person may have been rendered unresponsive by reason of treatment they have received, such as sedation, but, while that treatment is an immediate cause, it is not the real cause. The real cause is their illness, a matter for which (in the absent of special circumstances) the state is not responsible. It is quite different in the case of living arrangements for a person of unsound mind. If she is prevented from leaving her placement it is because of steps taken to prevent her because of her mental disorder. Cheshire West is a long way from this case on its facts and that, in my judgment, indicates that it is distinguishable from the situation of a patient in intensive care.

…

105… there was no evidence to suggest that the hospital would have refused a proper request to remove Maria or that Maria would have asked to leave…. her inability to leave was the consequence of her very serious physical condition.

(3) Not "state detention" under CJA 2009

The final, alternative, basis for dismissing the appeal was that the jurisprudence of the European Court

of Human Rights did not apply when interpreting the words "state detention" in the JCA 2009:

> *108… section 48(2) of the CJA 2009, properly construed, does not include ICU treatment as "state detention" because there is no clear and constant jurisprudence of the Strasbourg Court that such treatment involves a violation of Article 5.*

Un/authorised detention

Paragraph 66 of the Chief Coroner's Guidance No 16, *Deprivation of Life Safeguards,* revised 14 January 2016, stated that "*The person is not 'in state detention' for these purposes until the DoL is authorised*." In other words, the death need not be reported to the coroner unless an authorisation was in place. However, the Court of Appeal held that this was wrong:

> *104… It would be highly anomalous if, in order for there to be "state detention", there had to be authorisation for removing a person's liberty. Parliament cannot have intended such an absurd result.*

Comment

Whilst many may agree with the conclusion that a person in intensive care should not generally be described as being in State detention, the court's reasoning to that conclusion is likely to prove controversial, and permission to appeal is being sought. It is a shame that the court declined to consider the submission that Article 5 is about coercion (para 71). For interpreting a deprivation of liberty as coerced, or compulsory, confinement may ultimately provide a more principled answer to the restriction-v-deprivation dilemma. After all, according to *Winterwerp,* whether the unsoundness of mind justifies "compulsory confinement" is what Article 5(1)(e) is about.

The fact that the court found the primary answer in Article 5 means that it is likely to have significant consequences, not least of course in ICUs to which, in 2014/15, there were 163,000 admissions in England and Wales. What we seem to be witnessing is "deprivation of liberty" being interpreted differently in different contexts, with policy considerations very clearly in play. In *Cheshire West*, the policy was to ensure extremely vulnerable people had independent periodic checks on their best interests. In intensive care, this court was content to rely more upon the good faith of the clinicians. Without expressly referring to it, the approach of the court appears to reflect the type 1 / type 2 distinction which Lady Hale found "helpful" in *Cheshire West* (paras 43-44). Type 1 being situations that could be justified under Article 5(1) and type 2 being those that cannot.

The judgment is likely to be applied in other analogous care settings, such as palliative care, and disorders of consciousness because, typically, the person is receiving the same physical treatment as that given to a person of "sound mind". For example, it may well be difficult now to contend that *Paul Briggs* was deprived of his liberty. Distinguishing physical from psychiatric treatment is not straightforward. And trying to draw these fine distinctions when determining the scope of Article 5 will

be challenging. Indeed, much of the judgment refers to "unsound mind" or "mental impairment". But it is not clear what that means in this context. Does it mean "mental disorder" or "mental incapacity"?

That para 66 of the Chief Coroner's Guidance was held to be wrong is not a surprise but does have significant ramifications. It means that it does not matter whether the deprivation of liberty is authorised or not, a death therein will need to be reported to the coroner. Of course those caring at end of life, and best interests assessors, may use this judgment to contend that the person is not deprived of liberty. But, that apart, this ruling is likely to lead to an ever-growing demand on coroners to consider typically naturally deaths. In that regard, the amendment to the Coroners and Justice Act 2009 contained in the Policing and Crime Act 2017 (to which Royal Assent was given on 31 January) may only provide limited assistance. That amendment provides that "*a person is not in state detention at any time when he or she is deprived of liberty under section 4A(3) or (5) or 4B of the Mental Capacity Act 2005*." This means that natural deaths occurring where a person is deprived under DoLS, Court of Protection authorisations, or whilst applications to the court are being made will not need to be reported. But non-authorised deprivations of liberty will still have to be.

Ultimately, perhaps the court's conclusion is best explained by the underlying policy concerns:

> *111 … to require authorisation of the deprivation of liberty in what would be a normal ICU case would involve a significant dilution and distraction of clinical resource, time and attention. That must inevitably risk jeopardising the outcome for all ICU patients, for no apparent policy reason.*
>
> *112… the fact that the conclusion which I have reached will avoid substantial expenditure of human and financial resources, for which no semblance of a policy reason has been given to us, in my judgment is also supportive of the conclusion that I have reached.*

Public protection and s.21A (again)

N v A Local Authority [2016] EWCOP 47 (Peter Jackson J)

Article 5 ECHR – DOLS authorisations – best interests – contact

Summary

This was a second s.21A challenge, the first being reported as *Y County Council v ZZ* [2012] EWCOP B34, where Moor J upheld the supervision arrangements. It concerned a man in his 40s with mild learning disability and 'paedophilic disorder'. He had a history of fire-setting and self-harm and a tendency to try to make contact with children for sexual gratification. However, he had not engaged in any obviously risky behaviour for the past six years. Deprived of liberty in a locked residential placement for those with challenging behaviour, he was escorted at all times outside and closely monitored inside. Since 2016 he had been offered daily shadowed leave in the community.

The s.21A challenge was issued in April 2014, soon before the standard authorisation was to expire.

Since then his detention had been authorised by interim court orders. During the length of these proceedings, he had separately unsuccessfully challenged his guardianship order in the tribunal. The issues before the court were (1) whether N had capacity to decide on his care arrangements, and specifically to decide whether or not he should be accompanied in the community, and (2) if he did not, whether the deprivation of his liberty was necessary and proportionate and in his best interests.

On the first issue, Peter Jackson J found that:

> *11. N himself does not consider that he poses a risk to himself or others, and points to the fact that he has been largely compliant for the past six years. I note, however, that when speaking to MM he described his feelings for children as natural, saying that everyone has them to some extent. Also, for some years, he has expressed a wish to adopt a child, despite being repeatedly counselled that this is unrealistic. These are to my mind clear examples of his inability to understand the issues that have to be considered when making decisions about his care arrangements. I note Dr Noon's view that they might also be an example of minimization, but he too considered that N's paedophilic disorder probably also affects his capacity, though the fundamental difficulty springs from his learning disability…*
>
> *13. Having considered all the evidence, I accept the professional conclusion and, like Moor J, find that N lacks the capacity decide on his care arrangements. His learning disability deprives him of insight into the persistence of his paedophilic disorder. For him to go into the community alone would not be merely an unwise decision, but an action taken without any real understanding or balancing of the risks he poses and the risks he faces.* (emphasis added)

In relation to the second issue, Peter Jackson J held:

> *15 … The boundaries that are being set allow N to develop in a way that he is not able to achieve for himself. The level of risk if he was unsupervised is real and the nature of the risk is serious. It could lead to N being returned to a prison or hospital environment indefinitely, quite apart from the risk of a violent response from others.*
>
> *16. Mr O'Brien argues that the professional position has been over-influenced by an understandable concern to protect others, as opposed to giving benefit to N. I found no sign of this in the witnesses' evidence.* (emphasis added)

His Lordship found that the lack of risky behaviour over the past six years showed the success, rather than lack of necessity, of the supervision arrangements. They were necessary, proportionate and in his best interests. However, the efforts to relax supervision were to continue. After all, "*The granting of a deprivation of liberty authorisation permits controls but does not compel them*" (para 18). Accordingly, it was authorised for a further 12 weeks to allow the local authority to arrange a standard authorisation. Any further s.21A challenge was to be referred to his Lordship for directions or summary disposal.

The court was critical of the length of proceedings. The first case, before Moor J, had lasted for two years and ended in 2012. These proceedings lasted for 2½ years but should have been concluded

within around six months. His Lordship contrasted this with the guardianship appeal where "*the tribunal system was able to resolve the objectively more serious issue of guardianship in a matter of seven or eight months, appeal included*".

Comment

The first thing to note about this judgment is the interesting reference to N's "paedophilic disorder", for the psychiatric labelling of paedophilic thoughts is a controversial issue, albeit envisaged by the Mental Health Act 1983. Secondly, this case illustrates the interaction between harm to self and harm to others in the context of best interests, necessity and proportionality. There is clearly pressure in similar cases to liberally interpret "harm to P" by including the consequences to P if P's risk to others materialises.

Secondly, Peter Jackson J noted that Counsel for N "*rightly queried whether the Court of Protection should use its powers to extend a deprivation of liberty for longer than the statutory scheme allows. The short answer is that the question of an extension for longer than 12 months should not have arisen at all because the proceeding should have been concluded within, say, six months*." Whilst he did not expressly hold that the Court of Protection could not so use its powers, we suggest that the Court of Protection cannot lawfully extend authorisations beyond 12 months (see also in this regard the observations of Charles J in *Re UF*). It is important also to recall in this regard, as Charles J has recently reminded us in *Briggs v Briggs (1)*, the importance of ensuring that authorisations remain in place during the life of any CoP proceedings so as to ensure that there are no doubts as to the availability of non-means-tested legal aid.

Finally, it is worth emphasising that there was no criticism in principle to a second s.21A challenge being brought in this case, although there was significant delay, and the court envisaged further such challenges. The Court of Protection has yet to rule on the issue of the frequency by which P or their RPR are able to exercise their rights under Article 5/MCA s.21A.

Best interests and childbirth

Re CA (Natural Delivery or Caesarean Section) [2016] EWCOP 51 (Baker J)

Best interests – medical treatment

Summary

This case concerned a 24 year old woman, CA, with a diagnosis of autism and a mild learning disability who, it was thought, had undergone some form of female genital mutilation as a child. CA was very reluctant to allow herself to be examined and had only agreed to limited examination of the foetus during her pregnancy. She did not want to go to hospital, saying it was associated with too many bad memories of her childhood and her life. She wanted to give birth at home on her own. She appeared to have little or no understanding of what giving birth would be like, and the expert evidence was that her failure to take relevant information into account was the direct consequence of her autism.

Baker J concluded that CA lacked capacity to make decisions about the method of delivery, and a detailed balance sheet was drawn up comparing the options of a planned caesarean section and vaginal delivery. The treating doctors considered that 'taking into account her history of non-compliance and lack of capacity to consent to surgical intervention, an elective Caesarean section would be the safest, least traumatic and most appropriate mode of delivery.' A consultant psychiatrist expressed the view that the 'option of a vaginal delivery was unrealistic due to CA's refusal to allow the midwife to carry out repeated vaginal examinations to monitor the progress of her labour; her refusal to talk through various options for pain relief; her refusal to allow administration of any necessary injectable medication if required; her anticipation that the baby would just "pop out"; her lack of realisation that the experience of first delivery may be long and often painful; her reluctance to comply with instructions and the consequent risk of lack of cooperation, for example when instructed to push, leading to an uncoordinated or chaotic labour process.' Dr I also expressed the view, which the court accepted, that 'an emergency Caesarean section would cause the greatest degree of psychological damage to CA, and that a planned Caesarean section is likely to lead to the least psychological damage of the options in this case.'

Baker J authorised a plan for a caesarean section to include sedation and physical restraint if necessary.

Comment

As is common in these cases, the application was brought very late – less than two weeks before the due date. Baker J was very critical of the Trust's failure to follow the clear guidance previously given by the court about the need for prompt applications, and it is likely that in future cases, applications at short notice are likely to result in serious criticism and/or costs consequences for Trusts.

It is unsurprising given the unanimous medical evidence that the Trust's proposals were endorsed by the court, despite going against CA's clearly expressed wishes. A postscript to the judgment notes that CA's baby was born with minimal restraint to hold her hand to administer intravenous sedation, and that her baby was in the breech position.

This case and others will be discussed in the forthcoming seminar on Childbirth and the Court of Protection at 39 Essex Chambers on 8 March – please see the 'seminars' section of the newsletter for further details.

Anorexia – handing back control?

Cheshire & Wirral Partnership NHS Foundation Trust v Z [2016] EWCOP 56 (Hayden J)

Best interests – medical treatment

Summary

In *Re Z*, Hayden J had to contemplate three options on behalf of a woman, Z, detained under the Mental Health Act 1983, with very severe anorexia who had, in the 31 years since being diagnosed at age 15, had never engaged in any meaningful way with treatment, and who had, in consequence, both an extremely low BMI, severe osteoporosis and a low white blood cell count, and who was held not to have capacity to make decisions as to whether to undergo treatment for her anorexia.

The first possibility was to continue treatment under s.3 Mental Health Act 1983 which would involve detention in hospital and naso-gastric feeding under physical restraint until Z's weight and physical health improved to the point where it would be possible to discharge her. This possibility was agreed both by her treating doctor and the independent expert, Dr Glover (who has appeared in almost all reported cases involving anorexia under the MCA) to be highly unattractive, with a "*real risk that feeding under restraint here would be dangerous, to the extent that death might be caused iatrogenicaly i.e. the treatment risks killing the patient. The obvious psychological distress to Z and, if I may say so, to her parents and to the medical staff is difficult to justify. In addition, Z's osteoporosis is so severe that the medical consensus is that physical restraint faced with the resistance that is likely would probably result in significant musculoskeletal injury*" (paragraph 7).

The second possibility also involved continuation of feeding, again under s.3 Mental Health Act 1983, involving detention in hospital, but with the feeding to take place under chemical sedation. However, given her parlous state of health, the medical consensus was that sedation would involve a very significant risk, most particularly of respiratory or cardiac arrest. Hayden J held that anaesthesia would plainly be inappropriate even for insertion of the naso-gastric tube, and that even with the sedation, the risk that Z may try to remove the tube, whilst diminished, is not extinguished. Her treating clinician considered that there was a "*very high risk" of respiratory or cardiac arrest as well as the risk that the sedation option could lead to some other iatrogenic cause of death, which, as I referred to in relation to option 1, would be very traumatic for Z and all concerned*."

Both of these options had profound disadvantages considered in isolation, and it was also clear that the severity and duration of Z's anorexia itself indicated a resistance to treatment; it was therefore reasonable to predict, Hayden J held, that that she would use her very best efforts to resist them. The third option, by contrast, was very much less draconian, namely that she should be discharged from the framework of the Mental Health Act 1983 and treated, if she is prepared to engage at all, only on a voluntary basis. This was subject to a structured plan which had at its heart the objective of providing support and encouragement to comply with a feeding programme and general therapeutic assistance.

Hayden J noted that:

> *11. Reflecting his detailed knowledge of his patient, who has now been in his care since February 2011, Dr Cahill noted that Z at least fares better emotionally when she is not subjected to an enforced medical regime. Thus, it is hoped, and, in my judgement, it can be no more than that, that an indication to her that the hospital, the Trust and the doctors will withdraw from her life, to respect her wishes and her autonomy, may lead to a sense of emotional wellbeing which may at least enable her to cooperate and in some way, perhaps, to prolong life. It is only when this option is contrasted against the previous two that it has any real credibility. It is almost certainly a pious hope that Z will, if left broadly to her own devices, manage effectively to confront this terrible illness, which has darkened her life since she was 15. I am aware that her parents express a belief that she can manage this and I have no difficulty in understanding why they might cling to that hope. I however must be more objective in my analysis and reasoning. Although it will be a terribly painful for Z and her parents to hear it expressed in these terms, I have come to the clear conclusion that I am choosing between 3 palliative care options.*
>
> *12. Of course the further and obvious benefit of this third option is that it allows Z to take responsibility for herself, in so far as her illness permits her to do so. Through Dr Cahill and Mr. Patel, the Trust have been at pains to emphasise, and it is important that I repeat it, that the hospital doors are always open to Z and that she is encouraged by them to engage to whatever extent she can.*

In analysing where Z's best interests lay, Hayden J held that:

> *13. […] the Court, through the offices of the Official Solicitor, will look not only at what the doctors and nurses say but will also look at the broader canvas of her life, family and her interactions with the wider world; see: Re S (Adult Patient: Sterilisation) [2001] (Fam) 15; County Durham & Darlington NHS Foundation Trust v SS [2016] EWHC 535 (Fam). Sadly, in this case that has proved to be a very short exercise. Z's world, since she was 15 years of age, has been entirely circumscribed by her eating disorder. It has been described as 'her profession'. I have been told her anorexia is how 'she identifies her place in the world'. It has disabled her from making any significant interpersonal relationships or developing any kind of interests or hobbies beyond watching television programmes with her parents, who live only a few doors away.*
>
> *14. All this of course does not augur positively for the future. Z's own wishes (and feelings), communicated through the Official Solicitor on her behalf, are that she would wish to stay at home with her parents where she believes she is likely to survive. Despite a lifetime of evidence to the contrary she asserts, without rationalisation, that she will "do much better at home." As I have said Z is supported in that perception by her parents.*

Hayden J considered the case-law in this area, thus:

> *18. I am aware that the Courts have had to confront a number of particularly challenging cases involving patients with chronic anorexia nervosa. In A Local Authority v E [2012] EWHC Peter Jackson J considered that treating E was a justifiable violation of her Article 3 and 8 rights, in circumstances where the evidence was that she had a 20-30 % chance of success if maintained for 12 months in a*

> *specialist unit where she would be forced fed by naso gastric tube, either by sedation or physical restraint. It has to be said that the prognosis for successful treatment in that case was strikingly different to the facts presented in this case. In Re L [2012] Eleanor King J (as she then was) found herself confronted by circumstances where treatment was assessed as futile, given L's frailty and the likelihood of treatment itself causing death. That strikes me as a similar risk matrix to that which confronts me here but, that said, I have reached my conclusions in this case on its specific facts and not by way of a comparative analysis with the case law. The case law has been helpful only to the extent that it confirms the way in which the decision should be approached.*

Drawing the threads together, Hayden J held as follows:

> *19. In a recent case: Betsi Cadwaladr University Local Health Board v Miss W [2016] EWCOP 13, Peter Jackson J agreed with the medical evidence which advised ceasing coercive treatment and discharging W home to her parents with community support (§21, §48). Though he did not consider that any further admissions would prolong W's life, he took the view that it was "the least worst option" for her (§48). It does not really matter how option 3 here is characterised, it is ultimately the only proposal which carries any vestige of hope and most effectively preserves Z's dignity and autonomy.*

As a procedural point, Hayden J noted that whilst the effect of s.28 MCA 2005 would on its face prohibit the making of a declaration concerning coercive treatment within the scope of Part IV to the MHA 1983, he did not need to determine the point given the way that he had determined the case. Further, "*given this application is heard in the Court of Protection, sitting in the High Court, I would have had the scope to make the declarations under the Inherent Jurisdiction and so the debate seems to me to be arid*."

Hayden J, finally, noted that it had been possible to bring the case on from first hearing on 19 December to final hearing on 30 December (including the instruction of Dr Glover), and that "*the avoidance of delay should be regarded as a facet of Article 6 (i.e. a fair trial) in these cases. In this respect the Courts must play their parts too and ensure that case management centres upon the needs of the patient which cannot be derailed by administrative pressures faced by Trusts or the Courts*."

Comment

As with *Ms X*'s case (a case which we understand was cited to the court but not referred to by the judge), and Miss W's case, Ms Z's case leaves one with a strong impression not just of the challenges facing the individuals in question (including the clinicians) but also of the fact that, silently, the courts are developing a form of therapeutic jurisdiction in this area in which they go to careful lengths to emphasise the extent to which they are handing back control of the ultimate decision as to whether to accept or refuse food to the person at the heart of the proceedings, so as to give the best chance that the person will, in fact, make the "right" decision and accept food. Whilst it might be possible from some standpoints to contend that such represents collusion between the professionals (including the Official Solicitor) and the court, for our part we have not the slightest problem with this collusion. It must, at a minimum, be preferable to the extraordinary levels of coercion that would have been involved in option 1 in this case (and the scarcely lower levels in option 2); it can also, it seems to us, to be

characterised as an entirely proper and CRPD-supportive way in which to seek to support individuals with anorexia to bring into alignment what is often, as in this case, identified as being their will to live with their clashing preference not to eat.

NPM report on deprivation of liberty

The National Preventative Mechanism was established in March 2009 after the UK ratified the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) in December 2003. It is made up of 21 statutory bodies that independently monitor places of detention. Its 7th annual report, for 2015-16, touches glancingly on DOLS and on the prospects for reform in this area. It does not though comment upon such twiddly matters as whether deprivation of liberty for purposes of OPCAT can take place outside institutions.

PROPERTY AND AFFAIRS

Office of the Public Guardian's top tips for LPAs

On 6 January 2017, the OPG revealed that of the LPA forms the office receives from solicitors 15% have errors. In the OPG's blog, the OPG sets out ten of the most common mistakes. Some of these are elementary (for instance forgetting their client's name halfway through), and some more subtle. Perhaps the most interesting are the examples of the words that the OPG will most often to apply to have severed by the Court of Protection (or will refuse to register) are:

- instructions telling attorneys to make gifts which do not comply with Section 12 of the Mental Capacity Act 2005. Only the CoP can authorise these;
- instructions to assist with suicide or criminal activity;
- instructions in a property and finance LPA that relate to health and welfare and vice versa (the OPG notes that they appreciate that sometimes there is an overlap);
- instructions to follow the decision of someone else who is not an attorney.

The list ends with a helpful suggestion, rather than an example of a mistake, and that is to use the dedicated lawyer to lawyer enquiries email address. The email address is here: legal_enquiries@publicguardian.gsi.gov.uk.

Patricia Wass

We congratulate Patricia Wass TEP, of Foot Anstey LLP, on her appointment as the worldwide chair of STEP.

PRACTICE AND PROCEDURE

Costs and medical treatment

MR v (1) SR (by her litigation friend the OS) (2) Bury Clinical Commissioning Group [2016] EWCOP 54 (Hayden J)

CoP jurisdiction and powers – costs

Summary

This is a short judgment from Hayden J on the issue of costs arising from *Re N* [2015] EWCOP 76 (a medical treatment case to decide whether it was in the best interests of Mrs N who had MS to continue to receive life sustaining treatment).

Hayden J set out the principles briefly: (i) s.55(1) MCA 2005 provides that costs are in the Court's discretion; (ii) the general rule provides that in welfare cases there should be no order for costs (rule 157 of the Court of Protection Rules 2007); and (iii) factors to consider when departing from the general rule are non-exhaustively set out in rule 159.

Hayden J noted that the factors in Rule 159 such as 'conduct', 'manner of response', and 'success' were difficult to apply and were not wholly apposite to a case which ultimately had an investigative, non-adversarial complexion.

The judge identified the central complaint as being that the family should never have been put in a position where they were forced to make the application to the court in the first place and in consequence of the CCG's failure to follow Royal College of Physicians National Clinical Guidelines.

Noting that the determination of costs is not a precise science, but an intuitive art reflecting the Judge's feel for the litigation as a whole and refusing to 'deconstruct the particular instances of the CCG's un-reasonability', Hayden J held that the CCG's conduct had involved avoidable delay and a disturbing disregard for National Guidelines. He further held that the fact that N's daughter had to bring the application meant that she had incurred considerable costs which she should not have had to do.

Citing *London Borough of Hillingdon v Neary & Others* [2011] EWCOP 3522; *North Somerset Council v LW, University Hospital, Bristol NHS Foundation Trust* [2014] EWCOP 3 and *Re G* [2014] EWCOP 5, the judge held that the CCG should be responsible for meeting half the applicant's costs.

Comment

There are relatively few reported judgments on the issue of departing from the usual rule in welfare cases so this succinct judgment is welcome. Whilst it makes clear that each case will turn on its own particular circumstances and no gloss should be made to the legislative provisions, it also contains a judicial acknowledgment of the burdens of bringing an application as a family member rather than participating where the application is brought by the CCG.

Claiming within time

AP v Tameside MBC [2017] EWHC 65 (QB) (High Court QBC (King J))

Article 5 ECHR – damages

Summary

Those acting for the claimant sought declaratory relief and damages of between £100,000 and £150,000 for breaches of Articles 5 and 8 for a period of 30 months' unlawful detention. The claimant was 29 years old and had learning disability resulting from Down's syndrome, no sight, some hearing loss/noise sensitivity, and little speech. Following allegations of assault he was moved from the family home in to 'respite accommodation' (which was not a care home). After 30 months he was returned home on 12 August 2013.

It was not in dispute that the limitation period under the Human Rights Act 1998 s.7 ran from that date, expiring on 13 August 2014, as the alleged deprivation of liberty was a continuing act so time began to run when that act ceased, not when it began. A letter before action was sent on 20 August 2014 and the claim was not brought until 24 February 2016. The issue for the court was whether to exercise its discretion to extend the limitation period under s.7(5) HRA which provides that:

> *Proceedings under subsection 1(a) must be brought before the end of:*
>
> *(a) the period of one year beginning with the date on which the act complained of took place; or*
>
> *(b) such longer period as the court considers equitable having regard to all the circumstances, but that is subject to any rule imposing a stricter time limit in relation to the procedure in question.* (emphasis added)

As King J observed, this provision does not identify the factors which the court should take into account. There is no predetermined list, although proportionality will generally be taken into account (para 67). The claimant's lack of capacity did not create a rebuttable presumption in favour of extending the limitation period absent exceptional circumstances (para 68) and s.28 of the Limitation Act 1980 did not provide any exception by analogy (paras 69-70). Being under a disability lacking capacity and being dependent on others to bring an HRA claim is a factor in the balance and its weight must depend on the particular facts (para 72). His Lordship went on to hold:

> *73. In my judgment the weight to be given to this 'dependency' factor will vary according in particular to when the Claimant first had someone acting on his behalf and looking after his human rights interests, and when that person came into, or was in a position to come into, possession of knowledge of the essential facts, and the expertise held by that person in identifying human rights claims…*

> *74. … the court must take into account that the primary limitation period under the HRA is one year, not three years, and it is clearly the policy of the legislature that HRA claims should be dealt with both swiftly and economically. All such claims are by definition brought against public authorities and there is no public interest in these being burdened by expensive, time consuming and tardy claims brought years after the event.*

The court took into account the delay in issuing proceedings, trial prejudice to the local authority, the broad merits and value of the underlying claim, likely injustice to the claimant, but not matters relating to legal aid:

> *89… The matters relating to the obtaining of legal aid or the time taken to draft pleadings cannot in themselves make it equitable to extend time to the length required in this case. Legal aid matters are ones which in principle should be accommodated within the primary limitation period…*

On the facts, the court declined to extend the limitation period so that was the end of the claim.

Comment

This decision illustrates the importance of swiftly identifying human rights issues, securing legal aid where available, and if necessary issuing a protective writ to preserve the person's position. The claim in this case was brought in the civil courts. They can also be brought in the Court of Protection, although this has been challenged in *N v ACCG* and the Supreme Court's verdict is awaited. Those representing P are likely to face a greater uphill struggle for limitation extensions where HRA claims are brought within ongoing welfare proceedings. And then there is the statutory charge to contend with. Vindicating P's human rights is no easy battle in the current climate.

Frustrating the Court of Protection?

Kirk v Devon County Council [2017] EWCA 34 (Court of Appeal (Sir James Munby P))

CoP jurisdiction and powers – international jurisdiction

Summary

This is the sequel to the decision on contempt that we reported in the December 2016 Newsletter. The Court of Appeal, you will recall, allowed Mrs Kirk's appeal against her imprisonment for contempt in the face of her refusal to enable the return of P (MM) from Portugal. It also granted permission to Mrs Kirk to appeal the underlying decision of Baker J that it was in MM's best interests that he be so returned.

The parties ultimately compromised the appeal and submitted a consent order for endorsement by the Court of Appeal essentially providing for the underlying order of Baker J to be set aside and for the issues to be reconsidered on a speedy basis. Sir James Munby P endorsed the order through gritted judicial teeth on the basis that, for the reasons set out for the parties it was the proper course to adopt

and was in MM's best interests. He made clear that in approving the order he was proceeding on the footing that:

> *i) It is futile to make any further attempt to subject Ms Kirk to coercive orders designed to obtain MM's return to this country, and the Court of Protection will not be invited to make any such order.*
> *ii) Although the Court of Protection is to re-visit the question of MM's best interests, the considered view of the Official Solicitor is, as matters currently stand, that, as Ms Butler-Cole put it, there is "no realistic prospect of MM returning to [Devon]" and "nothing further the courts here can do that has a realistic prospect of affecting MM's situation" and that "it is not appropriate to expend any more of MM's funds pursuing judgments or orders in relation to his welfare."*

Sir James Munby P felt it necessary to add more about the fact that the basis of the order was in essence Ms Kirk's continuing obduracy:

> *12. On one view of the matter, Ms Kirk has achieved her objective by remaining adamantly obdurate in the face of the court's orders; and the court now is simply caving in to her demands. It is a point which has troubled me, whatever her reasons may be for the stance she has adopted (a matter which there is no need for me to explore). I am persuaded, however, that this is not a reason why, in the particular circumstances of this case, I should refuse to approve the consent order.*
>
> *13. The long-established principle is, as I put it in Re J (Reporting Restriction: Internet: Video) [2013] EWHC 2694 (Fam), [2014] 1 FLR 523, para 52, referring to what Romer LJ had said in In re Liddell's Settlement Trusts [1936] Ch 365, 374, that:*
>
> > *"the starting point is that the courts expect and assume that their orders will be obeyed and will not normally refuse an injunction because of the respondent's likely disobedience to the order."*
>
> *As I said in Re Jones (No 2) [2014] EWHC 2730 (Fam), para 15:*
>
> > *"The normal approach of the court when asked to grant an injunction is not to bandy words with the respondent if the respondent says it cannot be performed or will not be performed. The normal response of the court is to say: "The order which should be made will be made, and we will test on some future occasion, if the order which has been made is not complied with, whether it really is the case that it was impossible for the respondent to comply with it." There is a sound practical reason why the court should adopt that approach, for otherwise one is simply giving the potentially obdurate the opportunity to escape the penalties for contempt by persuading the court not to make the order in the first place."*
>
> *That said, however, there are limits to how far the court can go in seeking to coerce the obdurate. In the first place, as I went on to observe in Re Jones:*
>
> > *"I have to recognise that the court – and this is a very old and very well established principle – is not in the business of making futile orders."*

> *14. See also the discussion on this point in Re J, paras 60-62. Secondly, it is well recognised that there will come a point when even the most obdurate and defiant contemnor has to be released, despite continuing non-compliance with the court's order. Well-known examples of this principle are to be found in In re Barrell Enterprises [1973] 1 WLR 19, 27, and Enfield London Borough Council v Mahoney [1983] 1 WLR 749, 755-756, 758.*
>
> *In this case, it is important to note, the court is not caving in at the first sign of obduracy. Ms Kirk remains seemingly determined on her course despite having been taken to prison and, indeed, despite having spent some seven weeks incarcerated in what must for her have been most unfamiliar and very unpleasant conditions. Is there any real reason to believe that a further dose of this medicine might induce compliance within the kind of time it might be appropriate, having regard to the principles in Barrell and Mahoney, to require her to serve? I very much doubt it. Further attempts at coercion are most unlikely to be successful. Pressing on as hitherto is likely to be an exercise in futility. In the circumstances the consent order marks out the appropriate way forward.*

An advice had been referred to relating to the difficulty of securing cooperation in Portugal. Whilst Sir James Munby P noted that he had not seen the advice, and that this may be the case in relation to Portugal, he:

> *… would not want it to be too readily assumed that the Court of Protection will be as powerless in other similar cases. If a similar problem arises in future, it might be worth exploring whether the foreign country would recognise and be prepared to give effect either to an order of the Court of Protection or to an authority, of the kind Ms Kirk was ordered to execute in this case, executed by a Deputy or by an officer of the Court of Protection. It is also worth bearing in mind that there have been cases where the foreign court has acted both decisively and speedily in ordering the return to this country of an incapacitated adult who had been taken abroad: see, for example, Re HM (Vulnerable Adult: Abduction) [2010] EWHC 870 (Fam), [2010] 2 FLR 1057, paras 27-29.*

Comment

It is perhaps not entirely surprising that this decision does not appear to have been the subject of the same degree of media excitement as the contempt decision. It is, however, perhaps a rather more important decision, because it illustrates the limits of the court's powers in the cross-border capacity. It may well, however, be that earlier recourse to the taking of steps to obtain recognition and enforcement of English court orders would lead to better outcomes in other cases. It is also important to understand that the mere loss of habitual residence does not lead to an ending of the jurisdiction of the court (albeit the High Court under the inherent jurisdiction) to take protective measures in relation to British nationals: see the decision of Peter Jackson J in *Re Clarke*, and Alex's recent articles on adult abduction in the Elder Law Journal (more details on request).

Jordans' Court of Protection Practice: end of an era

[*Editorial note: to mark the retirement of Gordon Ashton OBE as general editor of Jordan's Court of Protection Practice, we are delighted to be able to reproduce this slightly altered version of his introduction to the forthcoming Court of Protection Practice 2017*]

Introduction

The Mental Capacity Act 2005 was enacted after many years of consultation to almost universal acclaim. Other jurisdictions are now developing with the benefit of experience gained from those who have trod this path before them and there is a danger that ours may be found wanting. The benchmarks are International Conventions that either did not exist or were not seen as relevant when our jurisdiction was developed and which when laying down broad principles did not take into account the special circumstances of those who lack the capacity to make their own decisions.

The objective of this book is to equip Court of Protection practitioners and judges with all the knowledge they may presently need, including both substantive law and court procedure. Nevertheless, as we approach the tenth anniversary of the implementation of our legislation it can do no harm to consider a different perspective, namely that of the general public and in particular those incapacitated adults and their carers and families who may need to rely upon our jurisdiction.

The public perspective

Are we out of touch?

When I was sitting as a nominated judge I was utterly defensive of the Court both as regards where it had come from and how it was developing. Since my retirement four years ago I have found myself on the other side of the 'bench' and been more influenced by my experiences as father of a son with severe learning disabilities, financial attorney of a 90-year-old mother and now carer of a wife with Parkinson's disease. I am fearful that as lawyers we are becoming out of touch with those whom the mental capacity jurisdiction was designed to serve and that the concerns being addressed by lawyers do not reflect those of carers and families.

Social awareness

The House of Lords Committee was troubled that people do not know about the Act and, where they do know about it, they do not understand it. Could this be because we are too busy creating lawyers' law that is too complex and out of touch with the culture and practicalities of delivering care? One would expect the leading disability charities to actively promote the jurisdiction and seek to educate people as to their responsibilities to incapacitated people, yet they do not seem to be taking a lead. Their websites do not mention mental capacity on the Home page and any information tends to be buried several layers deep where you have to look for it, assuming you know what you are looking for. In its valuable Dementia Friends information sessions the Alzheimer's Society does not even mention

this legislation and in a recent book *Taking Charge: A practical guide to living with a disability or health condition* Disability Rights UK merely mentions LPAs and DoLS. Neither draws attention to the fundamental need to assess capacity and make any necessary decisions on a 'best interests' basis. Is this a mere oversight or a deliberate omission? Could it be that disability organisations see this as lawyer territory when in reality it should be part of everyday life if there is some mental impairment? These concepts may seem complex when viewed through the pages of this book, but it is not difficult to explain them in simple terms.

Human Rights

Deprivation of liberty

With impeccable legal logic our courts have identified the need for safeguards against the deprivation of liberty that may even extend to ordinary family care situations where there is local authority support. Safeguards are important to prevent adults from being detained when there is no lawful justification for this, but they are merely a distraction for those who inevitably need intensive care and supervision in their best interests. Our son Paul died at the age of 28 years in the Bournewood Gap (before it was identified) due to failures of supervision but the subsequent safeguards would not have saved him. In times of austerity the priority should be good quality care rather than an assurance that incapacitated people are not being deprived of rights that they could not decide to exercise anyway. This obsession with their human rights also overlooks those of involuntary carers who have surrendered so many of their own freedoms.

I do not worry about being deprived of my liberty in the event that I become incapable just as long as good quality care is provided by people who treat me with respect and create opportunities for me to enjoy some activity. Being cared for by uncaring persons but with more freedom than one could cope with would be a worse fate than being excessively restricted by persons providing loving though misplaced care. I would rather be deprived of my liberty than allowed to behave in an inappropriate manner that would negate everything that I had stood for during my earlier life.

Safeguarding resources

In my view it would be preferable to focus on the enforcement of human rights where necessary rather than impose universal scrutiny. Otherwise the emphasis in care provision becomes minimum restriction rather than maximum support. I favour a whistle-blowing procedure to protect those who may be deprived of more liberty than is necessary, but with someone in authority capable of responding by making a reference to the Court of Protection for judicial oversight. That is a role for the Public Guardian. There should be widespread public knowledge of this procedure as part of the culture of care so that relatives and concerned persons may blow the whistle, and a designated local official to monitor the care of those who have no such contacts. Scarce resources would then be reserved for those who might actually need protection.

There are limits to what can be achieved. What does a Judge do if satisfied that deprivation of liberty is justified but concerned about the actual care provision? In making a 'best interests' decision for the individual the Court may be restricted to the options put forward by the funding authority. In reality it is 'best choice' rather than 'best interests'. We now have resource hungry safeguards but little has really changed in the delivery of care (apart from unduly limited funding being further depleted by the safeguards).

Disability and equality

Judicial interpretation

The UNCRPD Committee's interpretation is that the diagnostic threshold should be removed, supported decision-making is the way forward, a 'best interests' approach is inappropriate and decisions should not be delegated. How can a person who lacks capacity to make a decision be supported to do so? The outcome would inevitably be a decision steered by the supporter which amounts to delegated decision-making without the safeguards of the best interests checklist. As I have stated previously, our legislation contains all the ingredients to meet the Committee's expectations if it was interpreted accordingly, but failing this changes of emphasis could be introduced by statute following the current Law Commission consultation.

This Committee also seeks to impose a requirement to adopt the 'will and preference' of the incapacitated person, whether or not properly formed, yet none of us has freedom to follow our desires because we need to be heedful of the wishes and needs of others. Those who lack decision-making capacity are unlikely to be aware of these natural constraints. Our personal desires must be tempered by responsibilities to others, including family and carers, and should not become dominant simply because we lack capacity.

The Court process

Involving the incapacitated person

Another of the present challenges is how the Court should conduct itself. The senior Judges have struggled over whether the incapacitated individual should be made a party to any application, with the consequent need for a litigation friend. When we were first writing the Rules it was assumed that this was inevitable until I pointed out the implications especially in regard to the many uncontested property and affairs applications. My suggestion that this be a case management decision was then adopted. Rather than achieve their own objectives the parties should be constrained to address only the best interests of the person to whom the proceedings relate and the judge is the ultimate arbiter of this. If all concerned individuals have the opportunity to be involved, usually enough will emerge from this to make expensive and time-consuming independent representation by a litigation friend unnecessary.

My 'tea parties'

When sitting in the former Court of Protection I always endeavoured to meet the 'patients' (now 'P"). I included in my directions Orders that they should be "*enabled to attend any hearing if such attendance would not be too distressing or detrimental to health*". I explained to the Rules Committee that when it seemed appropriate we would have an informal chat in chambers over a mug of tea (whilst leaving my recording equipment running) and I would explain at a resumed hearing what had transpired. I requested that this be facilitated in the Rules but was told that it was not the role of a judge – as if there was no difference between a criminal judge and an incapacity judge. Surely s. 4(4) of the 2005 Act which provides that a decision-maker "*must … permit and encourage the person to participate … as fully as possible*" applied to the Judge too! The practice of judges seeing the subject of proceedings (whether children or 'P') without making them a party now seems to be finding favour but guidelines are needed.

Public hearings

More than 50 years in the law have taught me that times change and that which was deemed inappropriate yesterday may become the norm tomorrow. That is illustrated by the approach to private hearings on which I still have mixed feelings. I would feel more tolerant to admitting the press and public to contested hearings if earlier directions hearings were held in private and included more emphasis on dispute resolution. Families would then have the potential to resolve issues without being in the public gaze. The role of a judge has evolved from conducting trials if and when parties chose to bring their issues before the court into being a facilitator of settlements with a trial being the last resort. Dispute resolution hearings have become the norm in matrimonial and even some Chancery cases. There is a greater role for the Public Guardian here (which has not yet been adopted) but caution must be exercised because placating the parties does not always achieve the 'best interests' of 'P'.

Accessible justice

Judgments of the High Court are needed to interpret our law in particular for high profile cases and inevitably there are those who wish or need to achieve a 'Rolls Royce' trial before a High Court Judge sometimes as a prelude to a test case appeal. These cases receive all the publicity but represent merely the tip of a large iceberg for this jurisdiction and the public should not believe that this is the norm in the Court of Protection. The reality is that most of the work is conducted throughout the country by nominated District Judges and Circuit Judges with little specialist legal representation. A 'small claims' inquisitorial approach in a local courtroom will often resolve matters to the satisfaction of those involved. The real benefit of a regional Court of Protection is that local solicitors and barristers are becoming involved and providing a service to their own clients.

Personal reflections

Some theorise about rights and autonomy and others worry about vulnerability and protection - it depends upon your perspective. The Mental Capacity Act lays down principles and the Court of Protection handles disputes and uncertainty but a legal jurisdiction cannot provide all the answers.

Attitudes within families and society need to change and the implementation of our jurisdiction is helping to achieve this although progress is slow. Those who lack capacity to make their own decisions are dependent on others and what really matters is whether there are people who care about their welfare and there is adequate funding to meet their needs.

For more than 25 years I have dreamt of and worked for a jurisdiction that would resolve the vacuum in decision-making for those who lack capacity. Has my dream become a reality or is it turning into a nightmare? It all depends upon the approach of the lawyers and many other professionals who become involved. Will this be legalistic or pragmatic? A judicial outcome that does not work is of less value to those involved than a compromise that does.

Gordon R Ashton OBE
Grange-over-Sands
January 2017

Forced marriage protocol

December saw the publication of a new Protocol on the handling of 'so-called' Honour Based Violence/Abuse and Forced Marriage Offences between the National Police Chiefs' Council and the Crown Prosecution Service. The protocol identifies matters that should be considered in forced marriage cases and cross-refers to the wealth of guidance and other materials that exists in this area. This is relevant to Court of Protection cases both because marriages entered into without capacity to contract are to be considered forced marriages, even without any element of coercion (s.121 Anti-social Behaviour, Crime and Policing Act 2014), and because of the very clear statement of Parker J as to the duties upon social work and medical professionals to take active steps to secure against the risk of such forced marriages, especially where there is any risk that the person will be taken out of England and Wales.

Court of Protection Practitioners Association Website

The website of CoPPA, of which Katie Scott of 39 Essex Chambers, is now the chair of the London sub-group, is now live and can be found here. CoPPA is a multi-disciplinary organisation whose aims are to consolidate good practice and develop good practice in the Court of Protection and in the implementation of the Mental Capacity Act 2005.

THE WIDER CONTEXT

New MCA/DOLS online resource

The Medical Protection Society in partnership with Cambridgeshire County Council and NHS England has just launched a new Mental Capacity Act and Deprivation of Liberty online learning tool specifically for health professionals across England and Wales. This online resource, to which Alex has contributed, and which draws also upon the 39 Essex Chambers guides, is completely free and will help healthcare professionals understand:

- What the MCA is
- What they need to know
- How it affects them
- How it affects their patients
- How to apply this to their practice.

The modules are designed to support and update your knowledge whenever you need it and are supported with relevant case studies and films from experts in this field. The modules are also supported by a knowledge check which is also certificated

To access the new modules click here (registration is required, but the modules are free).

Capacity and the MHT

R(OK) v FTT and Cambian Fairview [2017] UKUT 22 (AAC) (Upper Tribunal (AAC) (Upper Tribunal Judge Jacobs))

Other proceedings – judicial review

Summary

The Upper Tribunal has held with impeccable (some might say remorseless) logic that the principles set down by Lady Hale in *R (H) v Secretary of State for Health* [2006] 1 AC 441 apply equally to patients detained under s.3 MHA 1983 as they do to patients detained s.2 MHA 1983. OK lacked capacity to apply to the FTT to challenge her detention. Her solicitor sought to do so on her behalf, but the proceedings were curtailed when it emerged that she had lacked the relevant capacity. She then applied to the Upper Tribunal (AAC) to judicially review the decision of the FTT, and argued that:

> *… that there is a gap in the legislation that fails to provide for patients who lack the capacity to decide to apply to the First-tier Tribunal. In order to overcome that deficiency, section 66 of the Mental Health*

> *Act 1983 should be interpreted, pursuant to section 3 of the Human Rights Act 1998, in a way that is compatible with the patient's Convention rights. The Convention rights engaged are Article 5, 6 and 14. The proposed interpretation that protects those rights is to read section 66(1)(i) as applying to a 'patient (with the assistance of a litigation friend if needed)'. In R (H) v Secretary of State for Health [2006] 1 AC 441, the House of Lords decided that the overall scheme of the Mental Health Act 1983 was compatible with the Convention rights of a patient detained under section 2 for assessment. That case is said to be distinguishable, because the patient here is detained under section 3, where different time scales apply.*

Upper Tribunal Judge Jacobs held that there was no basis upon which to distinguish *H*, noting that:

> *… the time periods differ according to the basis on which the patient is within the Act. The patient's solicitor is right that the House of Lords was concerned with a patient detained under section 2, for which the time limit was 28 days. But I cannot find anything in the speech of Lady Hale, with whom all the others agreed, to suggest that the period of time was significant, still less decisive. More important in her reasoning was the proper use of the Secretary of State's power to refer a case to the tribunal:*
>
> > *27. Even if the patient's nearest relative has no independent right of application, there is much that she, or other concerned members of the family, friends or professionals, can do to help put the patient's case before a judicial authority. The history of this case is a good illustration. The patient's mother was able to challenge every important decision affecting her daughter. Most helpfully, she stimulated the Secretary of State's reference to the tribunal very quickly after it became clear that her daughter was to be kept in hospital longer than 28 days. Had MH been discharged once the 28 days were up there would, in my view, have been no violation of her rights under article 5(4). It follows that section 2 of the Act is not incompatible with article 5(4). Section 29(4), however, is another matter.*
>
> *That reasoning is equally applicable to a patient detained under section 3 rather than section 2.*

Upper Tribunal Judge Jacobs therefore held that:

> *21. I accept that there appears to be a gap in the protection of a patient's right to bring their case before the First-tier Tribunal, but that is apparent only when the tribunal's rules of procedure are considered in isolation. It disappears when the various duties and powers under those rules, the Mental Health Act 1983 and the Mental Capacity Act 2005 are considered as a package. This case is governed by the reasoning in R (H). There is no violation of the patient's Convention rights. An application for the Secretary of State to refer his case could have been made under section 67 and, if that was refused, the patient could have had recourse to judicial review.*

Comment

It is more than a little concerning that Upper Tribunal Judge Jacobs reached his decision without any reference to the decision of the ECtHR in the Strasbourg case that followed *H*. In that case, the ECtHR

held that the system, as a whole, including the duty upon the SoS to refer upon application, complied with Article 5(4), but it was a very close-run thing:

> *95. The question might be asked whether such a hearing could have taken place had the applicant not had a relative willing and able, through solicitors, to bring her situation to the attention of the Secretary of State. However, the Court may only consider the case before it, and the facts of the present case clearly illustrate that in circumstances such as the applicant's, where the incompetent patient is "befriended", the means do exist for operating section 29(4) of the 1983 Act compatibly with the requirements of Article 5 § 4 of the Convention. For that reason, no failure to comply with those requirements can be found in the applicant's case as regards the period of her detention in issue under the present head.*

OK was, in this case, able to benefit from the assistance of a solicitor (even if they should have brought the case to the attention of the Secretary of the State, rather than the Tribunal) but is troubling that the implications of the Strasbourg judgment were not considered by the judge (or apparently brought to his attention).

Use of restraint in mental health settings

A new memorandum of understanding has been published by the College of Policing on the use of restraint in mental health settings. It has been endorsed by the National Police Chiefs' Council, Mind, the Royal College of Psychiatrists, the Royal College of Nursing and the Faculty of Forensic and Legal Medicine with a view to other organisations providing their formal support in due course.

The MoU descends to very considerable – and helpful – detail as to expectations as between police and healthcare providers, as well as useful examples of good practice. It also contains a helpful summary of the relevant legal provisions (albeit one which repeats the canard that reliance can be placed upon s.4B MCA 2005 to deprive a person of their liberty to enable a life-sustaining intervention or to prevent a serious deterioration in their condition without making clear that this can only be relied upon at the same time as an application is being made to the Court of Protection).

Mental health patients and care in general hospitals

The National Confidential Enquiry into Patient Outcome and Death has just published a report – "Mental Health in General Hospitals: Treat as One" – highlighting the poor quality of mental health and physical health care for patients aged 18 years or older with a significant mental disorder who are admitted to a general hospital. The report takes a critical look at areas where the care of patients might have been improved. The report also areas for improvement in the clinical and the organisational care of these patients.

New GMC guidance on confidentiality

The GMC has published new guidance on confidentiality, to come into force on 25 April 2017, including detailed guidance on addressing these questions in the context of those lacking the material decision-making capacity.

Seeing through the fog: Money and Mental Health Policy Institute

In a new report, "Seeing through the fog," the admirable MMHPI looks at the range of ways in which mental health problems can make it harder for people to manage their money, making important financial tasks like comparing different products and paying the bills on time much more difficult. For instance, the report found that people with PTSD often have memory problems, which can make remembering PINs and online banking details impossible, and that conditions such as ADHD and depression are associated with reduced attention span, which can make it harder to engage with complex financial tasks like budgeting.

Importantly, the report does not just stop there, but sets out a range of adjustments that could be offered by financial services providers, and others, to help people with mental health problems to overcome the extra challenges with money management that they often face.

Government's response to the Five Year Forward View for Mental Health

The Government has published its response to the Five Year Forward View for Mental Health. The response follows the recommendations made by the Mental Health Taskforce in its February 2016 report The Five Forward View for Mental Health: a report from the independent Mental Health Taskforce to the NHS in England (reported in our March 2016 newsletter). We are pleased to see that the Government has accepted all of the Taskforce's recommendations which are aimed at improving mental health services including expanding provision, more thorough monitoring and regulation, and the appointment of 'Mental Health Champions' in each community. Perhaps most relevant to mental capacity practitioner is the Taskforce's Recommendation No. 51:

> *The Department of Health should work with a wide range of stakeholders to review whether the Mental Health Act (and relevant Code of Practice) in its current form should be revised in parts, to ensure stronger protection of people's autonomy, and greater scrutiny and protection where the views of individuals with mental capacity to make healthcare decisions may be overridden to enforce treatment against their will.*

The Government has accepted this recommendation and added that:

Officials are currently exploring if any legal changes may be required to allow a person to be treated in the community for a mental health problem that would otherwise require a compulsory stay in hospital, through conditions placed in a Community Treatment Order.

Contracting out protections

The Local Government Ombudsman has sharply criticised Wokingham Borough Council and urged it to pay £4,000 after a vulnerable dementia patient lost a third of her body weight while living in the care home it contracted to look after her. The LGO was critical of the lack of activities organized at the home, the care provided for the woman who left the home malnourished, and the lack of action taken to address her weight loss. The LGO also criticized the care home's record keeping, and that staff did not seek specialist support for her low weight.

There is an important wider lesson to be heeded by all local authorities which was summed up by Dr Jane Martin, Local Government Ombudsman: *"This case highlights the need to remind councils that when contracting out services to third parties, they cannot contract out the accountability for those services.*

The news was reported on the Local Government Lawyer website here, and the LGO's full report is available here.

What is Truth? An Inquiry about Truth and Lying in Dementia Care

This interesting report published by the Mental Health Foundation, and based on work by an expert panel, explores the difficult issues relating to people with dementia experiencing a different reality or set of beliefs. People with dementia commonly experience different realities and beliefs from those around them. The experience of perceiving different realities usually becomes more frequent and persistent as the condition progresses. Practitioners and cares are often desperate for advice and guidance as to how best to respond in these situations. One of the most common questions is whether 'non-truth' telling can be justified in order to support the wellbeing of the person with dementia.

In summary, the panel felt that one should always start from a point as close to the whole-truth-telling as possible but, if this is causing unnecessary distress, move onto a response that might include an untruth. There is always a balancing act between wanting to stay as close to whole-truth-telling as possible and ensuring one is not causing distress. After considering all of the evidence the panel found six underlying principles of all responses and interventions that are critical in supporting the person living with dementia to have wellbeing:

1. Experiences of different realities and beliefs are meaningful to a person living with dementia. A key role of any carer or practitioner is to find out what this meaning is. This is a fundamental aspect of good quality care, and should not be considered a luxury agenda item, "*if there is time*."

2. Finding out what experiences of different realities and beliefs mean must be done with an open mind; a flexible, tailored approach; and with kindness. The more a carer or practitioner knows about the life story, personality and values of the person with dementia, the more likely they will be able to understand the meaning behind these experiences.

3. Responses and interventions should start as close to whole-truth-telling as possible. In other words, there may be situations where it is known from the start that whole-truth-telling will not be possible. But moves away from whole-truth-telling should only occur if it would cause unnecessary distress. 'Lies' (as in blatant untruths initiated by a carer or practitioner – as opposed to meeting a person with dementia in their reality) may only be used in extreme circumstances to avoid physical or psychological harm.

4. 'Environmental lies' should be avoided. These are artificial spaces designed to deceive, such as a painted shop front (as opposed to a real small shop within a care setting).

5. Responses and interventions should be kept consistent across family carers or staff teams.

6. What does and does not work should be documented and shared.

The full report can be accessed here, and the source document containing a review of the evidence is available here.

SCOTLAND

Solicitor "claiming an interest"

We reported previously the troubling decision of Sheriff Braid at Edinburgh Sheriff Court dated 22nd March 2016 refusing to warrant an application by *J, Solicitor* for appointment of partners in *J*'s firm as guardians to a client of hers under Part 6 of the Adults with Incapacity (Scotland) Act 2000 (the "2000 Act"). The sheriff took the view that the applicant had not averred a sufficient interest to entitle her to make the application. The refusal to warrant was referred to the Sheriff Principal, who on 1st August 2016, at [2016] SC EDIN 66, declined to make an administrative direction that *J*'s application should be warranted. We deferred commenting on that decision pending the eventual outcome, which was that the local authority made a fresh application resulting in the appointment of one of the original nominees to be guardian to the adult in question.

In relation to *J*'s application, the most significant passage of the Sheriff Principal's decision was this:

> *The sheriff's decision with regard to warrant in this case does not preclude an application by a solicitor as a person "claiming an interest in the adult's property and financial affairs". The sheriff's decision is restricted to the circumstances of this application. Other applications fall to be determined on their own facts and circumstances.*

Of greater general application is the confirmation by the Sheriff Principal of the route that may be followed by a pursuer dissatisfied with a refusal by a sheriff to warrant an application or action. The Sheriff Principal referred to *Fitzpatrick v Advocate General for Scotland* 2004 SLT (Sh Ct) 93, in which it had been held that an appeal to a Sheriff Principal challenging a sheriff's refusal to grant a warrant to cite is incompetent. In the present case, the Sheriff Principal confirmed that *Fitzpatrick* remains good law, as it followed the decision of the Inner House in *Davidson v Davidson* (1891) 18R 84. The appropriate route to follow is not an appeal, but a direction in terms of section 27 of the Courts Reform (Scotland) Act 2014 by the Sheriff Principal to the sheriff clerk to sign a warrant to commence proceedings. That is a direction of an administrative character.

Returning to the facts of the application by *J*, the relevant statutory provision is section 57(1) of the 2000 Act which allows an application to be made "*by any person (including the adult himself) claiming an interest in the property, financial affairs or personal welfare of an adult …*". What may have muddied the waters in relation to the application by *J*? Firstly, at the outset of her judgment the Sheriff Principal noted that in the application the pursuer was described as the adult's solicitor "*and has an interest in the adult's property and financial affairs*". Only in Part 5 of the 2000 Act does an applicant require to "have" an interest. For the purpose of all other provisions, an applicant need only be a person "claiming" an interest.

Secondly, an AWI report submitted with the application proceeded on the basis that the local authority, City of Edinburgh Council, were the applicants.

The Sheriff Principal referred to *Fitzpatrick* as setting the test which would justify the granting of an administrative direction such as was sought in the present case. In *Fitzpatrick*, the Sheriff Principal considered whether the refusal of warrant infringed the pursuer's right of access to justice in terms of Article 6 of the European Convention on Human Rights and concluded that:

> *"To deny the pursuer the opportunity to raise his action and deal in due course with such issues of competency as may arise would be, in my opinion, to deny him without sufficient justification his right of access to justice.*

In relation to *J*'s application, the Sheriff Principal noted that the object of the proceedings by Summary Application under the 2000 Act had the sole purpose of appointing a guardian to meet the needs of an adult with impaired capacity. Having regard to the section 1 principles, the Sheriff Principal commented that "it can be said that an adult lacking capacity has a right to a suitable and qualified guardian". The sheriff's refusal to warrant triggered the "fall-back" obligation of the local authority under section 57(2) of the 2000 Act to apply if "no application has been made or is likely to be made for an order under this section". Accordingly, there had been no denial of the adult's needs or right to a guardian, as the local authority was obliged to step in and make the relevant application.

Notably, in a carefully worded judgment, the Sheriff Principal did not assert that the sheriff was right to refuse to warrant the application. She merely held that this did not result in a denial of justice in terms of Article 6 of the European Convention which could only be remedied by a direction to warrant the application.

But for the "muddying" factors mentioned above, one may assert with some confidence that such an application by a solicitor in respect of the solicitor's own client, if in proper form and accompanied by the required reports, ought to be warranted. As noted above, only under Part 5 of the Act is an applicant required to have an interest. Part 6 does not require that an applicant should "have an interest", should demonstrate "a sufficient interest", or should "show an interest". The application may be made by any person "claiming an interest". Scottish Law Commission Report on Incapable Adults (Report No 151, September 1995) set out the rationale for what became the present Part 6 in terms which were not subsequently disputed or varied at any time in the proceedings up to and including enactment of the 2000 Act. It is clear from paragraph 2.38 of the Report that the Commission envisaged that solicitors would be among those who would apply, and that one of the purposes of "casting the net of title to apply wide" was to avoid undue burden upon local authorities.

In general terms, an application such as was made by *J*, namely an application by a solicitor whose client's capabilities had become impaired, is not only competent but the obligation of the solicitor, having regard to Rule B1.4 of the Law Society of Scotland Practice Rules 2011, which provides that solicitors "must act in the best interests of [their] clients", and Rule B1.12 which provides that solicitors "must not cease to act for clients without just cause". In a situation where a solicitor does withdraw from acting "so far as possible, the clients' interests should not be adversely affected". Under Rule

B1.15, solicitors "must not discriminate on the grounds of age, disability … in [their] professional dealings with … clients". It is clear that a solicitor-client relationship existed between *J* and F. If, upon F's capacity and ability to give instructions and to safeguard her own interests becoming impaired, *J* had simply abandoned F to her own devices, *J* would have been in breach of all of the foregoing requirements.

Curiously, while the application was made in respect of an 87-year old adult, the original decision of the sheriff referred to it having been made "in respect of the child F". The complete inappropriateness of a child law approach in relation to adults with impaired capacity was stressed in paragraph 2.50 of the Scottish Law Commission Report.

A startling omission from the sheriff's original decision was any reference to the absolute obligation upon the court to act in accordance with the principles in section 1 of the 2000 Act. Section 1(1) required the sheriff to give effect to those principles "in relation to any intervention in the affairs of an adult under or in pursuance of this Act". In the words of Mr Angus MacKay, Deputy Minister for Justice, at SPOR Vol 5, No 11, col. 1047: "An intervention can encompass a positive and a negative act". The sheriff's negative act in refusing to warrant *J*'s application was an intervention. The sheriff failed to demonstrate that such intervention was justified by the section 1 principles. He did not even appear to have asked himself whether it was. On the information available, it plainly was not. There could have been no benefit to F in leaving her unprotected. There appears to have been nothing in the information available to the sheriff to suggest other than that F's wishes and feelings were that *J* and her firm should look after F professionally. The application demonstrated a *prima facie* requirement for guardians to be appointed. The question of who should be appointed guardian can only be addressed if an application proceeds. Section 59(1) permits the sheriff to appoint as guardian "any individual whom he considers to be suitable for appointment and who has consented to being appointed". The identity of the applicant who brings the adult's need for protection before the court is irrelevant to that decision. The very act of bringing such an application before the court will normally transfer responsibility for the matter from the applicant to the court. Any refusal by the court to accept and act upon that responsibility raises a potential question as to whether the court has failed to perform its fundamental duty to ensure that justice is done.

Perhaps even the Sheriff Principal's decision is open to query to the extent that it relies upon the obligation of the local authority under section 57(2) of the 2000 Act. It could be queried whether the requirement of that section that "no application has been made or is likely to be made" can be said to have been triggered when an application has been made.

The difficulties, delays, inconsistencies and inefficiencies of the exercise of jurisdiction under the 2000 Act by sheriff courts have already led to the proposal by the Law Society of Scotland, in response to Scottish Government consultation, that a unified tribunal should have jurisdiction under the 2000 Act, the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Adult Support and Protection (Scotland) Act 2007. The progress of the *J* application could perhaps be contrasted with the approach

of the Court of Protection in England & Wales as exemplified in the recent case of *Cheshire & Wirral Partnership NHS Foundation Trust v Z* [2016] EWCOP 50 (covered in our Health, Welfare and Deprivation of liberty report), where Hayden J commended the speed with which that case had been brought to final hearing and commented that "The avoidance of delay should be regarded as a facet of Article 6 (i.e. a fair trial) in these cases. In this respect the Courts must play their part too and ensure that case management centres upon the needs of the patient [in Scottish terms, the adult] …".

Adrian D Ward

Cumbria County Council, Petitioner [2016] CSIH 92; 2017 S.L.T. 34

This decision by an Extra Division of the Inner House of the Court of Session related to a child, and would not normally have featured in this Newsletter. However, it provides a remedy to overcome a difficulty in a cross-border situation which might be of assistance in some situations concerning adults.

In this case, the High Court of England & Wales had made an order placing a child in secure accommodation in Scotland. The apparent reason for doing so was a shortage of such accommodation in England & Wales. Scottish legislation governing cross-border recognition of orders relating to the custody and care of children made no provision for such an order to be recognised and enforceable in Scotland. In terms of the legislation, and as analysed in a detailed judgment by Sir James Munby P ([2016] EWHC 2271 (Fam)), accordingly, the child was held in Scotland without legal authority.

The relevant English local authority, Cumbria County Council, petitioned the *nobile officium* of the Court of Session for interim orders finding and declaring that the order of the High Court ought to be recognised and enforceable in Scotland as if it had been made in the Court of Session.

The Court of Session held that it had an inherent power to exercise in its *nobile officium*, as *parens patriae*, jurisdiction over all children within the realm. In practice, the *parens patriae* jurisdiction has generally been subsumed into the *nobile officium*.

The legislation concerning cross-border recognition of court orders placing children in secure accommodation did not cover cases such as the present case. There was a gap in the legislation. The present case disclosed a clear *prima facie* case for application of the *nobile officium*. The balance of convenience clearly favoured making the interim order sought. The petition was granted.

The court noted that orders placing children in secure accommodation were not uncommon and were of utmost importance for the children concerned. The court recommended that urgent consideration be given to remedying by legislation the gap identified in this case. Such legislation would require to address whether the regular judicial review and monitoring of any deprivation of liberty, in accordance with Article 5 of the European Convention on Human Rights, ought to be vested in the High Court in

England & Wales or the Court of Session in Scotland, or jointly in both. It should however be possible to frame legislation to recognise the distinction between the overall responsibility for the child's welfare and the making of orders to secure the welfare, and on the other hand responsibility for enforcing them. It was suggested that a challenge to the existing arrangements ought accordingly to be competent in either jurisdiction. However, any remedy would be likely to be interim, leaving it to the English courts to decide the fundamental questions as to the child's welfare, and whether and on what terms any secure accommodation order ought to be continued.

The comparison between this case and the decision of the German Federal Constitutional Court which we reported in our December 2016 Newsletter, is interesting. Acting under a written constitution and basic law, the German court made an order filling a gap in German legislation regarding the circumstances in which treatment might be given without consent, and recommended that the legislature address the matter. The German court acted with reference to the constitutional duty of the German State to protect its own citizens. In the present case the Court of Session, by exercise of the *nobile officium*, also took steps to remedy a gap in legislation, and also recommended that the matter be addressed by the legislature. The obligations under the *parens patriae* jurisdiction could be said to be analogous to the German constitutional obligation to protect citizens.

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Alex is recommended as a 'star junior' in Chambers & Partners 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, including as Wellcome Trust Research Fellow at King's College London, and created the website www.mentalcapacitylawandpolicy.org.uk. He is on secondment 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.

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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 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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Conferences

Conferences at which editors/contributors are speaking

Royal Faculty of Procurators in Glasgow

Adrian will be speaking on adults with incapacity at the RFPG Spring Private Law Conference on 1 March 2017. For more details, and to book, see here.

Seminar on Childbirth and the Court of Protection

39 Essex Chambers is hosting a seminar in conjunction with the charity Birthrights about caesarean-section cases in the Court of Protection. The seminar aims to take a critical look at these cases, with a distinguished multi-disciplinary panel. The seminar is at 5pm-7pm on 8 March 2017, and places can be reserved by emailing beth.williams@39essex.com.

Hugh James Brain Injury conference

Alex will be speaking at this conference aimed at healthcare professionals working with individuals with brain injuries and their families on 14 March. For more details, and to book, see here.

Scottish Paralegal Association Conference

Adrian will be speaking on adults with incapacity this conference in Glasgow on 20 April 2017. 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.

Our next Newsletter will be out in early March. 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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