Essex CHAMBERS

MENTAL CAPACITY REPORT: COMPENDIUM

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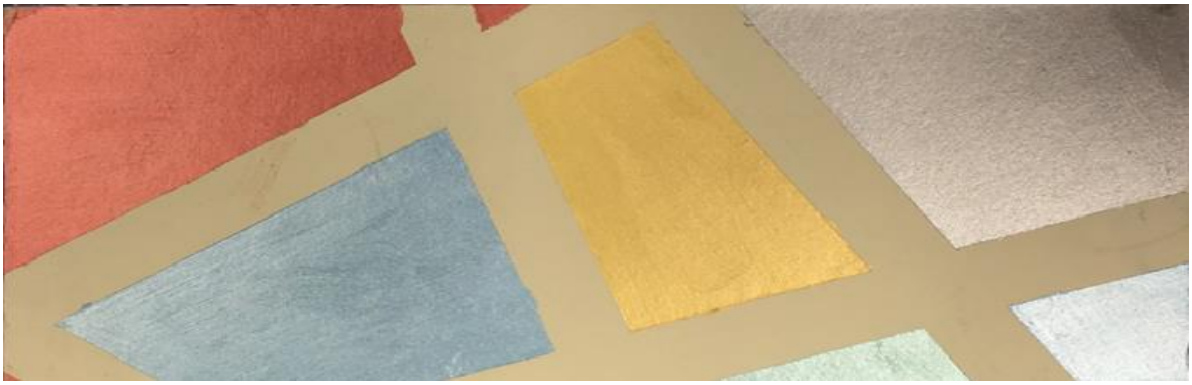

Welcome to the November 2017 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: the Court of Appeal considers parental consent to confinement, CANH withdrawal and the courts, and the latest DOLS figures;

(2) In the Property and Affairs Report: personal injury payouts and s.117 MHA 1983, calling in bonds and court approval of compromises through a human rights lens;

(2) In the Practice and Procedure Report: the Court of Protection Rules 2017 and what we can learn from the new Family Procedure Rules and PD concerning vulnerable witnesses;

(3) In the Wider Context Report: re-framing *Gillick* competence through MCA eyes, MHA changes coming into force, and CRPD developments and resources;

(4) In the Scotland Report: critical comments on practice rules, counter-proposals for guardians and parental consent to confinement from a Scottish perspective;

You can find all our past issues, our case summaries, and more on our dedicated sub-site here, and our one-pagers of key cases on the SCIE website. On our website, you can also find updated versions of our capacity and best interests guide, and new guide to without notice applications before the Court of Protection.

His fellow editors also take this opportunity to congratulate Neil on his very well-deserved nomination for the Bar Pro Bono award 2017.

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

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HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

'Teen Bournewood' – the saga continues

In the matter of D (A Child) [2017] EWCA Civ 1695 (Court of Appeal (Sir James Munby P, Richards and Irwin LJJ))

Article 5 ECHR Deprivation of liberty – children and young persons

Summary[1]

This significant ruling by the Court of Appeal concerns the extent to which parents are able to consent to the confinement of their incapacitated children in light of *Cheshire West*. Previously, when he was 15, his parents had agreed to him being confined in a mental health hospital and Keehan J had held that such consent meant that he was not deprived of liberty: Re D (A Child) (Deprivation of Liberty) [2015] EWHC 922 (Fam). Subsequently discharged from hospital, D was confined in what was essentially a residential school with his parents' agreement under section 20 of the Children Act 1989. Keehan J had held that such parental consent could not be relied upon after he turned 16: [2016] EWCOP 8. It was this second decision that was the subject of the appeal.

Allowing the appeal, the outcome of the Court of Appeal's judgment is that there is no bright line at 16 so parents can continue to consent to such confinement up to the age of 18 if that is an appropriate exercise of their parental responsibility. As a result, although D satisfied the acid test, he was not deprived of liberty because there was valid consent from his parents. The corresponding judicial safeguards were therefore not required until he became an adult. Before analysing the judgment in detail, my understanding of the present position is that:

- For under 18s who are confined and unable to consent, parents can give valid consent if that is an appropriate exercise of parental responsibility.
- Those of any age under an interim/final care order who are confined and unable to consent require Article 5 safeguards.
- Those under 18 who are able to make the relevant decision and object to their confinement will require Article 5 safeguards.

The relationship between assessing capacity under the MCA and as per *Gillick* is discussed in the commentary below.

(a) Objective element: a nuanced acid test for under 18s?

The essential character of a deprivation of liberty (the so-called *Storck*-criteria) consists of:

(a) the objective component of confinement in a particular restricted place for a not negligible length of time;

(b) the subjective component of lack of valid consent; and

(c) the attribution of responsibility to the state.

[1] Note, this summary and comment is prepared by Neil Allen, Alex and Tor both being instructed in the case.

The present case primarily concerned the second of these. But the local authority contended that the existing monitoring arrangements for looked after children meant that D was not deprived of liberty. This was rejected because these arrangements, such as the independent reviewing officer, did not afford the sufficiently independent safeguards and checks required by Article 5 (para 48).

Sir James Munby P (at paras 30-9) and Irwin LJ (at paras 158-9) both made observations in relation to the confinement of children, about which David Richards LJ preferred not to express a view (para 154). The President observed, "*Insofar as Cheshire West provides the answer, it is to be found in the judgment of Lord Kerr*," who used a comparator approach to confinement for those under 18 which involves:

> *77. … comparing the extent of your actual freedom with someone of your age and station whose freedom is not limited. Thus a teenager of the same age and familial background as MIG and MEG is the relevant comparator for them…*
>
> *79. … It is because they can – and must – now be compared to children of their own age and relative maturity who are free from disability and who have access (whether they have recourse to that or not) to a range of freedoms which MIG and MEG cannot have resort to that MIG and MEG are deprived of liberty.*

The President held:

> *39. Without deciding a point which is not before us, I am inclined to think that the effect of this is that, in Lord Kerr's view, the situation of the "young" or "very young" as he describes it does not involve a "confinement" for the purposes of Storck component (a), even though such a child is living in circumstances which plainly satisfy the Cheshire West "acid test." If this is so, though it is not something we need to decide for the purpose of disposing of this appeal and I express no concluded view, then the consequence, going back to my question, would be that the child living with foster-carers in their home is therefore not within the meaning of Article 5 being deprived of his or her liberty.*

Irwin LJ also noted:

> *158… Although it is not necessary for the decision in this case, I also agree with the President that the question whether there is "confinement" should be approached in the careful way analysed by Lord Kerr in Cheshire West, at paragraphs 77 to 79 … For all present purposes, "confinement" means not simply "confining" a young child to a playpen or by closing a door, but something more: an interruption or curtailment of the freedom of action normally to be ascribed to a child of that age and understanding.*

Furthermore, the Court expressly interpreted what had previously been implied, namely that in *Cheshire West,* the freedom to leave component of the acid test did "*not mean leaving for the purpose of some trip or outing approved by* [others]" but rather "*leaving in the sense of removing himself permanently in order to live where and with whom he chooses…*" (para 22).

(b) Subjective element: scope/zone of parental responsibility?

This was the crux of the appeal. The court fully endorsed the Strasbourg decision in *Nielsen v*

Denmark (1988) 11 EHRR 175 – applying it to under 18s – and recognised the continued role of *Gillick* incapacity/incompetence beyond the age of 16. In short, the court held:

1. *Nielsen* was a case about the second limb of *Storck* (i.e. about consent, rather than about the objective element of confinement), and that this proposition had been endorsed by Lady Hale in *Cheshire West* (paras 26 and 37).

2. In line with *Nielsen*, there are circumstances where consent by a holder of parental authority (i.e. in domestic terms a person with parental responsibility) may provide valid consent to confinement (paras 37 and 95).

3. For these purposes, the relevant rights of a person with parental authority are determined by reference to domestic law (para 50) which provides that parental responsibility is in principle exercisable in relation to a 16- or 17-year-old who "*for, whatever reason, lacks 'Gillick capacity'*" (paras 84-85 and 128).

4. There was no 'magic' in the age of 16, so none of the statutory provisions relied upon by Keehan J to identify a dividing line between those under 16 and those aged 16+ had a bearing on the ambit and extent of parental responsibility established by the common law (para 125). Nor did the international conventions put before the court (paras 136-140) or arguments based upon discrimination (paras 141-146).

5. The "zone" of parental responsibility was to be ascertained by reference to general community standards in contemporary Britain, the standards of reasonable men and women. The question was whether the restrictions being imposed by the particular parent in the particular case fell "*within ordinary acceptable parental restrictions upon the movements of a child*" (para 84).

(c) State imputability

The court rejected the submission that the care arrangements were not imputable to the state for the reasons given at first instance (paras 41-46). Accordingly, it followed that although confined with state imputability, D was *not* deprived of his liberty for Article 5 purposes because there was valid consent to such confinement by his parents.

Comment

The Court of Appeal's endorsement of Lord Kerr's more nuanced acid test is most welcome as it endorses a common-sense approach to Article 5 for those under 18. In my view, a typical 3- or 8-year-old child, for example, living in a family home or foster home at the same developmental stage as most children of that age would plainly *not* satisfy the acid test.

Where a child is confined, it is important for local authorities to ensure that parental consent to the *particular* circumstances giving rise to it is properly and thoroughly documented (para 150). Parents need to know what they are being asked to agree to where their child's liberty is at stake.

In terms of assessing the ability of someone under 18 to make decisions, it is important to stress that most of the MCA 2005 (except DoLS, statutory wills, LPAs, and advance decisions to refuse treatment) applies to those aged 16 and over. Some of it even applies to under 16s

(criminal offences and financial deputyship). But, it is suggested, Parliament clearly intended that, at least insofar as those with mental impairments are concerned, the statutory capacity test ought to be used from the age of 16.

The capacity of those under 16 to make decisions is gauged by *Gillick* although, as recently seen in *Re S* [2017] EWHC 2729 (Fam) (discussed in the Wider Context section of this Report), the courts are sensibly fleshing out that common law test with the more comprehensive approach of the MCA where appropriate. But, in our view, the MCA does not completely oust *Gillick* at 16. There will be situations where a 16- or 17-year old does not have an impairment of the mind or brain but lacks the maturity or intelligence to make the decision. In that situation, it is suggested, there is a continued role for *Gillick* capacity. And, of course, even an under 18-year-old with MCA- and *Gillick*-capacity can lawfully have their decision overridden by the courts (as in *An NHS Foundation Hospital v P* [2014] EWHC 1650 (Fam)) as their views are important but not yet decisive until adulthood.

The judgment, and indeed *Nielsen*, recognises that parental rights are not unlimited. Would the situation be different, for example, if D was objecting to his confinement? In my view, it would. The (English) MHA Code of Practice (2015) at para 19.41 assists in determining the scope of parental responsibility by reference to, in summary, the following matters:

1. Is this a decision that a parent should reasonably be expected to make? Consider factors such as:
    - The type and invasiveness of proposed intervention.
    - The age, maturity and understanding of child or young person: parental role should diminish as the child develops greater independence.
    - Does it accord with the child or young person's current wishes or will they resist?
    - Have they expressed any previous views?
2. Are there any factors undermining the validity of parental consent?
    - Does the parent lack capacity to consent?
    - Is the parent not able to focus on what is in their child or young person's best interests (eg due to an acrimonious divorce)?
    - Is there significant distress/conflict between parents which means they are unable to decide what is best?
    - Is there conflict between decisions of those with parental responsibility?

The more coercive the confinement needs to be, the more likely it is that the decision will fall outside the scope of parental responsibility in my opinion. For example, a *compulsory* admission to a psychiatric ward of an objecting incapacitated 16/17-year-old should not be attempted on the basis of parental consent. That would, it is suggested, be outside the scope and the young person would need Article 5 safeguards (of the MHA).

The judgment did not need to address the significant issue as to whether local authorities and parents can use shared parental responsibility to consent to confinement for those subject to interim or final care orders. But given the lack of dissent (at paras 109-110) on the issue, it is suggested that the prudent course is to assume that the law is unchanged. So there can be no valid consent where someone under a care order is confined according to the nuanced acid test. Local authorities involved in care proceedings may therefore want to continue to have cases listed before judges who can also exercise powers under the inherent jurisdiction so as to deal with deprivation of liberty authorisations.

There are a few other tangential but significant matters to be found in the judgment. Resource arguments cannot render nugatory the substantive and procedural protections of Article 5 (para 14). The court also, no doubt sensibly, avoided the international curve ball as to how Article 14(1)(b) of the UNCRPD – which prohibits detention on the grounds of disability – could be squared with Article 5(1)(e) ECHR (para 140). Finally, and with "*weary resignation*", the President observed (footnote 3) that the order in the court below was headed "*In the High Court of Justice Court of Protection*" and (noting that the responsibility for this appeared to lie with the court not the parties) said, '*The Court of Protection is not part of the High Court, so orders made by the Court of Protection should not be headed 'In the High Court of Justice': see section 45 of the 2005 Act. Is it too much to hope that, ten years after the Court of Protection came into being, this simple truth might be more widely understood and more generally given effect to*."

Neil Allen

Contraception, safeguarding and best interests

The Hospital Trust v Miss V [2017] EWCOP 20 (Cobb J)

Best interests – contraception

Summary

Miss V was a 21 year old woman with a severe learning disability, cerebral palsy and epilepsy. She is described in the judgment as having the understanding of a 3-5 year old and to be entirely unable to identify situations that may pose a risk.

In 2016 Miss V presented to her GP as 28 weeks' pregnant, neither Miss V nor her mother apparently aware of her condition. All the professionals engaged in Miss V's care agreed she did not have the capacity to consent to sexual intercourse.

Her baby was born by caesarean section following an order of the COP and immediately removed from her care. Both the fact of medical intervention and the removal of her baby are described as having caused Miss V great anguish: her social worker is noted in the judgment to observe that in 18 years of social work, she had never previously witnessed such extreme levels of distress.

An application was initially brought by the local Health Authority for an order for Miss V to be sterilised. This order was, however, abandoned in favour of an order for the prescription and application of a contraceptive patch.

Despite agreement as to the preferred method of contraception, the order was resisted by both Miss V's mother, Mrs W, and the Official Solicitor on the basis that even the least restrictive form of contraception has side effects and that it was not appropriate or in P's best interests for contraception to be administered "*just in case*": she was considered not to be sexually active and was the subject of extensive safeguarding and supervision, being in the constant company of a family member, albeit that evidence suggested that there were occasional unintentional lapses in her supervision.

On the matter of Miss V's capacity, the court found that she did have an ability to learn and could demonstrate a rudimentary understanding of some elements of contraception. However, applying the test as set down by Bodey J in *A Local Authority v Mr and Mrs A & Mr A* [2010] EWHC 1549 (COP) Cobb J held: "*in order to have capacity to make decisions about contraception, Miss V would need to be able to understand and weigh up the immediate medical issues including (a) the reason for contraception and what it does (which includes the likelihood of pregnancy if it is not in use during sexual intercourse); (b) the types available and how each is used; (c) the advantages and disadvantages of each type; (d) the possible side-effects of each and how they can be dealt with; (e) how easily each type can be changed; and (f) the generally accepted effectiveness of each*." He determined, and it was agreed by all the parties, that Miss V lacked capacity to consent to sexual relations and to make decisions in relation to contraception. That having been said, Miss V was considered by those involved in her care to be capable of expressing views, and that although there was a limit on the weight which the court could reasonably attach to these views, given her lack of capacity, Cobb J was "*nonetheless satisfied that she has a reasonable awareness of the contraceptive patch and its function and has indicated no opposition to wearing it*" (paragraph 35).

In circumstances where the combined objective of the parties – endorsed by the court – to ensure that Miss V was protected from further harm, Cobb J went on to determine that contraception was in Miss V's best interests. To do, he considered he needed to ask – in sequence – the following series of interlinked questions (at paragraph 24):

> *i) Is it in Miss V's best interests that she receives contraceptive protection?*
>
> *ii) If so, what form of contraception is in her best interests, as the less restrictive option?*
>
> *iii) If contraception is in her best interests, is it in her interests that such contraception is first trialled?*
>
> *iv) Linked to (ii), are there some forms of contraception which are so invasive and restrictive that, even if contraception would generally be regarded as being in her best interests, the disadvantages or restrictions associated with these invasive forms of contraception would outweigh the benefit(s)?*

In determining whether the contraceptive patch should be administered, Cobb J endorsed the view that the safeguarding plan advanced by the local authority was as robust as it could be given the heavy reliance that it placed upon the continuous supervision of Miss V by her parents.

He noted that the protection plan would be unaltered whether or not the contraception was administered. However, this did not mean – in his view – that there were:

> *43.* […] *not real advantages to Miss V in receiving contraception. The safeguarding plan is designed to reduce the risk of sexual exploitation particularly outside of the home; contraception is proposed to reduce the risk of pregnancy in the event that the plan fails. If this additional safeguard can be introduced without undue side effects, and is a safeguard which Miss V is not unwilling to accept, then the best interests balance tilts in favour of its use.*
>
> *44. The risk against which contraception is designed to guard is self-evidently a repeat pregnancy, delivery of the baby and probable removal, with its associated trauma; but pregnancy, even suspected pregnancy, usually brings with it a range of possible medical tests – the taking of weights, blood pressure and bloods, for instance. The very prospect of any medical intervention, even the simple task of being weighed and measured in a clinic, and of blood pressure being taken, has left Miss V 'petrified' in the recent past. It is incumbent on the court in the exercise of the discretion to reduce the need for such medical interventions, particularly since (and perhaps entirely predictably) Miss V displays a greater sense of mistrust of the professionals since the removal of the baby, and this adds another minor impediment to the effective monitoring of [the] plan.* (emphasis in the original)

Concerned, nonetheless, that the side-effects of the patch might be overly troublesome to Miss V, and that this could only be determined after a trial, Cobb J made a declaration that it was in her best interests for the contraceptive patch to be administered for a trial period of up to 6 months.

Comment

Cobb J was clearly aware of the sensitivity of the conclusion that he had reached. Confirming that his judgment was restricted to the facts of Miss V's specific case, he concluded: "*I wish to make clear that this decision is about Miss V, and her best interests; the decision is taken in the context of her unique situation. I wholly reject the submission on behalf of the Official Solicitor that by declaring contraception in Miss V's best interests I would in one way or another be setting a precedent for all incapacitous and vulnerable women.*" (paragraph 47).

We would echo this strongly, not least because the case should not be taken as a precedent for an approach to safeguarding which focuses on the 'easier' course of directing measures at the potential victim of abuse (whether those being consenting to the administration of medication, as here, or removing them from their home), rather than the perpetrators of the abuse, not least as this is directly contrary to the very concept of making safeguarding personal.

CANH withdrawal and the courts

The withdrawal of clinically assisted nutrition and hydration ('CANH') has been featuring very heavily in recent court decisions, summarised

here.[2]

PL

In *PL v Sutton CCG* [2017] EWCOP 22 , concerning potential CANH withdrawal from a woman who had "*suffered a catastrophic stroke which ha*[d] *left her very severely physically disabled, brain damaged, and significantly incapacitated*" (paragraph 1), Cobb J confirmed (at paragraph 29) that it would be wrong:

> *to conclude that where the patient is not diagnosed as MCS or VS, a significantly different approach to the determination of the case should be taken. Quite apart from anything else, as is well-recognised, the diagnosis is often difficult, and may indeed change over time. So just as it would not necessarily follow that someone who is in a 'vegetative state' would be bound to have life-sustaining treatment discontinued, the fact that someone retains consciousness and can answer questions is not in itself a reason not to consider discontinuance of life-sustaining treatment: see An NHS Trust v A [2006] 2 Lloyds Rep Med 29. It all depends, as I have indicated, on the individual facts, and every decision must ultimately be governed by what is in a patient's best interests.*

Cobb J confirmed (at paragraph 71) that the approach set down by Lady Hale at paragraph 39 of her judgment in Aintree:

> *reinforces the essentially limited value in considering previous case law otherwise than for general statements of principle or guidance. In any event, it is clear that the authorities to which I have been referred have concerned adults in MCS or VS. Adhering to the only authentic principle in cases of this kind – that the decision is taken in the best interests of P – ensures, so far as judicial ability and expertise permits, the right outcome.*

In determining whether it was in PL's best interests for CANH to be continued, Cobb J noted that:

> *76. I am conscious that in making the decision in relation to PL, I must not apply substituted judgment, even though there is a "strong element" of substituted judgment in the best interests' test. The Supreme Court in Aintree emphasised that while the court can, indeed should, accept that the preferences of the person concerned are an important component in deciding where her best interests lie, it is still a "best interests" test; see §24 of Aintree. As indicated above, Charles J in Briggs No.2 attached particular, even decisive, importance to the views of P, making the powerful point that someone with capacity could, through advance decision, displace the ordinary expectation of treatment in order to preserve life. This followed Lord Goff's comments in Bland to which I have also referred (§68 above: "a patient of sound mind may, if properly informed, require that life support should be discontinued"). On these facts, as I have made clear, I am satisfied that PL made her views about life-sustaining treatment well-known to her family and friends; I have accepted their evidence, and further accept that her views apply to her*

[2] Note, Tor, Katie and Annabel have been involved in various of these cases (Tor in all of them), and Alex will be involved in the Y case if the Supreme Court hear it. Tor, Katie and Annabel have not contributed to the commentaries on their own cases; Alex has provided the neutral summary of the Y case.

> *current situation. Had PL's views been specific to the provision of CANH, I would probably have regarded them as decisive of this application; as it is, her views weigh heavily in the balance.*
>
> *77. I have weighed carefully the views of the family, to the extent that they wish me to do what they regard as the right thing, namely to authorise the discontinuance of treatment, not for themselves, but for PL.*
>
> *78. So, I return to the fundamental question whether it is in PL's best interests to continue to receive CANH. I have reviewed and considered PL's welfare in the widest sense, and on balance I have concluded that it is* not *in her best interests; it follows that the discontinuance of the CANH treatment is therefore lawful.*

Cobb J also confirmed, applying *Ferreira* and *Briggs*, that PL would not be deprived of her liberty when moved to the hospital where CANH withdrawal would take place, where she would be "*in a state of very low cognition and possibly consciousness, receiving palliative care, as her life ebbs away* […] *placed in a coma-like state to anaesthetise her from any distress associated with the discontinuance of treatment*" (paragraph 79).

Mrs P[3]

In *Salford Royal NHS Foundation Trust v Mrs P & Q* [2017] EWCOP 23, Hayden J was concerned with a woman in a minimally conscious state as a result of extensive widespread damage to the brain consistent with pre-existing cerebrovascular disease, the effects of hydrocephalus, and areas of focal cerebral infarction. The central issue in the case was the extent to which Mrs P's past wishes and feelings about life sustaining treatment could be ascertained. Both experts were of the view that her views would be determinative of the question of where her best interests lie, Hayden J agreed, endorsing the following "*uncontroversial*" principles to be taken from the "*evolving case law*:"

> *i. The sanctity of life is not an absolute principle, and can be outweighed by the need to respect the personal autonomy and dignity of the patient: Aintree v James [2013] UKSC 6 at [35];*
>
> *ii. There is no prohibition to conducting a best interests analysis of the continued provision of CANH even though MRS P is not in a vegetative state: W v M [2011] EWHC 2443 (Fam) at [102] per Baker J;*
>
> *iii. There can be no further guidance beyond the wording of s.4 other than that "decision makers must look at his welfare in the widest sense, not just medical but social and psychological; they must consider what the outcome of that treatment for the patient is likely to be; they must try and put themselves in the place of the individual patient and ask what his attitude to the treatment is or would be likely to be; and they must consult others who are looking after him or are interested in his welfare, in particular*

[3] For a 'storify' of the case prepared by Celia and Jenny Kitzinger of the Coma and Disorders of Consciousness Research Centre, gathering together and adding to their live Tweets from the case, see here.

for their view of what his attitude would be." Aintree at [39] per Baroness Hale.

iv. *Where the patient's condition may improve, a best interests decision may be based on the 'best case scenario' as advised by the relevant clinicians and experts: Briggs overview at (25) per Charles J;*

v. *It is incumbent on the court fully to investigate and consider the values and beliefs of the patient as well as any views the patient expressed when she had capacity that cast light on the likely choice the patient would have made and the factors that the patient would have considered relevant or important: M v N at [70] per Hayden J, Briggs at [54] per Charles J;*

vi. *Where the patient's views can be ascertained with sufficient certainty, they should generally be followed (Briggs at [62] per Charles J) or afforded great respect (M v N at [28] per Hayden J), though they are not automatically determinative. '...if the decision that P would have made, and so their wishes on such an intensely personal issue can be ascertained with sufficient certainty it should generally prevail over the very strong presumption in favour of preserving life. Briggs at [62ii] per Charles J.'...the 'sanctity of life' or the 'intrinsic value of life', can be rebutted (pursuant to statute) on the basis of a competent adult's cogently expressed wish. It follows, to my mind, by parity of analysis, that the importance of the wishes and feelings of an incapacitated adult, communicated to the court via family or friends but with similar cogency and authenticity, are to be afforded no less significance than those of the capacitous.' M v N at [32] per Hayden J;*

In Mrs P's case, Hayden J found that Mrs P would have found '*her present circumstances not only intolerable but humiliating. More than in any other sphere in her life she kept her health issues completely private. Her present high level of dependency and minimal awareness would, to her, have been 'a travesty of life', to adopt her own phase*.' He accordingly refused the Trust's application for a declaration that it was in her best interests for CANH to continue.

The judge was invited to give general guidance on a range of issues that had arisen in the case but declined. What he did say however (at paragraph 42) was that "*cases in the Court of Protection must always be driven by the needs of the patient and not by the exigencies of the litigation*." This is of course undoubtedly right!

Re Y

In *Re Y* [2017] EWHC 2866 (QB), O'Farrell J, applying the reasoning of Peter Jackson J in Re M, declared that it was not mandatory to bring before the Court of Protection the withdrawal of CANH in the case of Mr Y, who has prolonged disorder of consciousness, in circumstances where the clinical team and Mr Y's family were agreed that it was not in his best interests to receive that treatment. The judgment is important because it is a judgment from the High Court, rather than the Court of Protection, making a declaration (under Part 8 CPR) as to the legal requirements. It is also important because the Official Solicitor was formally involved (as Mr Y's litigation friend). There is, in

the circumstances, no question that the conclusions of the judge – which would apply in other, similar, cases – are obiter, unlike the question mark that has been placed by some over the conclusions of Peter Jackson J in *Re M.*

O'Farrell J certified the case as fit for the Official Solicitor to "leapfrog" to seek permission to appeal from the Supreme Court to appeal her decision, as well as for expedition. If the Supreme Court grants permission, it is likely, therefore, that the issue of whether, when and why cases of CANH withdrawal[4] need to come to court will be considered by the highest court in the land in the very near future.

DOLS applications continuing to rise

NHS Digital has now published its DOLS report for England for 2016-17 (also available in whizzy interactive form here). Headline statistics include:

- There were 217,235 applications received during 2016/17; an increase of 11% on 2015/16.
- The number of applications that were completed increased by 45% to 151,970 during the same period.
- The reported backlog of cases that were not completed as at year end increased by 7% to 108,545 over the year.
- Four new applications were being made for every three being completed.
- The average number of days from applications being received to being completed across England was 120 days.

For enthusiasts wishing to dig further into the statistics, it is important to emphasise that it is not straightforward (or indeed, often possible) to make comparisons between statistics relating to individual authorities, because of the widely differing approaches that have been taken amongst local authorities to addressing both the backlog and new DOLS applications. Differences between two apparently comparable local authorities should therefore be taken as a starting point to ask more questions, rather than a simple measure of which local authority is doing better or worse.

Interim Government response to Law Commission's Mental Capacity and Deprivation of Liberty report

Jackie Doyle-Price (Parliamentary Under-Secretary of State for Health), set out in a written statement on 30 October the Government's Interim Response to the Law Commission's MCD report as follows:

> *I am today announcing the publication of the Government's interim response to the Law Commission's report on Mental Capacity and Deprivation of Liberty, a copy of which is attached. In England, around 2 million people with conditions such as dementia, learning disability or an acquired brain injury may be unable to always make decisions about their care or treatment, including where they live,*

[4] And, indeed, life-sustaining treatment more broadly, the logic of the Official Solicitor's argument not being limited to CANH.

because they lack mental capacity. In 2007, the Government amended the Mental Capacity Act to introduce the deprivation of liberty safeguards (DoLS), which provide a legal framework for such decisions. However, the framework has been subsequently criticised in both Houses, as well as by charities, Local Authorities and families. The current regime is inflexible and complex and the system is bureaucratic and unwieldly meaning that it is unnecessarily cumbersome to ensure that vulnerable people are afforded the rights and protections to which they are entitled. The current system does not always empower people or place them at the heart of decision making about their care as set out by the Care Act 2016.

The Commission were asked to conduct a fundamental review of the Deprivation of Liberty Safeguards provisions which are rooted in the Mental Capacity Act and integrated into healthcare practices for joined-up person-centred care. Our expressed priority at the time was that any new scheme delivers real tangible benefits for individuals and their families, and this remains the case. Any new scheme must improve the quality of care for people, improve access to safeguards and be cost-effective.

I welcome the publication of the Law Commission's report which we are carefully considering and thank them for their careful and considered work. We will now engage with a range of stakeholders to understand in greater detail how these changes can be implemented. We will also consider what enabling actions need to be taken to support the Mental Capacity Act ethos of greater empowerment and care centred around people, their wishes and aspirations.

This Government is committed to take action to reform mental health and transforming care for people with conditions such as dementia, learning difficulties and autism. Action to reform the current Deprivation of Liberty Safeguards regime is an important contribution towards achieving these aims including effectively protecting some of the most vulnerable people in our society.

The Government will provide its final response on the Law Commission report to the House in Spring 2018.

The fuller response is available here, in which the Minister notes also that:

As you are aware, the government has committed to reform of mental health legislation and ensuring that parity of esteem is at the heart of treatment. We will ensure that our work on deprivation of liberty for the purpose of care and treatment is undertaken in consideration of our work reforming mental health.

PROPERTY AND AFFAIRS

Personal injury payouts and s.117 MHA – the Court of Appeal pronounces

Tinsley v Manchester City Council & Ors [2017] EWCA Civ 1704 *(Court of Appeal (Court of Appeal (The Master of the Rolls, Longmore and Irwin LJJ))*

Deputies – financial and property affairs

Summary

We reported on this case at first instance, the facts being found here. The Court of Appeal defined the question before them as "*whether a person who has been compulsorily detained in a hospital for mental disorder under section 3 of the Mental Health Act 1983 and has then been released from detention but still requires "after-care services" is entitled to require his local authority to provide such services at any time before he has exhausted sums reflecting the costs of care awarded to him in a judgment in his favour against a negligent tortfeasor*."

Mr Tinsley submitted that Manchester's refusal to provide after-care services unless it was satisfied that Mr Tinsley's damages awarded had run out, was unlawful in the light of the decision of the House of Lords (as it then was) in *Stennett* [2002] 2 AC 1127 (where it was decided that the relevant authorities providing s.117 after-care could not charge for those services).

The local authority argued that (1) that on the true construction of s.117 of the 1983 Act, Manchester was not obliged to provide after-care services if the claimant had been awarded damages for future care and (2) that to allow such a claim would offend against the principle against double recovery which has been established in the decided cases in the personal injury field, most notably by the *Court of Appeal in Crofton v NHSLA* [2007] 1 WLR 923 and *Peters v East Midlands Strategic Health Authority* [2010] QB 48.

Perhaps unsurprisingly [5] the Court of Appeal rejected the local authority's arguments and upheld the first instance judge's decision in a short and unanimous decision.

Lord Justice Longmore, who delivered the leading judgment described the argument that there was no duty to provide, arrange or provide after-care services if a claimant has funds for that purpose provided by a tortfeasor, as an "*impossible*" one on the basis that "*a refusal to pay for such services is effectively the same as providing such services but charging for them*."

The Court of Appeal also had no trouble in disposing of the arguments about double recovery, finding that:

- There is nothing wrong or immoral about a claimant who has received damages for future care from a tortfeasor then applying to the state for care.
- Thus, unless there was some specific inhibition on deputies appointed by the Court of Protection arising from the risk of double recovery, there was no reason why Mr Tinsley should not now claim the benefit

[5] Although we understand Manchester are seeking permission to appeal.

to which he may be entitled under s.117 of the 1983 Act.

- A court, when assessing a damages claim for a claimant, will of course seek to avoid double recovery by testing whether the claimant really intends to pay for private care, or to rely on state care.
- The local authority's concerns about claimants who have been awarded damages for future care in tortious claims then claiming local authority care while still having the funds for private care, might be overstated. "*Few claimants who have been awarded the costs of private care will voluntarily seek local authority care while the funds for private care still exist.*"

Comment

Perhaps the most interesting point about this case is what the Court of Appeal had to say about the fundamental problem with the *Peters* decision. The Deputy in that case made an undertaking to the Court at the damages hearing that she would seek from the Court of Protection (a) a limit on her authority as the claimant's Deputy whereby no application for public funding of the claimant's care under section 21 of the 1948 Act could be made without further order, direction or authority from the Court of Protection and (b) provision for the defendants to be notified of any application to obtain authority to apply for public funding of the claimant's care under section 21 of the 1948 Act and be given the opportunity to make representations in relation thereto.

The idea behind this approach was that if the Deputy wished at some later date to claim state provision for the claimant, she would have to (i) put the defendant on notice and (ii) seek permission from the Court of Protection. There are two reasons why this as a scheme does not achieve the result that was intended. The first is because following the case of *Re SK* [2012] EWHC 1990 (COP) it is doubtful that a defendant tortfeasor would be able to bring him/herself within the definition of a person who can be joined to Court of Protection proceedings. The second reason is that, even if the defendant tortfeasor could be joined, the question for the Court of Protection would be whether it would be in P's best interests to make an application for state funded care. In making this decision, the court would not of course consider the position of the tortfeasors. It is almost inconceivable therefore that the court would conclude that it was not in P's best interests to be able to make such an application.

Bonds, liabilities and the Court of Protection

Re M [2017] EWCOP 24 *(HHJ Purle QC)*

Deputies – financial and property affairs

Summary

In this rather odd case, HHJ Purle QC had to consider whether he should order part of a bond held by E (the mother and deputy of M, the subject of the proceedings) to be called in in circumstances where it was said that she had failed to act in accordance with her deputyship duties by failing to pay a means tested contribution which the local authority assessed as due from M in respect of accommodation costs. Judicial review proceedings had previously been brought in M's name by his

father in respect of the local authority's failure to fund M's education at a suitable establishment outside the local authority's area. The judicial review proceedings were ultimately compromised in an agreement between the relevant parties, including the local authority and the Learning and Skills Council, which provided (inter alia) for the LSC paying for M's educational provisions and the local authority paying both for the accommodation aspect, ancillary to the educational provision, and travel costs.

The local authority, following the agreed compromise, met the accommodation and transport costs, but sought to recoup some of the accommodation costs (but not any part of the transport costs) following means testing of M, whose means appear to consisted entirely of state benefits. E as M's Deputy refused to pay any part of the means tested costs. It is this refusal which was said by the local authority to amount to a failure to carry out her deputyship duties, and (inferentially) to have caused M's estate loss. The local authority therefore brought an application in on-running welfare proceedings involving M and her parents for part of the deputyship bond to be called in to enable it to recoup the costs it had incurred.

HHJ Purle QC rejected the application, construing the compromise agreement in the judicial review proceedings as both one which provided for unconditional funding on the part of the local authority, and one that was within the powers of the local authority to enter into. There was therefore no basis for the claim that the local authority sought to advance, and the application to call in the bond was rejected. In addition:

26. […] *I am bound to say that I am puzzled as to the propriety of the procedure that has been adopted in calling in the bond in a summary way by an application made within the Court of Protection proceedings by the local authority. As Ms Bretherton QC demonstrated in relation to another claim, to which I shall come, the powers of the Court of Protection are limited. Leaving aside powers to grant focussed, declaratory best interest orders, none of which is relevant to the present case, the power is to take decisions for a person ("P") which P by virtue of incapacity is unable to take.*

27. The calling in of the bond requires the prior determination of whether or not E as Deputy is liable for loss caused to M by virtue of her failure properly to carry out her duties. The guarantor is only liable if E is liable. Thus it must first be established (a) that E failed properly to carry out her duties; (b) that this failure occasioned loss to M's estate.

28. There was at one stage, to my mind, an ambiguity in the way in which the local authority were approaching the matter, as it appeared to focus at least in part upon the impropriety of other expenditure incurred by E, and not the failure to pay the sums due to the local authority. However, Ms Bretherton QC confirmed in her submissions that this was not the legal basis of the claim to call in the bond. The sole complaint was that E, whilst Deputy, had not in fact paid - which she did not - any of the means tested contributions that the local authority required from M. That, however, did not give the local authority any cause of action against E, nor did it cause M's estate any loss. E, as Deputy, was answerable to M (not the local authority),

the Public Guardian and the Court of Protection (acting in M's interests) in respect of any mismanagement of M's assets, but not to the local authority.

29. In my judgment where there is a disputed case of mismanagement, it is not appropriate for that dispute to be adjudicated upon in a relatively informal application, made to the Court of Protection, for the calling in of the bond. Once of course liability is admitted or established, the calling in of the bond is a routine matter. But first the liability of the person who is ultimately liable to the guarantor once the bond is called in must be established, and that can ordinarily only be established in proceedings brought by, or on behalf of, P - in this case M - against the officeholder in question, which in this case was E. M, of course, is not in a position to bring proceedings because he lacks capacity to do so. The local authority are not his representative. J is and J has not sought to make any complaint against E in this connection, nor do I see how she could do so. The Public Guardian might initiate the calling in of the bond but still the underlying liability of the Deputy must first be established because until such liability is established the guarantor is not liable under the bond. In a case therefore where the liability of the Deputy (and therefore of the guarantor) is disputed, that liability must first be established by proceedings brought by someone with standing to do so.

30. As far as the local authority is concerned they are a third party creditor of M, assuming for present purposes (contrary to what I have already held) that they are entitled to a means tested contribution from M. They have no cause of action against E, any more than any other creditor would be entitled to bring proceedings to enforce obligations owed not to the creditor but to that creditor's debtor. A creditor dealing with someone of full capacity may enforce payment of a debt, which may result in bankruptcy resulting in the appointment of a trustee in bankruptcy, who can then enforce the obligations owed to the bankrupt. But what is not legitimate is to short circuit all that by enabling creditors to bring proceedings in their own name for obligations owed not to them but to someone else, even when that someone else owes the creditor money. That is simply not the way in which the law of obligations works.

31. Accordingly it seems to me that the local authority's application was misconceived because (a) there must first be established a liability under the Bond, which is dependent on E being liable for loss occasioned by her breaches of duty; (b) no proceedings have been brought to establish that liability; (c) only M, or his Deputy on his behalf with the approval of the Court of Protection, or possibly the Public Guardian, could bring such proceedings.

32. In addition, the mere failure to make the means tested payments did not cause M any loss falling within the bond. Even if the means tested amounts were due, his estate was not diminished by the failure to pay them, so that there was no recoverable loss. As mentioned earlier, there was some ambiguity in the case as originally advanced because it appeared to be suggested that there was improper expenditure in other respects. The extent and precise amount of the supposed improper expenditure was not examined in detail, however, and, as recorded earlier, Ms Bretherton QC confirmed that

> *the sole legal basis of the claim for calling in the bond was not by reference to what E spent on other things, but on her failure to make the means tested payments to the local authority. On that basis, M's estate has suffered no loss.*

It is clear that HHJ Purle QC was then asked to provide further reasoning in this regard, and did so:

> *35.* [Counsel for the local authority] *said rightly that the local authority is not seeking to recover the monies for itself but is merely seeking the calling in of the bond, which is properly a Court of Protection matter, and will result in the monies being paid into M's estate. I agree that once liability is established, or admitted under the bond, the calling in of the bond is a matter which the Court of Protection, or the Public Guardian, can effect. This is not however a case where liability is admitted, so it has to be established by appropriate action. I have sought to explain why, given that prior requirement, liability can only be established at the suit of M or those representing him (not the local authority) as M's estate has on this hypothesis suffered a loss, not the local authority. Further, it seems to me vital, in a case of disputed liability, that there should be a determination of that dispute with pleadings and the procedural safeguards that proper case management provides. Further, for the Court of Protection to determine such a dispute (which is a necessary pre-requisite of the calling in of the bond) would be beyond its narrow function and power of making best interest decisions for M. The Court of Protection can decide that proceedings to enforce the disputed liability be taken for the benefit of M, as he is in no position to take that decision himself. What it should not in my judgment do is try that dispute.*

HHJ Purle QC also rejected claims by M's parents that they had been caused loss by the acts of the local authority on the basis that the local authority (once it had taken over as deputy) had withheld monies due to M, leading his parents to spend monies of their own in looking after M and in providing for his necessities. The judge made clear not only was this not a matter that could be considered by the Court of Protection, but also that – substantively – it was one for economic loss, "*which presupposes that the local authority owes a duty to E and A directly. This is one of the most difficult areas of the law to make good and I have heard nothing which has persuaded me that E and A might even arguably get over that hurdle*."

Comment

This application was – to put it mildly – a surprising one for the local authority to make, both substantively and procedurally. It is perhaps unfortunate that HHJ Purle QC did not have drawn to his attention the decision of HHJ Hodge QC in *Re Meek* [2014] EWCOP1, in which HHJ Hodge QC had had cause to consider in some detail when the court will call in a bond. The two judgments are not inconsistent, but the earlier judgment provides useful context for the operation of the bond scheme. As HHJ Hodge QC had noted (at para 38):

> *Effectively, the bond scheme offers an alternative to a deputy bringing an action against a previous defaulting deputy to recover lost or stolen funds. It provides an immediate, and straightforward, mechanism by which the court can*

> *ensure that an incapacitous person is compensated for losses that have been incurred through the default of his deputy. It avoids the delay and expense which the incapacitous person would otherwise face in bringing proceedings against a defaulting deputy, who may be of questionable solvency, and enforcing any judgment obtained within those proceedings. The defaulting deputy does not get off scot-free, but he is instead likely to face proceedings brought by the bond provider.*

In the earlier case HHJ Hodge QC had held both that the decision whether to call one is is one to be taken for or on behalf of P (therefore on a "best interests" basis) and that (at para 93) that "*the appropriate course the Court of Protection should take in cases of default by a deputy is to call in the security bond almost as a matter of course*."

In *Re Meek*, the default was clear. In the instant case, the default was not clear, and it is therefore hardly surprising that the court was troubled at the idea of using the summary procedure for calling in a bond.

Protected parties, compromises and human rights

Penn v Revill [2017] EWHC 2630 (QB) (High Court (Dingemans J))

Other proceedings – civil proceedings

Summary

In this case, Dingemans J was asked to consider whether the provisions of CPR 21.10 are incompatible with the rights protected by article 14 of the European Convention on Human Rights when read with either article 6 or article 1 of the first protocol of the ECHR. CPR 21.10 requires that a compromise in civil proceedings with a protected party (i.e. a person lacking the capacity to conduct the proceedings) is not binding unless and until it is approved by the Court. This means that either the protected party or the other party to the compromise may withdraw from the compromise at any time before its approval.

The issue arose in the context of a situation in which the Defendant to a personal injury claim sought to resile from a compromise agreement reached with a protected party Claimant before it had been approved by the court (because of the impact of the reduction in the change in discount rate). It was common ground that, absent the impact of the ECHR, the Defendant would be entitled to do so. The question was whether the ECHR dictated a different approach.

The Claimant contended that the proper approach dictated by the ECHR and, indeed, the CRPD, was that set down in the family law proceedings:

> *46. Mr Weitzman* [for the Claimant] *referred to the approach which had been taken in Family law proceedings to compromises in Smallman v Smallman [1972] Fam 25. In that case the words "subject to the approval of the Court" did not prevent a binding agreement being made or entitle one party to resile from its terms before the court had been asked to approve it. The clause simply suspended carrying out the terms of the agreement until it had been approved. In Sharland v Sharland [2015] UKSC 60; [2016] AC 871 at paragraphs 27 and 28, Baroness Hale commented on differences between compromises in family proceedings and*

civil proceedings. Mr Weitzman's essential point was that the CPR could have adopted the approach to "the approval of the Court" in family law proceedings. Mr Weitzman submitted that such an approach would have been consistent with the United Nations Convention on the Rights of Persons with Disabilities, would have involved less interference with Mr Revill's ECHR rights, and would have been a proportionate approach to the issue of protected parties. Such an approach would have meant that Mr Damiani could not have withdrawn from the compromise unless the Court did not approve the compromise. Mr Grime [for the Defendant] *submitted that the approach taken by the rule making committee to this provision of the CPR was a proper approach, well within the discretionary area of judgment for the rule-making committee.*

Dingemans J held that:

49. […] *the approach taken by CPR 21.10 to compromises and court approval was a proportionate means of achieving the legitimate aim of ensuring the protection of protected parties from: other parties; from themselves; and from legal representatives. This is because, as was common ground, the objects set out in paragraph 21 above required the implementation of a scheme which required court approval of a compromise made by a protected party before that compromise would bind the protected party. This was because the protected party required protection from inadequate compromises, other parties required a means of obtaining a valid compromise, and consequential matters of distribution of the damages and costs needed to be resolved. This means that, as was common ground, CPR 21.10 pursued a legitimate aim.*

50. Although it is right that the CPR could have been rewritten so that the approach in family law cases was adopted, in my judgment the approach taken by the CPR was proportionate. This was for two main reasons. First the decision whether to continue with the "civil cases" approach set out in CPR21.10 or the "family proceedings" approach was within the discretionary area of judgment for the rule-making committee. There are factors in favour of the family proceedings approach. In this case it would have meant that Mr Damiani would have been held to the compromise, assuming that the court approved the compromise. However there are factors in favour of the approach taken by CPR 21.10. These include the facts that: (1) the compromise rule now set out in CPR 21.10 is long established so that all practitioners know where they stand, meaning that everyone can enter into negotiations to attempt to compromise the action knowing the legal position; and (2) permitting all parties, including the protected party, to withdraw from a compromise before it had been approved maintained a fair balance between protected parties and the other party who might want to withdraw. The family proceedings approach requires permission from the court to withdraw from a compromise, and such permission might not be provided. This could create uncertainty with all the attendant worry and cost. It might also be undesirable, for example legal representatives acting in a case where a protected party had developed groundless fears about the effect of a compromise (which compromise would

affect the rest of that protected party's life) and which groundless fears would never have been sufficient to justify a court refusing to approve the compromise, might withdraw from the compromise. This would enable the protected party to be reassured, providing as much autonomy as possible to the protected party consistent with the UN Convention, before a further compromise was made. That further compromise would either meet the protected party's concern or at least provide as much comfort as possible to the protected party. It was for the rule making committee to decide which approach between the civil damages and family proceedings approach to pursue. The approach taken by CPR 21.10 was well within the discretionary area of judgment accorded to the rule making body to make the relevant procedural arrangements to secure the good administration of justice and to protect the relevant rights engaged.

51. Secondly CPR 21.10 formed part of a series of rules which, among other matters, included the duty on the court to provide active case management. […]. *The powers of active case management permit the court to ensure that cases involving protected and unprotected parties are managed in a proportionate and efficient manner, thereby securing the good administration of justice and protecting the relevant rights.*

Comment

Although the attempt by the Claimant to maintain the benefit of the compromise agreement in this case was ingenious, it is hardly surprising that Dingemans J saw fit to maintain the conventional approach to CPR 21.10, as to do otherwise would have to have been to wreak havoc in such cases. A really rigorous approach to interpreting Article 13 CRPD (the right of access to justice, making one of its very rare outings in the English courts) would have involved a far more root and branch challenge to the very concept of 'protected party' (see further in this regard the article by Alex, Neil and Peter Bartlett here).

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PRACTICE AND PROCEDURE

The Court of Protection Rules 2017 (and associated Practice Directions)

As of 1 December 2017, the *look* of the Court of Protection Rules is to be dramatically changed with the coming into force of the Court of Protection Rules 2017 ('the 2017 Rules'), which will recast all of the Rules into the same format as the Civil Procedure and Family Procedure Rules. The new-look Court of Protection Rules will also incorporate those rules relating to case management which have, since September 2016, been implemented by way of the Case Management Pilot. The accompanying Practice Directions are amended where necessary to reflect the renumbering of the Rules, and will also cement into the practice of the Court the Transparency Pilot and the Section 49 Report Pilot.

This note [6] sets out the background to the changes and highlights some key features for practitioners to be aware of under the new regime.

Background

It is now ten years since the MCA came into force and the 'new' Court of Protection opened its doors for business. After an abortive start in 2010, a rolling programme of incremental reform has been undertaken since 2014 by the ad hoc Rules Committee to respond to a range of challenges. These include, most notably, participation of 'P,' concerns that welfare cases in particular were not being managed as effectively as they should, and the concerns as to whether the public interest mandated a greater degree of transparency about the court process. The Court of Protection (Amendment) Rules 2015 began the process in earnest, in particular with the introduction of Rule 3A, requiring the court to consider a menu of options at the outset of each case as to how P is to participate (these changes and the others were described in Alex's article "The next stage of the journey – the Court of Protection (Amendment) Rules 2015" [2015] Eld LJ 150). Much of the work since then has been done by way of pilots, in particular the Case Management Pilot introduced with effect from 1 September 2016, providing for the introduction of three distinct pathways for COP proceedings: 1) a Property and Affairs pathway, 2) a Health and Welfare pathway, and 3) a hybrid pathway for cases that have elements of both. A Transparency Pilot introduced on the same date provided, in essence, for all hearings to be held in public subject to reporting restrictions (the Pilot was amended earlier this year to merge the approach under this Pilot and that traditionally adopted in serious medical treatment cases, which had, similarly, been held in public with reporting restrictions). Finally, a Pilot also introduced on 1 September 2016 sought to address problems that had been encountered with securing reports from NHS bodies and local authorities under the provisions of s.49 MCA. A limited number of amendments to the Rules were subsequently introduced earlier this year to add provisions relating to civil restraint orders and rules for cross-border cases arising under Schedule 3 to

[6] A version of which will appear in the next issue of the Family Law Journal. It would have appeared in the Elder Law Journal but for the sad – and unwarranted – demise of that important publication at the hands of LexisNexis.

the MCA.

During the course of the incremental reform process, it became increasingly clear that it was unhelpful that that the Court of Protection Rules were numbered in sequential fashion, and that it would be more appropriate for them to be recast into the same format as the governing rules of Family, Civil and Criminal courts. The Case Management Pilot introduced recast rules for those cases falling within the Pilot; the 2017 Rules adopts the re-cast structure and reformats the entirety of the remainder of the Rules in the same fashion.

Changes brought about the 2017 rules

There have been only minimal changes implemented by the 2017 Rules as they are predominantly consolidating provisions. There will be an inevitable learning curve while practitioners find their way around COPR 2017: to ease the pain, an unofficial destination table can be found at the end of this note. In this regard, it should also be noted that "Rule 3A representatives," often called on in deprivation of liberty proceedings, are now "Rule 1.2 representatives."

The only new rules are contained in the new Part 21. These are modelled on provisions in the CPR and FPR and contain comprehensive freestanding provision for proceedings in relation to contempt of court, replacing the much more limited provisions in Part 21 of the 2007 Rules. It should perhaps be noted that Case Management Pilot approach to expert evidence has been implemented in Part 15 of the 2017 Rules confirming that the Court of Protection is now in alignment with the restrictive approach to such evidence taken in family proceedings.

Changes brought about by the Practice Directions

Accompanying the 2017 Rules are a new suite of Practice Directions. For the most part these roll forward the relevant Practice Directions accompanying the 2007 Rules with relevant renumbering. The pilots set out above have all been incorporated into the practice of the court (through PD3B, Case Management; 4C, Transparency; and 14E, Section 49 reports respectively).

One important point to note is in relation to serious medical treatment cases. Practice Direction 9E to the 2007 Rules, concerning serious medical treatment, will not be replaced in the new suite of practice directions, and it is not clear at this point whether a further practice direction will be promulgated in due course concerning this issue. What is now PD3A (on allocation) has also been amended to remove any reference to serious medical treatment, which had always to be allocated to High Court judges. It now provides that "*where an application is made to the court in relation to an ethical dilemma in an untested area, the proceedings must be conducted by a Tier 3 judge* [i.e. High Court] *judge*." Pending any decision of the Supreme Court in the *Y* case, we are in somewhat uncharted waters at the moment as to the question of precisely what medical treatment cases need to come to court; the removal of PD9E and the amendment of (now) PD3A means that we are also in uncharted waters as to what should happen to them when they reach the court.

Transitional provisions

Practitioners need to be aware of the strict PD24C, providing for transitional provisions, as these could easily trip up the unwary. They provide that applications under the previous rules or pilot PDs received on or after 1 December will be returned, albeit that an application made using the old forms will be accepted until close of business on 12 January 2018 or such later date as the Senior Judge may direct. Where proceedings are ongoing as at 1 December, the general presumption will be that any step in proceedings which were started (i.e. the application form was issued by the court) before 1 December which is to be taken on or after that date is to be taken under the 2017 Rules, subject to any directions given by the court.

Destination table for Court of Protection Rules 2007 as now recast as Court of Protection Rules 2017

Notes:

1. The Court of Protection Case Management Pilot introduced Pilot Parts 1–5 and 15, which had the same numbering as the COPR 2017.

2. Part 22 in the COPR 2007 (as amended), providing for transitional arrangements, has been deleted and replaced with a new Part 22 addressing Civil Restraint Orders. The contents of Parts 21-4 of the COPR 2007 (as amended) have also been moved around within the Parts of the COPR 2017; the destination table proceeds by reference to the organisation of the COPR 2007 as opposed to the organisation of the new COPR 2017.

COPR 2007 (as amended)	COPR 2017
Part 2: The overriding objective rr3–5	Part 1: The overriding objective rr1.1–1.6
Part 3: Interpretation and general provisions rr6–9A	Part 2: Interpretation and general provisions rr2.1–2.6
Part 4: Court documents rr10–24	Part 5: Court documents rr5.1–5.16
Part 5: General case management powers rr25–28	Part 3: Managing the case rr3.1–3.9
Part 6: Service of documents rr29–39H	Part 6: Service of documents rr6.1–6.19
Part 7: Notifying P rr40–49	Part 7: Notifying P rr7.1–7.11
Part 8: Permission rr50–60	Part 8: Permission rr8.1–8.6
Part 9: How to start proceedings rr61–76	Part 9: How to start and respond to proceedings, and parties to proceedings rr9.1–9.16
Part 10: Applications within proceedings rr77–82	Part 10: Applications within proceedings rr10.1–10.10
Part 10A: Deprivation of liberty r82A	Part 11: Deprivation of liberty r11.1
Part 11: Human rights r83	Part 12: Human rights r12.1
Part 12: Dealing with applications rr84–86	Part 3: Managing the case rr3.1–3.9
rr87–89	Part 13: Jurisdiction, withdrawal of proceedings,

	participation and reconsideration rr13.1–13.4
Part 13: Hearings rr90–93	Part 4: Hearings rr4.1–4.4
Part 14: Admissions, evidence and depositions rr94–118	Part 14: Admissions, evidence and depositions rr14.1–14.25
Part 15: Experts rr119–131	Part 15: Experts rr15.1–15.13
Part 16: Disclosure rr132–138	Part 16: Disclosure rr16.1–16.8
Part 17: Litigation friends and rule 3A representatives rr140–149	Part 17: Litigation friends and rule 1.2 representatives rr17.1–17.14
Part 18: Change of solicitor rr150–154	Part 18: Change of solicitor rr18.1–18.5
Part 19: Costs rr155–168	Part 19: Costs rr19.1–19.14
Part 20: Appeals rr169–182	Part 20: Appeals rr20.1–20.14
Part 21: Enforcement rr183–184	Part 21: Applications and proceedings in relation to contempt of court rr21.1–21.32
Part 21: Enforcement rr185–194	Part 24: Miscellaneous rr24.1–24.6
Part 22: Transitory and Transitional Provisions rr195–199	Deleted and not replaced
Part 23: Miscellaneous rr200–202	Part 24: Miscellaneous rr24.3–24.5
Part 23: Miscellaneous r203	Part 22: Civil restraint orders r22.1
Part 24: International Protection of Adults rr204–209	Part 23: International protection of adults rr23.1–23.6

The table above is reproduced with permission of the Legal Action Group, and is taken from the revised second edition of the Court of Protection Handbook which is to be published at the start of December, and which will include both hard copies of the Rules and an introductory overview of significant changes in the law in the past year.[7]

Accredited Legal Representatives

The first cohort of Accredited Legal Representatives have now been approved by the Law Society – congratulations to them all (the list can be found here).

We now await further progress from HMCTS and the judiciary to outline precisely when and how ALRs will be appointed as part of the initial consideration by the court of P's participation under (soon to be) Rule 1.2 of the COPR 2017.

[7] A supplement containing the introductory overview and the new Rules will be available as a free eBook and PDF. A hard copy will be sent out automatically (for free) to people who bought the second edition directly from LAG but can be requested (by email to lag@lag.org.uk) for free by those who bought from other outlets.

The table also appears on the Handbook website, where the new Rules and Practice Directions can also all be found.

In the interim, however, we see no reason[8] why proactive steps cannot be taken by an approved solicitor who has been approached by P, an RPR or an IMCA in an s.21A application. In such a case, the solicitor may consider filing a witness statement confirming their accreditation, describing their interaction with P and explaining why this could be a suitable case for P to participate through the appointment of an ALR rather than via a litigation friend.

The Law Society has also, importantly, published its *Practice Note on Accredited Legal Representatives in the Court of Protection*. This practice note, available here,[9] includes detailed advice on:

- the role of an Accredited Legal Representative
- communicating with and taking instructions from your client
- representing P and ensuring P's effective participation
- your duties of confidentiality and disclosure
- good practice in the Court of Protection
- funding of P's legal costs
- applications under s21A Mental Capacity Act 2005
- other issues e.g. breach of the HRA 1998.

New Family Procedure Rules on Participation of Vulnerable People: Enabling the Court of Protection to pick up the pace?

[*We are very pleased to be able to include this guest article by Professor Penny Cooper on what we can draw from the new procedures introduced into the Family Courts with effect from the end of this month*]

The Family Procedure (Amendment No. 3) Rules 2017 are in force from 27th November 2017. They are supplemented by Practice Direction 3AA - Vulnerable Persons: Participation in Proceedings and Giving Evidence. The Ministry of Justice explanatory memo says these changes "*were informed by a 2015 report of the judicially-led Vulnerable Witnesses and Children Working Group, established by the President of the Family Division*." It was a slow journey from the report of that group to the consultation and finally the rules. The aim is simple: To improve the participation of parties and witnesses in the family cases.

What follows is a quick overview of the new rules and Practice Direction; they contain some useful points of reference for Court of Protection practitioners.

There is a common-sense approach to the meaning of *participation*. The court's decision about whether a party or witness's participation is likely to be diminished by reason of

[8] See also in this regard Sophy Miles' note on the Court of Protection Handbook website, Sophy having been instrumental in the work leading to the establishment and approval of ALRs.

[9] Although the Practice Note is free, it is – somewhat unhelpfully – at present behind a wall on the Law Society website which requires registration.

vulnerability should take into account their ability to:

> *a) understand the proceedings, and their role in them, when in court;*
>
> *(b) put their views to the court;*
>
> *(c) instruct their representative/s before, during and after the hearing; and*
>
> *(d) attend the hearing without significant distress.* (PD 3AA, 3.1)

The new rules and the PD together result in a checklist for *vulnerability*. When considering the vulnerability of the party or witness the court must have regard to the matters set out in paragraphs (a) to (j) and (m) in rules 3A.7 (FPR 3A.3).

> *(a) the impact of any actual or perceived intimidation, including any behaviour towards the party or witness on the part of—*
>
> *(i) any other party or other witness to the proceedings or members of the family or associates of that other party or other witness; or*
>
> *(ii) any members of the family of the party or witness;*
>
> *(b) whether the party or witness—*
>
> *(i) suffers from mental disorder or otherwise has a significant impairment of intelligence or social functioning;*
>
> *(ii) has a physical disability or suffers from a physical disorder; or*
>
> *(iii)is undergoing medical treatment;*
>
> *(c) the nature and extent of the information before the court;*
>
> *(d) the issues arising in the proceedings including (but not limited to) any concerns arising in relation to abuse;*
>
> *(e) whether a matter is contentious;*
>
> *(f) the age, maturity and understanding of the party or witness;*
>
> *(g) the social and cultural background and ethnic origins of the party or witness;*
>
> *(h) the domestic circumstances and religious beliefs of the party or witness;*
> *(i) any questions which the court is putting or causing to be put to a witness in accordance with section 31G (6) of the [Matrimonial and Family Proceedings] 1984 Act;*
>
> *(j) any characteristic of the party or witness which is relevant to the participation direction which may be made;*
>
> *(k) whether any measure is available to the court;*
>
> *(l) the costs of any available measure; and*
>
> *(m) any other matters set out in Practice Direction 3AA.'* (FPR 3A.7).

The Practice Direction supplements this by adding that abuse includes concerns arising from:

- domestic abuse, within the meaning given in Practice Direction 12J;
- sexual abuse;
- physical and emotional abuse;
- racial and/or cultural abuse or discrimination;
- marriage or so called 'honour based violence';
- female genital or other physical mutilation;
- abuse or discrimination based on gender or sexual orientation;
- and human trafficking.

The rules represent progress on the definition of vulnerability. There is a significant nod to the criminal justice system (as the 2015 report had intended) but fortunately the rules do not copy the confusing, bifurcated 'vulnerable' or 'intimidated' definition that criminal courts sometimes struggle with. 'Special measures' have quite rightly become simply 'measures'. The family court must have regard to (a) to (m) when deciding whether to make a '*participation direction*' about '*measures*' (FPR 3A.8) such as live link, an intermediary or 'anything else' in PD 3AA.

The rules are straightforward but implementing them will not always be so; nothing in the rules gives the court power to direct public funding must be made available for a measure (3A.8(4)). Moving locations if a measure is not available at one court (3A.8 (2)) is possible, but in some cases solving one issue (such as the need for a live link) could be at the expense of unsettling or making travel arrangements harder for a vulnerable person. However, it is encouraging to see that the Practice Direction (5.4) allows for the pre-recording of a witness's evidence.

Some people will remember that one of the tasks of the 2015 working group (of which I was a member) was to review the Family Justice Council's April 2010 *Guidelines for Judges Meeting Children who are Subject to Family Proceedings* [2010] 2 FLR 1872. Anyone hoping for some new pointers here will be disappointed; neither the new rule not the PD addresses this topic.

Ground Rules Hearings were born in the criminal justice system as were 'toolkits' for advocates working with vulnerable people. The family court's new Practice Direction has a section on *Ground Rules Hearings* and also says that advocates (including litigants in person) should be familiar with The Advocate's Gateway toolkits (PD 3AA, 5.7).

Whatever the impact of these new provisions in family courts, one thing is for certain, the spotlight continues to fall on the topic of practitioner competence. In the Court of Appeal Criminal Division in August 2017, Lord Thomas CJ issued a mighty judgment dealing with, in part, vulnerable defendants and advocates' duties:

> *We would like to emphasise that it is, of course, generally misconduct to take on a case where an advocate is not competent. It would be difficult to conceive of an advocate being competent to act in a case involving young witnesses or defendants unless*

> *the advocate had undertaken specific training.*[10]

Developments about participation for vulnerable people in the criminal and family courts will no doubt continue to inform practice in the Court of Protection. Recently CoP guidance has been issued to "*provide helpful suggestions as to how practitioners might consider enhancing participation of* [the vulnerable person] *in proceedings in the Court of Protection.*"[11] This represents a very good start; however, I am reminded of the words of Lucy Series and colleagues:

> *Surprisingly given it is a jurisdiction wholly devoted to matters concerning people with mental disabilities, the CoP has until recently given no systematic consideration to the special measures and reasonable adjustments that would be needed to facilitate the participation of P. Recent (non- binding) guidance encourages judges and parties to consider these matters, but there is no provision in the* [CoP Rules] *or practice directions in relation to this matter, and questions remain as to how such measures would be funded.*[12]

The Court of Protection seems to be moving along a fairly well-trodden path which ought to mean the pace can pick up. Perhaps the ad hoc Rules Committee of the COP will take FPR 3A and PD 3AA as a starting point and see where re-using and up-cycling takes them, just as the family courts did with criminal justice practice.

Professor Penny Cooper, Barrister, Door Tenant, 39 Essex Chambers, Chair of The Advocate's Gateway and Principal Investigator on 'Vulnerability in the Courts', funded by the Nuffield Foundation

[10] *R. v Grant–Murray & Henry; R. v McGill, Hewitt & Hewitt* [2017] EWCA Crim 1228, para. 226.

[11] Charles, Mr. Justice. (2016). Facilitating participation of P and vulnerable persons in Court of Protection Proceedings.

[12] Series, L., Fennell, P. & Doughty, J. (2017). The Participation of P in Welfare Cases in the Court of Protection. England: Cardiff University & The Nuffield Foundation. 15.

THE WIDER CONTEXT

Reframing *Gillick* competence through the prism of the MCA?

Re S (Child as parent: Adoption: Consent) [2017] EWHC 2729 (Fam) *(Family Division (Cobb J))*

Mental capacity – assessing capacity

Summary

We briefly mention this decision because it is the first time MCA-concepts and language have been expressly endorsed and adopted when assessing the *Gillick* competence. In short, S was under 16 and had given birth to a baby by caesarean section under general anaesthetic. The central issues were whether she had the competence to make decisions as to her child being (a) voluntarily accommodated under section 20 of the Children Act 1989 and (b) adopted.

It was not in dispute that, given her age, S's competence was to be assessed by reference to *Gillick*. That is, whether she had achieved *"a sufficient understanding and intelligence to enable … her to understand fully what is proposed."* Cobb J held that in so doing, "*I regard it as appropriate, and indeed helpful, to read across to, and borrow from, the relevant concepts and language of the Mental Capacity Act 2005*" (para 15). His Lordship went on to state:

> *16. I do so, cognizant of some fundamental differences between the assessment of a child's competence at common law, and the assessment of capacity of a person over the age of 16 under the MCA 2005. Most notable of the differences is that the assumption of capacity in a person aged 16 or over in section 1(2) of the MCA 2005 does not apply (in relation to the equivalent issue of competence) to a young person under that age. Furthermore, there is no requirement to consider any 'diagnostic' characteristic of a young person under 16 (i.e. impairment of, or a disturbance in the functioning of, the mind or brain) in the assessment of their competence, as there is under section 2(1) of the MCA 2005 in respect of those aged 16 and over.*
>
> *17. It seems to me, nonetheless, that the following principles relevant to decision-making under the* MCA 2005 *can usefully be applied to Gillick decisions:*
>
> *(i) The determination of a child's competence must be decision-specific and child-specific. It is necessary to consider the specific factual context when evaluating competence, for "removing the specific factual context from some decisions leaves nothing for the evaluation of capacity to bite upon" (City of York Council v C [2013] EWCA Civ 478; [2014] Fam 10 at [35]);*
>
> *(ii) Just because S lacks litigation competence in the placement order proceedings for example does not mean that she lacks subject matter competence (say, in relation to consent): Sheffield City Council v E [2004] EWHC 2808 (Fam) at [23] ("someone can have capacity for one purpose whilst simultaneously lacking capacity for another purpose");*
>
> *(iii) The assessment of competence must be made on the current evidence, and in respect of this current and specific*

decision, as is the approach under the MCA 2005: see §4.4 Mental Capacity Act Code of Practice ("the Mental Capacity Code").

18. The approach outlined in [14]-[17] above is advanced by the Local Authority in this case, though not wholeheartedly supported on behalf of S or T. That said, it is agreed by all parties that in order to be satisfied that a child is able to make a Gillick competent decision (i.e. has "sufficient understanding and intelligence to enable him or her to understand fully what is proposed": see Lord Scarman in Gillick above), the child should be of sufficient intelligence and maturity to:

(i) Understand the nature and implications of the decision and the process of implementing that decision;

(ii) Understand the implications of not pursuing the decision;

(iii) Retain the information long enough for the decision-making process to take place;

(iv) Weigh up the information and arrive at a decision;

(v) Communicate that decision.

19. For my part, I consider it helpful to test Gillick competence in the way outlined in [18]. As I have said above, while it is abundantly clear that the MCA 2005 does not apply to those under 16 years of age, there is an advantage in applying relevant MCA 2005 concepts and language to the determination of competence to the under-16s, for this will materially assist in maintaining consistency of judicial approach to the determination of capacity or competence of a parent to give consent to adoption or placement, whether that parent is under or over 16 years of age. The capacity to give consent under the ACA 2002 for the over-16s is specifically to be determined by reference to the MCA 2005: see section 52(1)(a); it would be illogical if the court applied a materially different test of capacity/competence depending on which side of their 16th birthday the parent fell.

His Lordship identified the information relevant to the section 20 accommodation decision (para 62(vi)) and the adoption decision (para 62(vii)) in a most useful, concise summary of his reasoning.

Comment

This is a particularly important judgment for anyone working with those under 18. It very much implements that which is advocated in the MHA Code of Practice, namely the fleshing out of the common law *Gillick* competence test with the clarity of the MCA, recognising the fundamental differences where appropriate. The concepts embedded in the MCA were very much more fully embraced in this decision than they were by the Court of Appeal in *Re D* [2017] EWCA Civ 1695. And the greater degree of clarity should assist practitioners.

One potential area of confusion is the distinction drawn "*between the competence to make a decision, and the exercise of decision-making*" (para 59). At least in MCA-terms, it is the person's ability to decide that counts rather than the wisdom of their decision. But decision-making ability includes the ability to "use" the relevant information and to communicate the

decision. If, by "exercising" decision-making, the court had in mind the need to be provided with all the salient details of the decision so that the decision is an informed one, that would avoid confusion.

CQC state of care report

The CQC has published its report "The state of health care and adult social care in England 2016/17."

The report concludes that:

- Health and care services are at full stretch
- Care providers are under pressure and staff resilience is not inexhaustible
- The quality of care across England is mostly good
- Quality has improved overall, but there is too much variation and some services have deteriorated
- To put people first, there must be more local collaboration and joined-up care

The report is wide ranging, considering acute hospitals, mental health and adult social care. Of particular interest is the section on DOLS. We set out below the key points:

- There is variation in the practical application of the Deprivation of Liberty Safeguards (DoLS) with uneven use across the health and social care sector, thus while most care home providers comply with DoLS legislation there is a wide variation in the its implementation and use.
- DoLS should not be one-size-fits-all – good practice in person-centred care is at the heart of ensuring decisions made around the Mental Capacity Act and DoLS are in the person's best interests. Concerns were raised about gaps in knowledge about the practicalities of DoLS and how these could impact on a person's care and the fact that DoLS is often viewed as a paper exercise with the application as the end point, rather than the beginning of the care planning process.
- There are however examples of good practice that providers can learn from, for example personalised ways to assess capacity, and using new technology to increase people's independence.
- While staff training levels are relatively good, translating this knowledge into practice is still less effective and needs to improve.
- Across all sectors there was a lack of understanding about what constitutes a restrictive practice or restraint and how to recognise them. This led to instances where people's rights and wishes were not being respected. Further problems arose from:
    - Staff not fully understanding aspects of the legislation, partly due to its complexity, and also as a result of not enough training or translating that training into practice. This can lead to the use of overly restrictive practices; generalised decisions around a person's capacity; and a lack of person-centred care. Where there are staff shortages and pressures, this can also lead to restrictive practices to help save time
    - Blanket restrictions in adult social care and hospital settings. These were either

where a restriction that could potentially be a deprivation had not been identified as that, or where a restriction had been applied to a group of people, rather than on an individual basis. Examples included: people being locked in communal living areas or wards; people not allowed to take part in certain activities; the use of bed-rails to restrict people without a proper risk assessment; and the use of anxiety medication as a chemical restraint

- Delays to the processing of DoLS applications is noted to be a continuing problem, although some providers have found ways to work together with local authorities to manage the situation. During 2016/17 there remained a backlog of DoLS applications – according to the ADASS budget survey 2017, "*Only 29% of directors who responded to the survey are fully confident of being able to deliver all of their statutory duties this year (including for DoLS), falling to just 4% who think they can do so next year*." Against this, the providers who had notified the CQC of the outcome of a DOLS application or if they withdraw an application increased by 33% in 2016/17 from the previous year. It still, however, remains on the lower side of what the CQC was expecting given the increased applications to local authorities over the years (this number is higher than the notifcations the CQC receive).

Modern slavery, coercion and control

On 28 July 2016, the Home Secretary commissioned Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services to inspect the police's response to the implementation of the Modern Slavery Act 2015 in England and Wales. The inspection took place between November 2016 and March 2017 and the Report entitled 'Stolen freedom: the policing response to modern slavery and human trafficking' has just been published.

The report notes that "*modern slavery and human trafficking takes many forms, but all of them involve coercion and result in the erosion of individual volition and freedom*." Of particular interest for those who work in the mental capacity field is the importance placed on identifying victims outside the communities often associated with slavery and trafficking. The report makes it clear that those with vulnerabilities such as age or learning difficulties are more prone to exploitation in this field and less able to seek help, even if they have freedom of movement. Thus those of us that work in this field must be astute to the possibility of modern slavery when coming across vulnerable adults who appear to have been coerced into either working for little or not pay, or perhaps to handing over their benefits.

The two conclusions of particular relevance for our purposes are:

- The failure to identify victims remaining a significant problem, with frontline officers having only a patchy, inconsistent understanding of signs and indicators of this type of offending. In some cases attitudes remain that modern slavery and human trafficking is rare and not an issue in their areas.
- A prevalent desire to close cases early once the victim has been safeguarded, leaving the

perpetrator free to continue victimising more people. This reflects a general lack of understanding about the perpetrators of these crimes, and what will stop their offending.

All this of course calls for joined up working between those whose primary duty is to safeguard and protect victims, and those whose primary duty is to apprehend perpetrators.

Legal literacy, capacity, and the 'thinness' of autonomy

The recently published Safeguarding Adults Review into the death of Mr A written by Professors Suzy Braye & Michael Preston-Shoot makes sobering reading as to the lack of legal literacy amongst the health and social care professionals involved in the case of a man who was consistently (but query? without capacity) refusing medical treatment. However, putting to one side the details of this depressingly familiar story, it can also be seen as a challenge to the "thin" model of autonomy advocated by some proponents of the CRPD. On one view of the facts of this case (summarised expertly in the Community Care story on the report), treatment could and should never have been provided to Mr A because such would have contravened his rights under Articles 12, 14 and 17 CRPD. On another view, such would have meant Mr A was left to die (with maggots infesting the wounds in his legs) with his rights on.

Mental Health Act changes coming into force on 11 December

The changes to ss.135 and 136 MHA introduced by the Crime and Policing Act 2017 are coming into force on 11 December. The effect of these changes, together with links to the associated regulations and (non-statutory) guidance is all usefully summarised here in a letter sent out by NHS England. The admirable Mental Health Cop Michael Brown OBE has also summarised the effect for front-line professionals in a post on his website here.

In this context, further:

1. The Angiolini report (the Independent Review of Deaths and Serious Incidents in Police Custody) finally published at the end of October reminds us of the risks involved and the human cost of individuals with mental health difficulties being detained by police officers.

2. The private members Mental Health (Use of Force) Bill also represents an attempt both to regulate and ensure the better reporting of force in hospitals and care homes in the context of those with mental disorders (it should be noted that the definition of 'physical restraint' is very similar to that contained in s.6 MCA 2005, which may well be something that needs to be addressed if it does make further Parliamentary progress.

Short note: personality disorder and deprivation of liberty

In *Nawrot v Poland* [2017] ECHR 922, the Strasbourg court again noted its doubts about whether deprivation of liberty on the basis of personality disorder can be justified.

Mr Nawrot had been charged with a number of criminal offences, but following the receipt of a psychiatric opinion which concluded that he suffered from a chronic psychotic disorder of a

delusional type related to organic lesions in his central nervous system, and also from a personality disorder which meant that at the time of the offences he would not have been aware of and could not have controlled his actions, the criminal proceedings were discontinued. The criminal court however held that Mr Nawrot should be held in a psychiatric hospital.

Mr Navrot subsequently made an application for his release from hospital on the basis that he was simulating suffering from a mental illness. This was supported by a subsequent psychiatric opinion that had been obtained in conjunction with further criminal proceedings brought against him, which concluded that he was not suffering from a mental illness, but a personality disorder.

Mr Nawrot's claim was for interference with his Article 5(1) and 5(4) ECHR rights. We consider here only the challenge to his Article 5(1) rights on the basis of the failure of the criminal courts to release him from psychiatric hospital despite the evidence that he was not suffering from a mental illness, but from a personality disorder.

The court reiterated the Winterwerp principles, namely that "*for the purposes of Article 5 § 1 (e), an individual cannot be deprived of his liberty as being of "unsound mind" unless the following three minimum conditions are satisfied: firstly, he must reliably be shown to be of unsound mind, that is, a true mental disorder must be established before a competent authority on the basis of objective medical expertise; secondly, the mental disorder must be of a kind or degree warranting compulsory confinement; thirdly, the validity of continued confinement depends upon the persistence of such a disorder.*"

As to whether, once the evidence established, that Mr Nawrot was not suffering from a psychotic disorder, but only a personality disorder, he was of 'unsound mind', the Court held that it was doubtful. At paragraph 73 the Court said this:

> *Moreover, in order to amount to a true mental disorder for the purposes of sub-paragraph (e) of Article 5 § 1, the mental disorder in question must be so serious as to necessitate treatment in an institution appropriate for mental health patients…. The Court has further expressed doubts as to whether a person's dissocial personality or dissocial personality disorder alone could be considered a sufficiently serious mental disorder so as to be classified as a "true" mental disorder for the purposes of Article 5 § 1..*

Comment

The Court's conclusions, while couched in somewhat uncertain terms, adds to the debate about whether it is lawful to deprive a personality disordered patient, of their liberty pursuant to Article 5(1)(e) ECHR. Both the MHA and MCA allow (in principle) a person who is diagnosed (solely) with a personality disorder, to be deprived of his/her liberty. The key to considering whether the deprivation of liberty of a personality disordered patient may be an interference with article 5(1) rights lies, we would suggest, in whether the mental disorder is so serious as to necessitate treatment in a mental health institution.

World Guardianship Congress

The 5th World Congress on Adult Guardianship to be held in Seoul, Korea, on 23rd – 25th October

2018 (with an additional day of workshops, principally for Asian countries, on 26th October 2018). The website for the 2018 Congress is here.

Alex attended the 4th World Congress in 2016 in Germany as one of the (disappointingly few) number of attendees from the United Kingdom: it was both an extremely interesting and extremely useful insight into how others across the world seek to grapple with the same problems through different legal frameworks and in different socio-economic traditions. There is every reason to expect that the 2018 conference will provide the same.

One note – 'Guardianship' is in this context misleading for English readers. The Congress is, in fact, concerned with what we would consider to be Deputyship, as well also as broader issues of mental capacity law.

CRPD developments and resources

A resolution was passed by the UN Human Rights Committee at the end of September on Mental Health and Human Rights. It can most easily be accessed via the International Disability Alliance ('IDA') website. The website also gives an interesting perspective on the 'take' of the Alliance and the CRPD Committee on the Resolution and the negotiations leading to it. We note with some interest that the UK was one of the sponsoring states for the Resolution, and it can therefore perhaps be seen evidence of the UK's considered position as to what the CRPD in fact demands: this is some way off the Committee's view, the Committee's chair specifically noting her "*concern*" at the "*strong resistance from Member States, during the informal negotiations, to include clear mention on the prohibition of forced treatment and confinement*."

We use this opportunity also to draw to your attention some useful resources available to assist thinking through how the CRPD could be operationalised in different contexts (and also, although we emphasise this is not their primary purposes, to test the propositions that the Committee derives from the Convention). Three in particular should be singled out:

1. The IDA has published an extremely helpful compilation of the concluding observations of the Committee on the states that have reported to date, broken down both by state and – even more helpfully – individual article;

2. The report of the Special Rapporteur on the rights of person with disabilities on the provision of different forms of rights-based support for persons with disabilities, including access to adequate decision-making support when seeking to make informed health-related choices. This can be found here;[13]

3. The World Health Organisation's QualityRights website, focused on mental health, but also mental capacity, contains detailed guidance and toolkits, including one on realising supported decision making and advance planning.

[13] In passing, it is hugely ironic that UN reports and other materials relating to disability are almost with exception exceptionally difficult to find and then link to.

SCOTLAND

Korean visit and World Congress 2018

Scotland's adult incapacity law, practice and administrative expertise continue to command worldwide respect and interest. At least since the 1990s, Scotland's Mental Welfare Commission has been recommended as a prime example of the "independent authority" recommended by the World Health Organisation. The functions of Scotland's Office of the Public Guardian, and the way in which the performance of those functions has been developed by Ms Sandra McDonald, the current Public Guardian, continue to be of worldwide interest. A particular focus has been upon the Scottish provisions for powers of attorney, and upon the increase in the volume of powers of attorney granted attributable in part to the unique "mypowerofattorney" campaigns.

Following the visit to Scotland on 23rd and 24th March 2017 by the Norwegian Central Guardianship Authority, on which we reported here, Scotland hosted a further similar visit on 23rd and 24th October 2017, this time from a team of four from the Office of Legal Counsel, Ministry of Justice, (South) Korea, accompanied by Professor Cheolung Je from Hangyang University. The first day of the visit was hosted by the Law Society of Scotland. Presentations were given by Sandra McDonald, Public Guardian; Jill Carson and her team from the "mypowerofattorney" campaigns; and Mike Diamond, Executive Director of Social Work, Mental Welfare Commission. The second day comprised a visit to the Office of the Public Guardian in Falkirk. The visitors then travelled south and took in a visit to the Offices of the Public Guardian for England and Wales on 25th October.

Professor Cheolung Je leads the organisation for the 5th World Congress on Adult Guardianship to be held in Seoul, Korea, on 23rd – 25th October 2018 (with an additional day of workshops, principally for Asian countries, on 26th October 2018). One of his principal purposes in joining the visit was to have lengthy discussions with me in my role as a member of the four-person steering group of the International Advisory Board for these World Congresses.

The website for the 2018 Congress is at http://koreanguardianship.or.kr/wcag2018/; see also the item in Wider Context on the Congress.

Adrian D Ward

North Strathclyde Practice Rules

The Sheriff Principal of North Strathclyde issued amended Practice Rules on 20th October 2017. Part 3 deals with applications under the Adults with Incapacity (Scotland) Act 2000. Unfortunately, they will not alleviate concerns at inconsistencies in practice across Scotland or the variable quality of Practice Rules in different jurisdictions. Two peculiarities of the North Strathclyde Rules stand out.

Firstly, Rule 3.02(f) requires the Initial Writ to "contain averments as to the known existence or otherwise of any existing power of attorney granted by the adult", but only where the grant of financial powers is sought, and for unexplained reasons not where only welfare powers are sought. Experienced practitioners will no doubt continue to include averments broadly similar to Statement 2 of the Statements of Fact which I offered in Appendix 6 to "Adult Incapacity"

(2003): "No guardianship or intervention orders in terms of [the Adults with Incapacity (Scotland) Act 2000] and no appointments which have become guardianship appointments in accordance with the transitional provisions of said Act are in force or have ever been granted in respect of [the adult]. [The adult] has no continuing attorney or welfare attorney." That last sentence can confidently be stated in absolute terms, as the registers of the Public Guardian can be accessed for this purpose, and are definitive.

Secondly, Rule 3.02(e) reads: "The Initial Writ must contain details of the names and addresses of all known next of kin of the adult, or, if there are no known next of kin, averments to that effect." Next of kin are neither referred to nor defined in the Adults with Incapacity (Scotland) Act 2000. It is necessary to specify (a) the "nearest relative", as defined in that Act, (b) the "primary carer", as defined in that Act, and (c) any "named person" as defined in that Act (or a statement that there is none). The sheriff is obliged to take account of the views of all of these (insofar as it is reasonable and practicable to do so), therefore the sheriff will need to know who they are in order to comply with the sheriff's obligations. Similarly, the sheriff will require to know the identity of "any guardian, continuing attorney or welfare attorney of the adult who has powers relating to the proposed intervention". Experienced solicitors generally consider themselves obliged to include an account of the persons, both relatives and non-relatives, significantly involved in the adult's life. The reasoning behind the reference to "next of kin", and how the phrase is intended to be interpreted for this purpose, are unclear.

There may of course be reasons peculiar to the Sheriffdom of North Strathclyde for picking out certain matters for prescriptive coverage in the Rules, and leaving others to the general responsibilities of applicants' solicitors to the court. This may be why there is no requirement to specify various further matters, such as whether the adult has a person providing independent advocacy services (with reference to section 3(5A) of the Act), or whether the adult resides in an "authorised establishment" (Summary Applications Rule 3.16.4(3)). As with some other equivalent Acts of Court elsewhere, it seems to be directed almost exclusively to applications under Part 6 of the Act, and not the various other forms of application provided for in the Act.

Adrian D Ward

Minutes no longer required for counter-proposals for guardians

In *Aberdeenshire Council (Applicant and Respondent) v JM (Respondent and Appellant)*, [2017] CSIH 65, the Second Division of the Inner House refused the appeal by JM against the decision of the Sheriff Appeal Court on 8th July 2016 which we reported in the August 2016 Mental Capacity Law Newsletter. The Opinion of the Inner House was delivered by Lady Dorrian, the Lord Justice Clerk. The court held that there was "no merit in any aspect of this appeal". Accordingly, beyond the points which we reported previously and our comments on the decision of the Sheriff Appeal Court, the main interest for practitioners in the decision of the Inner House is on a procedural point not addressed previously in the history of this case, nor elsewhere above the level of decisions at first instance. The point concerns the procedure to

be followed where a party other than the applicant in guardianship proceedings seeks to propose as guardian a person other than the person proposed by the applicant. Hitherto, relying upon *Arthur v Arthur*, 2005, SCLR 350 and *Cooke v Telford*, 2005, SCLR 367, the procedure followed was to make the counter-proposal by Minute, treating it as a "subsequent application" in terms of Rule 3.16.8, but not requiring a separate set of reports in terms of section 57(3) of the Adults with Incapacity (Scotland) Act 2000. The Inner House pointed out either a counter-proposal was a separate application to which the whole requirements of section 57(3) would apply "which would be absurd when there is no dispute that a guardianship order is required", or it was not. The Inner House concluded that: "The proper approach is that a counter-proposal such as this is not separate from the application to which it is a response nor is it an application subsequent to the earlier one. A Minute is not required, and the report-lodging requirements of section 57(3) do not apply." The counter-proposal is made during the currency of an application which the court is still considering, and may be advanced in Answers to the Summary Application. Such a counter-proposal in Answers is not subject to the report-lodging requirements of section 57.

Where an application has been made and refused, then a subsequent application would require to be made by Minute, and would be subject to the report-lodging requirements of section 57. Again, however, any counter-proposal in Answers to the Minute would not be subject to the report-lodging requirements.

The Inner House stressed the importance of the distinction between the guardianship and the person who is guardian, albeit only in the context of procedure upon an application. It is however a point that cannot be stressed often enough. Failure to recognise the distinction seems frequently to cause difficulties in practice. The following clear statement by the Inner House is accordingly to be welcomed: "It is important to recognise that there are two separate matters which the Court has to consider. One is whether a guardianship order is required; the other is who should be appointed guardian." These matters are dealt with respectively in sections 58 and 59 of the 2000 Act, though the Inner House understandably criticise as "infelicitous" the inclusion in section 58(4), rather than in section 59, of the provision that when granting an application the sheriff shall make an order "appointing the individual or office holder nominated in the application".

The Inner House also points out that although it is not a statutory requirement for a counter-proposal to be supported by a suitability report from the mental health officer, the sheriff still requires to be satisfied as to the suitability of the individual proposed in the counter-proposal. The requirements of section 59 apply. It is competent for the sheriff to call for further reports under section 3. That may include a report from the mental health officer.

The foregoing is a summary of paragraphs [15] to [24] of the Opinion of the court delivered by Lady Dorrian, which should be required reading for any solicitor acting for the first time in an application where the choice of guardian is disputed, or consulted with a view to contesting the choice of guardian.

Adrian D Ward

To be or not to be 'an adult' is the question: the *Birmingham CC v D* ruling and deprivation of liberty

Just when we thought that things couldn't get any more complicated on the deprivation of liberty and persons lacking capacity front the English Court of Appeal published its *Birmingham City Council v D (a child)* [14] ('the Birmingham ruling') in October 2017. This was an appeal from an earlier ruling [15] by the Court of Protection which essentially determined that the parents could not consent to a deprivation of liberty for their 16 and 17year olds who lacked capacity. The Court of Appeal ruling reversed this and although its rulings are only persuasive and not binding in Scotland it nevertheless raises some issues worthy of consideration for this jurisdiction.

It is not intended to provide a full analysis of the *Birmingham* ruling here (although I would strongly recommend that readers read the Court of Appeal judgment, the excellent commentary on the Mental Capacity Law and Policy website and Neil Allen's commentary in the Health, Welfare and Deprivation of Liberty section of this Report) but rather to briefly consider its potential implications from a Scottish perspective.

As in England and Wales, we have been wrestling with the legacy of the *Bournewood* and *Cheshire West*, and related rulings, for some time now in Scotland particularly in regard to Adults with Incapacity (Scotland) Act 2000 interventions and section 13ZA Social Work (Scotland) Act 1968[16]. This has been discussed in earlier issues of the *Mental Capacity Law Newsletter*.[17].

In a nutshell, we now know that if a person who is unable to give consent to their living arrangements is under continuous supervision and control and is not free to leave (however well-intended the objective of these restrictions are) [18] then they are deprived of their liberty engaging Article 5 ECHR (the right to liberty). Moreover, where there is such a deprivation of liberty then the individual is entitled to certain legal and procedural safeguards, including a 'real and effective' ability[19] to apply to a court to have the lawfulness of such deprivation of liberty tested (Article 5(4)), and there is ongoing debate in Scotland about we are to achieve this.

Alongside this has been the issue of whether others may legitimately consent to a deprivation of liberty on behalf of a person who lacks capacity. Certainly, in the absence of clear direction from Strasbourg that this would definitely not result in a deprivation of liberty engaging Article 5 ECHR, it would appear that there is a need for additional safeguards to accompany welfare attorneys and guardians consenting to a deprivation of liberty[20]. Although

[14] *Birmingham City Council v D* (a child) [2017] EWCA 1695.
[15] *Birmingham City Council v D*(A Child) [2016] EWCOP 8.
[16] Section 13ZA allows local authorities to move incapacitated adults to residential care.
[17] See March and April 2014 and March and April 2015 issues.
[18] *HL v UK* (2005) 40 EHRR 32, paras 91-91*; P (by his litigation friend the Official Solicitor) (Appellant) v Cheshire West and Chester Council and another (Respondents); P and Q (by their litigation friend, the Official Solicitor)(Appellants) v Surrey County Council (Respondent)* [2014] UKSC 19, per Lady Hale at 49.
[19] *Stanev v Bulgaria* (2012) 55 EHRR 22, para 170; *DD v Lithuania* (2012) ECHR 254, para 165; *MH v UK* (2013) ECHR 1008, paras 82-86; *Stankov v Bulgaria (Application No. 25820/07)* judgment of 17 March 2015.
[20] Scottish Law Commission, *Report Adults with Incapacity*, (Scot Law Com No 240), 2014, paras 3.56-

Scottish courts have directed that welfare guardians (with appropriate powers) may authorise a deprivation of liberty [21] it would therefore appear that additional safeguards, not currently available under the Adults with Incapacity (Scotland) Act 2000, are required.

The 2000 Act defines an adult as someone who is aged 16 years or older[22] and the provisions of the Act will only apply, subject to its other underpinning principles and certain criteria, if the adult is functionally 'incapable' as defined by section 1(6) and implicit is a presumption of capacity. The Birmingham ruling, however, potentially complicates the issue. It states that parents with parental authority may consent to a deprivation of liberty of their 16 and 17 year olds who are *Gillick* incompetent [23] . Where such arrangements are attributable to the state then such consent would mean that Article 5 ECHR, and thus the requirement for its legal and procedural safeguards, would not be engaged. Noting that the *Gillick* test applies to children under 16 (as does the Age of Legal Capacity (Scotland) Act 1991 which makes similar provision), the ability of those with parental responsibility to consent to the deprivation of liberty of a young person who would be deemed to be extended to an 'adult' falling within remit of the 2000 Act.

This therefore begs the question about which stance should be adopted for an 'incapable adult' aged 16 or 17. Should it be the 'procedure light', perhaps more pragmatic on occasion, 'Gillick' approach but one where Article 5 ECHR safeguards are absent? Alternatively, should the more cumbersome, and expensive, welfare guardianship route be adopted? Although not 'Article 5 perfect' the latter does provide a level of protection under the 2000 Act at least in terms of judicial oversight of the powers that granted, recall and a requirement that the court considers, and guardians act in accordance with, the principles of the Act such as, as previously stated, the presumption of capacity and functional capacity assessment[24] as well as the requirement that any intervention provides a benefit to the adult not otherwise achievable[25] and is the least restrictive option[26].

Similar confusion appears to arise in relation to the compatibility of the Birmingham ruling with the Mental Capacity Act 2005 in England and Wales. It will therefore be interesting to see whether the Court of Appeal decision will be appealed to UK Supreme Court and, if so, how this will be addressed there. Meanwhile, in Scotland, it is suggested that pending the reform of the 2000 Act it is this Act that continues to be followed applying both its principles and the Article 12 UNCRPD requirement to provide appropriate support for the exercise of legal capacity for young persons of 16 and 17.

Jill Stavert

3.60. The *Stankov* ruling also reinforces the need for caution here.

[21] *Muldoon, Applicant* 2005 SLT (Sh Ct) 52 at 58K,59B, Doherty (unreported), Glasgow Sheriff Court, 8 February 2005; *M, Applicant* 2009 SLT (Sh Ct) 185 at 84 and 87; *Application in respect of R* 2013 GWD 13-293.

[22] s 1(6).

[23] *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] UKHL 7.

[24] s 1(6).

[25] s 1(2).

[26] s 1(3).

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Conferences

Conferences at which editors/contributors are speaking

Deprivation of Liberty in the Community

Alex is delivering a day's training in London on 1 December for Edge Training on judicial authorisation of deprivation of liberty. For more details, and to book see here.

Deprivation of Liberty Safeguards: The Implications of the 2017 Law Commission Report

Alex is chairing and speaking at this conference in London on 8 December which looks both at the present and potential future state of the law in this area. For more details, 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 the dementia charity My Life Films in return for postings for English and Welsh events. For Scottish events, we are inviting donations to Alzheimer Scotland Action on Dementia.

Our last report of 2017 will be out in December. Please email us with any judgments or other news items which you think should be included. If you do not wish to receive this Report in the future please contact: marketing@39essex.com.

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