

Compendium

Introduction

Welcome to the April 2015 Newsletters. Highlights this month include:

- (1) In the Health, Welfare and Deprivation of Liberty Newsletter: 'baby Bournemouth?', an update on the long-awaited Guidance on Deprivation of Liberty, deprivation of liberty at home, the 7th IMCA report and an important ECtHR ruling on the acid test;
- (2) In the Property and Affairs Newsletter: an important decision on the interaction between the CICA and the COP, anonymisation of judgments and changes to LPA forms;
- (3) In the Practice and Procedure Newsletter: details of the first stage of reform of the COP rules, the new Practice Direction on contempt of court, vulnerable witnesses, and funding questions;
- (4) In the Capacity outside the COP Newsletter: an editorial comment on the Care Act and capacity, the House of Lords debates the Select Committee report, recruitment for the chair of the National Mental Capacity Forum, an extremely important decision of the Supreme Court on informed consent, and the publication of the first work on the international protection of adults edited (inter alia) by Alex and Adrian;
- (5) In the Scotland Newsletter: a bumper selection of important material, including news of a new project to consider compatibility of both Scots and NI legislation with the CRPD, the potential for the introduction of designated specialist sheriffs for adult incapacity work, and commentary on recent case-law of relevance to practitioners in the area.

We are also delighted to announce that, as of this month, Beverley Taylor, until recently the Deputy Official Solicitor, will be providing regular guest contributions.

Remember to visit our [sub-site](#) for all our resources.

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

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Deprivation of liberty at home

W City Council v Mrs L [2015] EWCOP 20 (Bodey J)

Article 5 ECHR – Deprivation of Liberty

Summary

The central issue was whether Mrs L, a 93-year old lady with Alzheimer’s dementia, was “deprived” of her liberty in her home, where care and safety arrangements had been set up for her between her adult daughters and the Local Authority. The Local Authority contended that she was; her daughter, acting as litigation friend, L contended that she was not.

Mrs L had been living in the upper floor flat of a 2-storey building for around 39 years. Owing to the risks, her family arranged for a fence and two gates to be erected, enclosing the garden. The front door to her flat which led into the garden

was locked with a Yale lock, which Mrs L could operate so she could access the garden when she wished. At night, door sensors switched themselves on in the evening and off in the morning and would be activated if Mrs L were to leave the property at night. An alarm call would be automatically be made to one of her daughters nearby and, if not available, would re-route to the emergency services. This would enable Mrs L to be guided safely back home and had not been triggered since they were installed. The Local Authority provided a care package consisting of three visits a day by specialist dementia carers.

Bodey J summarised the law, noting that “[t]he fact that *Cheshire West* was heard by 7 Supreme Court Justices and that the decision was by a majority of 4 to 3 demonstrates the difficulty of the topic.” After outlining the respective positions of the parties, his Lordship held that the circumstances did not constitute a deprivation of liberty or, if they did, it was not imputable to the State. In light of the importance of the issue, we set out the court’s reasoning in full:

*“22. It is clear from *Cheshire West* that there may be situations where a person is not free to leave a place, but is not under such continuous supervision and control as to mean that the arrangements put in place constitute a deprivation of liberty (per Lady Hale, cited at paragraph 11 above). It is well established that the difference between a deprivation of liberty and a restriction of liberty is one of degree or intensity, not one of nature or substance. The bulk of the jurisprudence can be seen to concern individuals in State-run social care institutions or hospitals, and not individuals in their own homes. This per se cannot of course be decisive in a given case for saying that a deprivation of liberty does not exist (for it is easy to envisage arrangements in a person’s own home which would*

constitute just such a deprivation of liberty); but, in my judgment, the ‘own home’ consideration must be a relevant factor in the mix.

*23. There are also references in the authorities suggesting that it has been relevant that the individual concerned, or someone acting on his behalf, was the complainant; in other words, was oppositional concerning the arrangements. For example at paragraph 71 of *Cheshire West* Lord Neuberger said:*

‘... It is a fair point that the Strasbourg court has never had to consider a case where a person was confined to what may be described as an ordinary home. However, I cannot see any good reason why the fact that a person is confined to a domestic home, as opposed to a hospital or other institution, should prevent her from contending that she has been deprived of her liberty.’
[Emphasis added]

*Again, in paragraph 41 of *Cheshire West*, Lady Hale spoke about the complainant being under the complete supervision and control of the staff and not free to leave [emphasis added]. Such considerations do not apply here, although they are clearly not pre-requisite to a deprivation of liberty: see paragraph 12(a) above. But it is overwhelmingly clear that Mrs L is where she always wanted to be when she was capacitous: and where not only has she not shown or expressed any dissatisfaction with the arrangements, but has demonstrated positively a continuing satisfaction with being in her own home. Further, her home is clearly not a ‘placement’ in the sense of a person being taken or taking herself to some institution or hospital.*

24. The fact of Mrs L referring to, and demonstrating by her demeanour, this

continuing contentment in her home is not in issue. It is right that she is of course not capacitated. Otherwise, this case would not be happening. But I do find that she is capable of expressing her wishes and feelings, as is referred to in the documents and shown in such things as for example her choice of clothes, the choice of what she does around the property, and in her going in and out of the garden at will. Although I accept the general need for the caution which Miss Hirst urges me to exercise, this consideration must be relevant in the evaluation of whether Mrs L is being 'deprived' of her 'liberty' within Article 5.

25. This case is thus different from one involving institutional accommodation with arrangements designed to confine the person for his or her safety, and where that person, or someone on his or her behalf, is challenging the need for such confinement. At paragraph 38 of Cheshire West Lady Hale spoke about 'the presence or absence of coercion' being a relevant consideration. As I have said, the range of criteria to be taken into account includes the type, duration, effects and manner of implementation of the arrangements put in place. The fact that those criteria are prefaced by the words 'such as' demonstrates that they are not intended to be exhaustive. It is a question of an overall review of all the particular circumstances of the case.

26. I observe too that Article 5 refers to everyone having a right to 'liberty and security of person' [emphasis added]. Mrs L's 'security' is being achieved by the arrangements put into place as being in her best interests, even though involving restrictions. Such restrictions are not continuous or complete. Mrs L has ample time to spend as she wishes, and the carer's visits are the minimum necessary for her safety and wellbeing, being largely

concerned to ensure that she is eating, taking liquids and coping generally in other respects.

27. This is a finely balanced case; but on the totality of everything that I have read in the files, I have come to the conclusion and find that whilst the arrangements (clearly) constitute restrictions on Mrs L's liberty, they do not quite cross the line to being a deprivation of it. If I were wrong about that, and if there is a deprivation of Mrs L's liberty, is it to be imputed to the State? On the facts, I find not. This is a shared arrangement set up by agreement with a caring and pro-active family: and the responsibility of the State is, it seems to me, diluted by the strong role which the family has played and continues to play. I do not consider in such circumstances that the mischief of State interference at which Article 5 was and is directed, sufficiently exists.

28. In these circumstances, my decision is simply that there is no deprivation of Mrs L's liberty. This is not per se because Mrs L is in her own home; nor because she wishes to be there. Those features alone would not necessarily stop particular arrangements amounting to a deprivation of liberty. Rather it is a finely balanced decision taken on all the facts of the particular case..." (emphasis added)

Comment

Alongside *Rochdale MBC v KW* (a further iteration of which is discussed below), this is the second reported case that has sought to distance its factual circumstances from *Cheshire West*. The court's reluctance to place significant weight on the "own home" feature is understandable, given that some might contend that P and MIG were living at "home", albeit not their "own". Similarly, KW lived in her "home" but this was not her "own" because it was a rented property. Were a person's accommodation status to be relevant to

the triggering of Article 5 would mean that we would run the risk of very fine distinctions being drawn in determining what constitutes a “home”. Indeed, in *R (G) v Nottinghamshire Healthcare NHS Trust and others* [2009] EWCA Civ 795, the Trust suggested that Rampton high security hospital was the detained patient’s “home”.

What we might be witnessing is the emerging relevance of Article 8 in the triggering of Article 5: an argument put to, but not referred to by, the Supreme Court. “Home”, in Article 8 terms, is “the place ... where private and family life develops”: *Gomez v Spain* (2005) 41 EHRR 40 at para 53. And clearly, the lower the threshold for “deprivation of liberty,” the greater the intrusion on people’s Article 8 rights. The following passage from the Court of Appeal’s judgment in the *Rampton* smoking ban case might become increasingly relevant:

“42. Article 8 seeks to prevent intrusion by the state into the physical and private space which the concept of home represents. For example, what one eats or drinks may not be important, but that the state should dictate what a person eats or drinks in the privacy of a person’s own home would be regarded as deeply intrusive. As Isaiah Berlin put it:

‘The desire not to be impinged upon, to be left to oneself, has been a mark of high civilization both on the part of individuals and communities. The sense of privacy itself, of the area of personal relationships as something sacred in its own right, derives from a conception of freedom which for all its religious roots, is scarcely older, in its developed state, than the Renaissance or Reformation. Yet its decline would mark the death of a civilization, of an entire moral outlook.’ (Inaugural Lecture, Oxford 1958)”

As Mostyn J did *Rochdale*, Bodey J cites the reference in Article 5 to “liberty and security” of person. Whether the appellate courts begin to shift their focus in this way will be interesting given the ECtHR’s stance to date, which is that “security of person” does not provide any separate interpretation from the right to liberty, its inclusion serving to emphasise that detention must not be arbitrary: see, e.g., *Altun v Turkey* [2004] ECHR 237 at para 57. This can be contrasted with the interpretation afforded to analogous provisions in the Universal Declaration of Human Rights (article 3), the International Covenant on Civil and Political Rights (article 9), and the American Declaration on the Rights and Duties of Man (article 1).

It is a matter of some considerable regret that the Local Authority only introduced very late in the day questions relating to the circumstances in which the State might be responsible for violating its positive obligations under Article 5 ECHR to protect people from arbitrary interferences by private persons. So this aspect of the case was not considered in any depth by Bodey J. However, it is analysed in the Law Society guidance discussed below (guidance drafted before the transcript of Bodey J’s judgment had been published but with limited information as to his conclusions).

It is not known whether this decision is to be appealed. As matters stand, it seems that *W City Council* provides a rare example of when someone is not free to leave but is not under continuous or complete supervision and control.

‘Baby Bournemouth?’

D (A Child) (Deprivation of Liberty) [2015] EWHC 922 (Fam) (Family Division (Keehan J))

Article 5 ECHR – Deprivation of liberty – Children and young persons – Interface with inherent jurisdiction

Summary

This case concerns the question of the application of the ‘acid test’ to those under 16. D, the child at the centre of the proceedings, was 15, with a number of difficulties including ADHD, Asperger’s and Tourette’s. He was informally admitted to hospital (‘hospital B’) in 2013 for a multi-disciplinary assessment and treatment. The psychiatric unit had six beds, with a school room attached to the building. It was locked; he could not leave with staff or family member; he was under 30-minute observation but sought out more regular contact with staff. He left the unit daily, accompanied by staff, going off site for activities including in the community on a one-to-one basis.

D was assessed as not being *Gillick* competent to consent to his residence and care arrangements. In light of the decision in *Cheshire West*, the hospital Trust issued an application in December 2014 under the inherent jurisdiction of the High Court seeking a declaration that the deprivation of D’s liberty by the Trust was lawful and in his best interests.

The matter came on for final determination before Keehan J on 9 and 10 March 2015. His Lordship was asked to determine the following principal issues:

1. Did the placement of D at Hospital B satisfy the first limb of the test propounded by Baroness Hale in *Cheshire West*?
2. If so, did the parents’ consent to his placement come within the exercise of parental responsibility in respect of a 15

year old young person? In other words, were the parents able to consent to what would otherwise amount to a deprivation of liberty?; and

3. If not, should the court exercise its powers under the inherent jurisdiction to consider declaring that the deprivation of liberty of D at Hospital B was lawful and in his best interests?

The applicant hospital Trust submitted that D was objectively confined, and that his parents could not consent to this placement because consenting to what would otherwise be a deprivation of liberty fell outside the zone of parental responsibility. The local authority submitted that D was not deprived of his liberty, both (initially) because his circumstances did not amount to a deprivation of his liberty and because the decision of D’s parents to consent to his placement at Hospital B fell within the proper exercise of parental responsibility. None of the other parties (or the children’s guardian) advanced substantive arguments on this issue.

Keehan J held the following:

1. The observations of Thorpe LJ in *RK v BCC and others* [2011] EWCA Civ 1305 to the effect that a parent may not lawfully detain or authorise the deprivation of liberty of a child (a) were obiter; (b) did not correctly state the legal position; (c) were arguably inconsistent with the views of Lords Neuberger and Kerr in *Cheshire West*; and (d) were not binding upon him;
2. The essential ratio of *Cheshire West* did not apply to the circumstances of D’s case. However:

“42. The protection of Article 5 of the Convention and the fundamental right to liberty applies to the whole of the human race; young or old and to those with disabilities just as much to those without. It may be those rights have sometimes to be limited or restricted because of the young age or disabilities of the individual but ‘the starting point should be the same as that for everyone else’, per Baroness Hale: Cheshire West at paragraph 45.

43. The majority in Cheshire West decided that what it means to be deprived of liberty is the same for everyone, whether or not they have a physical or mental disability: per Baroness Hale in Cheshire West at paragraph 46.”

Therefore, the acid test definitions of a deprivation of liberty applied as much to D as they did to the subjects of the appeals in *Cheshire West*. In reaching this conclusion, Keehan J expressly rejected the submission that he could and should adopt the ‘relative normality’ approach adopted by the Court of Appeal in *P and Q*;

3. The essential issue in this case was whether D's parents could, in the proper exercise of parental responsibility, consent to his accommodation in Hospital B and thus render what would otherwise be a deprivation of liberty not a deprivation of liberty (i.e. mean that the second in *Cheshire West* is not satisfied);
4. He was ‘wholly satisfied’ that D lived in conditions which amounted to a deprivation of his liberty:

“He is under constant supervision and control. The fact that D enjoys residing in the unit in Hospital B, that he is comfortable there and readily seeks out and engages with members of staff are irrelevant factors when considering whether there is a deprivation of liberty. So too are the facts that the arrangements have been made in his welfare best interests and have been, and are, to his benefit. A gilded cage is still a cage.” (paragraph 52)

5. When considering the exercise of parental responsibility in this case and whether a decision falls within the zone of parental responsibility, it was:

“55. [...] inevitable and necessary that I take into account D's autism and his other diagnosed conditions. I do so because they are important and fundamental factors to take into account when considering his maturity and his ability to make decisions about his day to day life.

56. An appropriate exercise of parental responsibility in respect of a 5 year old child will differ very considerably from what is or is not an appropriate exercise of parental responsibility in respect of a 15 year old young person.

57. The decisions which might be said to come within the zone of parental responsibility for a 15 year old who did not suffer from the conditions with which D has been diagnosed will be of a wholly different order from those decisions which have to be taken by parents whose 15 year old son suffers with D's disabilities. Thus a decision to

keep such a 15 year old boy under constant supervision and control would undoubtedly be considered an inappropriate exercise of parental responsibility and would probably amount to ill treatment. The decision to keep an autistic 15 year old boy who has erratic, challenging and potentially harmful behaviours under constant supervision and control is a quite different matter; to do otherwise would be neglectful. In such a case I consider the decision to keep this young person under constant supervision and control is the proper exercise of parental responsibility."

6. Given that it was incontrovertible that D's parents were acting on medical advice and were making decisions of which he was incapable, in his welfare best interests, to protect him and provide him with the help and support he needed, it would be "*wholly disproportionate, and fly in the face of common sense, to rule that the decision of the parents to place D at Hospital B was not well within the zone of parental responsibility.*"
7. In the exercise of their parental responsibility for D, D's parents had and were able to consent to his placement, thereby meaning his placement did not amount to a deprivation of liberty.

Keehan J expressly declined to give wider guidance either as to the approach to be taken by hospital trusts or local authorities in the cases of young people under the age of 16 who are or may be subject to a deprivation of liberty. "*These cases are invariably fact specific and require a close examination of the 'concrete' situation on the ground*" (paragraph 68); further, he declined

to comment upon the approach to be taken by the local authority "still less the Court of Protection" once D had attained the age of 16.

Comment

Whilst some may well welcome this decision as a sensible curtailment of the scope of the acid test, we must register a significant note of disquiet at the approach taken.

Keehan J – rightly – emphasised the importance of the universality of Article 5 and the right to liberty, regardless of disability, and rejected the invitation of the local authority to apply the 'relative normality' test propounded by the Court of Appeal in *P and Q*. However, he then reached his conclusion on the basis of an approach that compared D's situation not with that of an 'ordinary' child of 15, but with that of a child of 15 with significant disabilities.

This approach appears to contradict the comparator for those under 18 that was identified by Lord Kerr in the Supreme Court at paragraphs 77 to 79, namely "*children of their own age and relative maturity who are free from disability*" (paragraph 79).

It is arguably predicated on an approach that ends up denying the recognition of D's right to liberty (albeit by a different route) in precisely the same ways that the Courts of Appeal had done in the cases of MIG, MEG and P. In concrete terms, it resulted in a disabled 15 year old being confined in a psychiatric hospital for fifteen months without any formalised admission procedures indicating who could propose admission, for what reasons, and on the basis of what kind of medical and other assessments and conclusions. There was no requirement to fix the exact purpose of the admission; no limits in terms

of time, treatment or care attached to the admission; no independent scrutiny; and D was afforded independent representation to challenge the circumstances. This was justified, in essence, on the basis of the bona fides of his parents and the treating doctors. Readers would be forgiven for wondering whether this does not chime significantly with HL's circumstances.

Given that Keehan J was absolutely clear that D's situation amounted – objectively – to confinement and that this confinement was, in part, for purposes of assessment and treatment of his mental disorder, we suggest that this decision is likely to be viewed in due course as being just as – if not more – controversial than the decision in *Nielsen*. There, a 12 year old boy was hospitalised for five and a half months, at his mother's request, for therapeutic purposes where the assistance rendered by the authorities was only of a limited and subsidiary nature, in contrast to the present case.

This case also illustrates the potential relevance of Article 8 to the interpretation of Article 5: that is, the lower the threshold for “deprivation of liberty”, the more the State is required to interfere with people's right to respect for private life, family life and their home, in particular, in order to protect their right to liberty.

Short note: [Rochdale rumbles on](#)

In the latest twist in the *Rochdale* saga, Mostyn J has, in essence, held ([\[2015\] EWCOP 13](#)) that the Court of Appeal did not have the power to allow the appeal against his original [decision](#) as it had purported to do by way of endorsing (without a hearing) a consent order. Given that things continue to move apace in relation to this case (the latest development being that KW is seeking permission to appeal Mostyn J's most recent

decision to the Court of Appeal¹), we do not propose to cover matters further at this stage. We would, though, note that we continue to recommend that pending any further developments before the Court of Appeal, very considerable caution is given to the conclusions reached by Mostyn J as to KW's circumstances in his earlier decision for the reasons we gave in our comment thereupon.

Deprivation of Liberty Guidance

The Law Society Guidance that Alex and Neil have been working on for several months, along with Sophy Miles, Beverley Taylor and Paula Scully, was due out on 1 April. A major fire in the area stymied the Law Society from being able to make the final arrangements to host it, but it should be available early in the week commencing 6 April on the Society's [website](#), along with a podcast in which Alex discusses the key points.

In the interim, and give the flavour of the Guidance, we reproduce here the Executive Summary:

“There are many people in different settings who are deprived of their liberty by virtue of the type of care or treatment that they are receiving, or the level of restrictive practices that they are subject to, but they cannot consent to it because they lack the mental capacity to do so. In March 2014, the Supreme Court handed down judgment in two cases: [P v Cheshire West and Chester Council and P & Q v Surrey County Council](#) [2014] UKSC 19. That judgment, commonly known as Cheshire West, has led to a considerable increase in the numbers of people in England and Wales who are considered to be “deprived” of their liberty for the purposes of receiving care and

¹ With thanks to Jola Edwards of Peter Edwards Law, the solicitor instructed on behalf of KW, for confirming this.

treatment. The judgment also emphasised the importance of identifying those who are deprived of their liberty so that their circumstances can be the subject of regular independent checks to ensure that decisions being made about them are actually being made in their best interests.

The Department of Health commissioned guidance to assist those professionals most directly concerned with commissioning, implementation and oversight of arrangements for the care and treatment of individuals who may lack the capacity to consent to such arrangements. Its purpose is to provide practical assistance in identifying whether they are deprived of their liberty, and hence to ensure that appropriate steps can be taken to secure their rights under Article 5 of the European Convention on Human Rights ('ECHR'). It serves – in some ways – as an informal update to Chapter 2 of the DOLS Code of Practice, although it does not have the same statutory status, and the views expressed in it are those of the authors rather than representing Department of Health policy. It does not constitute formal legal advice, which should always be sought where necessary on the facts of difficult cases.

This guidance is not a panacea for Article 5 ECHR: there are a number of important limitations. First, it relates only to those who lack the mental capacity to consent to their residential and care arrangements: it does not cover situations where those with capacity are objecting to the same. Second, those of any age could potentially be deprived of their liberty; however, this guidance focuses solely on those aged 16 and over because that is the minimum age at which the Court of Protection can authorise a deprivation of liberty. Third, its principal aim is to assist in identifying a deprivation: it does not address in detail how that deprivation ought to be authorised. Nor does the guidance consider the law regarding

the challenging of a deprivation of liberty under Article 5(4) ECHR; resources addressing that question can be found in Chapter 11.

The guidance starts in Part I with an overview of the legal framework and of the key legal questions that must now be asked following the decision of the Supreme Court. Part II is the heart of the guidance, applying the legal principles across the following settings: the hospital setting, the psychiatric setting, the care home setting, supported living/shared lives/extra care, at home, and in relation to those aged 16 and 17. Where relevant, the guidance identifies particular sub-divisions within the care setting covered in the chapter (for instance, Accident and Emergency departments and Intensive Care Units within the hospital setting).

For each setting or sub-category, a list of potentially 'liberty-restricting' factors are given that may indicate that a deprivation of liberty is occurring; three scenarios are also given, one illustrating a deprivation of liberty, one a potential deprivation of liberty depending on the circumstances, and one a situation unlikely to amount to a deprivation of liberty. Each chapter then concludes with a list of questions that professionals may want to ask themselves whenever they are confronted with a situation which may amount to a deprivation of liberty. Each chapter can be downloaded separately, as can the list of questions for that chapter, so professionals need only have with them those parts of the guidance that are most relevant to the circumstances they are likely to encounter.

In Part III is to be found summaries of key cases (including those which must in light of Cheshire West be read with a health warning) and further information and resources for those needing to keep themselves abreast of

developments. The law is stated as at the end of February 2015.

Given that there remain a significant number of areas in which the law has yet to be clarified by the courts, this guidance serves as much to provoke professionals to seek further specific advice in difficult cases as it does to give answers. It will, inevitably, be superseded in due course by further judgments of the court but will at least provide a starting point to assist professionals to ask the right questions.

ADASS forms and guidance

The ADASS DOLS forms have been slightly revised to take account of the judgment in [AJ](#). Guidance to accompany the forms has also now been produced. Both should be available shortly [here](#); in the interim, and with thanks to Lorraine Currie, the guidance is available [here](#).

Joint Guidance on Deprivation of Liberty in Children's Homes withdrawn

With thanks to James Batey of HMCTS for bringing this to our attention, we understand that the Guidance “*Deprivation of liberty - guidance for providers of children's homes and residential special schools - agreed by the President of the Court of Protection and Ofsted and dated the 12 February 2014*” has been withdrawn with immediate effect. We are informed that “[t]his has been agreed by the President of the Court of Protection and Ofsted in light of developing case law.”

DOLS debate in the House of Lords

The week after the debate on the post-legislative scrutiny report of the House of Lords Select

Committee (discussed in the Capacity outside the Court of Protection Newsletter), a short debate on DOLS debate took place on 16 March at the instigation of Baroness Finlay. The Hansard report is available [here](#), but in summary form, Baroness Finlay was concerned to obtain assistance from the Government as to the scope of the implications of the Cheshire West judgment and say whether it is seen to be appropriate to interpret the implications so widely. She, and other peers, identified the substantial burdens imposed upon local authorities in consequence of the judgment, and also flagged up other questions that have been exercising others since the decision was handed down. Particular interesting was the intervention of Lord Hope, the former deputy President of the Supreme Court, and his observations upon the judgment (and his agreement with Lord Brown, another former Law Lord) that the cases of P, MIG and MEG represent the extreme limits of what English courts would conclude involves a deprivation of liberty.

In his response on behalf of the Government, Earl Howe made clear that:

“the Supreme Court judgment has challenged us to think about how we regard the most vulnerable members of society. The ultimate test is for those of us fortunate to have full capacity to put ourselves in the place of those who do not. If we were prevented from leaving a hospital ward—if we could exercise no choice over our day-to-day activities, over whom we met and when we met them—I wonder how we would feel. I suspect that we would expect at the very least to have a legal route of redress. Those who lack capacity deserve and are entitled to exactly the same. The challenge now is to deliver these rights in a busy and pressurised health and care system upon which demand continues to rise.”

Whilst he noted steps such as the reduction in the number of forms required for DOLS as a result of the work of the ADASS task force, Earl Howe made clear that there will be no immediate legislative “quick fix”:

“The noble and learned Lord, Lord Hope, and my noble friend Lord Howard questioned whether there might be changes to the law that we could make more quickly to help alleviate the pressure on the system pending the Law Commission report. I know that some partners have called for rapid legal changes. One example is increasing the time for which hospitals can authorise a deprivation of liberty—that is, instead of the current seven days, perhaps 14 or 21 days. Another suggestion that I have heard is to change the requirement for local authorities to process applications within 21 days by extending that period. Although I sympathise with local authorities and hospitals because of the pressures they are under, the counterargument that I know many others make is that, with something as important as fundamental human rights, government should not weaken the safeguards. My own belief is that the changes proposed should be considered in the round with the wider changes that the Law Commission is currently considering so that we do not inadvertently cause negative or unhelpful side-effects.”

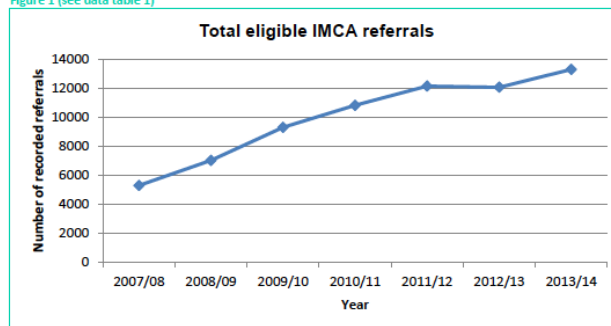
Further:

“The noble Baroness, Lady Finlay, questioned whether there should be a test case—and, if so, who should do it and where the funding should come from. In terms of a test case to take to the Supreme Court, the Government are not yet minded to force this issue.”

The Seventh Year of the Independent Mental Capacity Advocacy (IMCA) Service

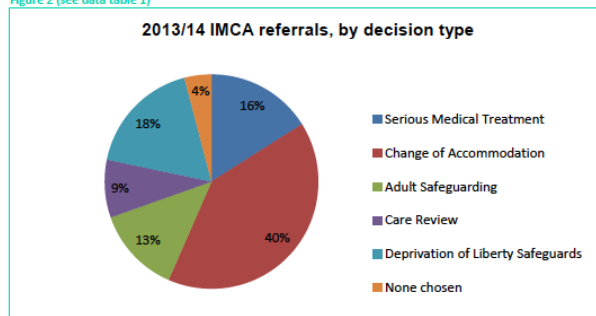
This [report](#) (covering England only), which came out on 26 March, is well worth a read. It covers the reporting period of 1 April 2013 to 31 March 2014 and provides a useful insight into the IMCA service prior to the impact of the *Cheshire West* decision. There are also a number of case studies to assist practitioners. Overall, the data shows a trend in the number of referrals:

Figure 1 (see data table 1)



The two most common conditions, in respect of which a referral was made, were dementia (42%) and learning disability (20%). The proportion of referrals for each type of decision were:

Figure 2 (see data table 1)



The report contains a number of key messages:

- Capacity: It is important that a person’s capacity to make decisions about their

treatment is considered and an IMCA appointed if appropriate;

- Care plans: If a person lacks capacity their lack of objection to existing arrangements should not mean that care plans are not scrutinised. An IMCA should be appointed if appropriate;
- Discharge planning: It is important that accommodation decisions are considered early in hospital stays to avoid delays at discharge;
- Right to appeal: If a person who lacks capacity wishes to appeal against a DoLS authorisation then they should be supported to do so even if the Relevant Person's Representative feels the DoLS is in their best interests [note, this report does not cover the decision in [AJ](#), which makes this point even more strongly];
- Safeguarding: Half of the people who lacked capacity did not have any support from an advocate, family member or friend during the safeguarding referral.

The report makes four recommendations:

- That IMCAs and MCA leads in hospitals work to build links and improve awareness of the MCA and the IMCA service among clinicians;
- Responsible bodies should ensure that they have a documented policy on when safeguarding cases should be referred to an IMCA. They should revisit the criteria within the policy to ensure that those who would benefit from an advocate have the opportunity to do so. In particular,

consideration should be given to cases where there is no appropriate family member or friend to support a person who lacks capacity;

- All local authorities should review their processes and procedures for providing IMCA support to unpaid Relevant Person's Representatives to ensure that the right people are given access to this valuable service;
- All IMCA providers should review the draft guidance on training and development, provided with this report and consider how it could be implemented in their organisation. Commissioners should also consider training standards when reviewing contracts.

Deprivation of liberty – the ECtHR pronounces again

In *Stankov v Bulgaria* (Application No. 25820/07, decision of 17 March 2015), the European Court of Human Rights has given a further important judgment in relation to Bulgarian care homes (thanks, in significant part, to the excellent work of the [Mental Disability Advocacy Centre](#)). Jill Stavert covers the decision – currently available only in French – and its implications in the Scotland section of this Newsletter, but we would emphasise two points of particular importance to those concerned with deprivation of liberty in England and Wales:

1. The court held (at paragraph 87) that Mr Stankov was “*sous un contrôle constant et n’était pas libre de quitter le foyer sans autorisation à tout moment lorsqu’il le souhaitait*” (i.e., in our unofficial translation “*under constant control and was not free to*

leave the care home without permission at any point that he wished.” In so holding, the court was less concerned with examining the circumstances within the care home than it was with the circumscription of Mr Stankov’s ability to come and go from the care home without permission (and the fact that the police would potentially be called if he did so). This undoubtedly suggests – at least in the context of social care placements – an approach that is not concerned with micro-analysis of the regime in the placement but takes a broader-brush (dare one say common sense?) approach to the question of deprivation of liberty;

2. The court also confirmed that in asking whether a person has the capacity to consent (and has properly consented) to their confinement for social care purposes, the same approach is to be taken as in relation to placement for psychiatric treatment purposes: see paragraph 90. In other words, the consent of a person can only be considered valid if (in our unofficial translation) there is *“sufficient and credible proof to suggest that the person’s capacity to consent and to understand the consequences of their consent was established during the course of a fair and appropriate procedure, and that all necessary information concerning the placement and the proposed treatment was provided to the person concerned in an adequate fashion.”*

Whilst this case came too late to be considered in the Law Society guidance, the approach suggested in the guidance in relation to both of these points is consistent with that taken in *Stankov*. We would note, in particular, that the approach taken in relation to capacity to consent is – as is suggested in the guidance – in essence

consistent with that suggested by Baker J in [A PCT v LDV](#) [2013] EWHC 272 (Fam), and that this approach should apply to consideration of whether the capacity requirement under paragraph 14 of Schedule A1 is met, whether in hospital or a care home. This is, we suggest, a more stringent test than may sometimes have been appreciated, and requires, in particular, the communication of and the functional ability to process the core elements of the confinement that will result from admission. Put another way – and very bluntly – a person cannot be said to have consented to their confinement if they have not been told of and do not understand the core features of that confinement.

The (not so?) great confinement

For those of you who want to take a step back and ask whether we are on the right track as regards deprivation of liberty, we would strongly recommend (sparing Neil’s blushes) the article Neil has written in the most recent issue of the *Elder Law Journal* on *Cheshire West* and its impact. A sneak preview is to be found [here](#).

The CICA and the COP

Newcastle City Council v PV and Criminal Injuries Compensation Authority [2015] EWCOP 22
(Senior Judge Lush)

COP jurisdiction and powers – interface with personal injury proceedings

Summary

In this case, Senior Judge Lush had to decide various issues arising out of a large (just over £2.8 million) CICA award decided under the 1990 scheme as a result of an application made in March 1996.

Senior Judge Lush ruled that, as the result of the fact that there is no equivalent to CPR Part 21 in the rules governing applications to the CICA, an application to the CICA by an adult who lacks mental capacity should be made by the holder of a property and affairs EPA or LPA or a deputy or person specifically authorized so to do by the Court of Protection (see paragraph 28).

He ruled, in line with civil claims, that the Court of Protection's approval is not necessary for awards to be accepted on P's behalf, whether as to quantum or conditions (see paragraphs 30 and 32).

He further ruled that where the CICA makes it a condition of an award that there is a trust, then the Court of Protection, where the applicant lacks capacity so to do, should set up the trust and an application must be made to the Court of Protection for an order under section 18(1)(h) of the MCA (see paragraphs 38 – 41, differing here from the position of the Official Solicitor, who had invited him to find that it was the CICA/the

Tribunal to establish the settlement and execute any relevant instruments).

Senior Judge Lush ruled that, although the terms of the trust were in the Court of Protection's discretion, he doubted whether the court could do other than approve the terms stipulated by the CICA or the Tribunal and he could not envisage a situation in which the court would not approve terms which, for policy reasons, were so fundamental as to be non-negotiable (see paragraphs 43 and 44). He ruled that a deputyship might not be necessary where there was a trust, (see paragraphs 45 – 48). He further ruled that the deputy could also be a trustee but that the trust should contain a power for P, and hence the Court of Protection, to remove and replace trustees, (see paragraph 59).

Finally, Senior Judge Lush ruled that a *Peters* (*Peters v East Midland Strategic Health Authority* [2010] QB 48) undertaking was appropriate (see paragraph 67) or, if the deputyship order is discharged, there should be a suitable restriction of the trustees powers, (see paragraph 72).

Comment

Senior Judge Lush's decision is of importance for outlining (for the first time) the respective tasks of the CICA and the Court of Protection in relation to recipients of CICA awards who are unable to manage their property and affairs. His pragmatic approach (e.g. to the question of whether and how applications were to be made in the absence of rules providing for litigation friends before the CICA) is unsurprising.

Senior Judge Lush's approach to the question of *Peters* undertakings is unlikely to be of much future relevance in relation to CICA awards given the current £500,000 cap on CICA awards. It is, however, of interest in relation to personal injury

awards (although Senior Judge Lush has previously expressed some scepticism about the role of the Court of Protection in seeking to ensure that double-recovery does not take place: see his earlier decision in [Re Reeves](#)).

Short Note: Anonymity in judgments

The only other judgment of Senior Judge Lush from March that merits specific mention is that in *Re AW (DB v DW)* [\[2015\] EWCOP 16](#).

In this case Senior Judge Lush was faced with competing claims to be appointed P's deputy. One applicant was P's nephew, the other the brother in law of P's former companion. The Senior Judge referred to paragraph 20(iii) of the practice guidance which says that "*anonymity in the judgment as published should not normally extend beyond protecting the privacy of adults who are the subject of the proceedings and other members of their families, unless there are compelling reasons to do so.*" He then referred to Article 6 of the European Convention on Human Rights which requires that a fair balance should be struck between the opportunities afforded to the parties involved in litigation and *Dombo Beheer BV v Netherlands* (1993) 18 EHRR 2013 where, at paragraph 33, the European Court of Human Rights stated that "*in litigation involving opposing private interests, 'equality of arms' implies that each party must be afforded a reasonable opportunity to present his case - including his evidence - under conditions that do not place him at a substantial disadvantage vis-à-vis his opponent.*" He ruled that in those circumstances, he would direct anonymity for both parties.

Amendment of LPA forms from July 2015

The Lasting Powers of Attorney, Enduring Powers of Attorney and Public Guardian (Amendment) Regulations 2015 (SI 2015/899) come into effect on 1 July 2015, to introduce new prescribed forms for both health and welfare and property and affairs LPAs; to remove the requirement for two certificate providers in cases where the donor does not want anyone to be notified of an application for registration; and to revise the application to register form. They also replace the term "named persons" with the more logical "person [or "people"] "to notify."

The new prescribed forms will have to be used from 1 July, but transitional provision is made to permit the continued use of the existing version of the prescribed forms provided that execution of the form occurs before 1 January 2016.

A useful practical guide to the changes to the forms introduced by the Regulations prepared by Caroline Bielanska can be found [here](#).

All change at the Court of Protection (Part 1)

The [Court of Protection \(Amendment\) Rules 2015](#) were laid before Parliament on 9th March. Unless (which is very unlikely). The first part of the Rules comes into force in part on 6th April and the second, larger, part on 1st July.

They represent the first tranche of rule changes that will bring about the most fundamental reform of the Court's processes since it came into being in 2007, reflecting the experiences of the first seven years of its life.

An unofficial consolidated version of the Rules as they will stand on 1 July 2015 can be found [here](#) and an unofficial consolidated version with commentary by Alex can be found [here](#).

This note serves as an overview.

The most important rule change – and the rule that we think it is proper to say most exercised the brain cells of the members of the ad hoc Rule Committee (including Alex) – is the new Rule 3A, coming into force on 1st July 2015. This rule fundamentally refocuses the approach of the Court of Protection to the participation of P. It requires in each case the Court to consider, either on its own initiative or on the application of any person, consider whether it should make one or more of one of a 'menu' of directions relating to P's participation. That menu includes:

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

3. Specific provision for P to address (directly or indirectly) the judge determining the application; or
4. No direction or an alternative direction (meeting the overriding objective) if P's interests and position can properly be secured.

Equally importantly, assuming that the necessary steps are taken to enable this to happen by way of the creation of a panel of such representatives, Rule 3A provides that a direction may be made appointing an accredited legal representative ('ALR') to represent P. This can be done whether or not P is a party; importantly, if P is a party, then an ALR may be appointed without a litigation friend being appointed to act for P. This innovation, drawn from Rule 11(7) of the Mental Health Tribunal Rules, is designed to supplement, not supplant, the role of litigation friends; the intention (as spelled out in the accompanying Practice Direction, 2A) is that ALRs can provide assistance where urgent orders are required and it is not possible to appoint a litigation friend. They may also play an important role in 'narrow' applications such as applications under s.21A MCA 2005, thereby allowing the resources of litigation friends – whether the OS or otherwise – to be reserved for more complex cases where, for instance, expert evidence will be required.

Other important rule changes include (this summary being drawn in part from the Explanatory Note):

- Amending rule 4 to reinforce the duty of the parties to co-operate so as to further the overriding objective of dealing with cases justly having regard to the principles in the MCA 2005, and making express that a failure

- to cooperate (and to be full and frank in the disclosure of information and evidence to the court) can sound in costs. This is a precursor to what we anticipate will be more detailed consideration to be given in the second tranche of rules to the question of how case management in the COP can be reinforced as to ensure that limited public monies and judicial time are deployed in a way properly calibrated to the nature of the issues at stake (i.e. picking up concerns voiced by Peter Jackson J in [Re A and B \(Costs and Delay\)](#) [2015] EWCOP 48);
- Substituting a new Rule 9, which allows for the COP – in the case of a lacuna – to choose whether rules contained in the CPR or the FPR most appropriately fit the problem to be addressed. There is also provision to enable the version of the CPR or FPR to be applied to be specified – thereby getting round the problem which exists at present in light of the mismatch between the CPR post-Jackson and the COPR as regards costs provisions;
 - Making amendments to Parts 8, 9 and 12 to remove the need for a separate application where permission is required, removing the requirement for permission in certain cases (most obviously *Re X* type applications where authority is sought by way of an order under s.16(2)(a) MCA 2005 to deprive a person of their liberty), and making it easier for the requirement for permission to be removed in other cases;
 - Introducing a requirement (in Rule 87A) that permission is required to withdraw proceedings (mirroring the provision in FPR r.29.4(2));
 - In Part 12 (dealing with applications), making amendments in relation to allocation of types of cases to levels of judge, reflecting the introduction of Tier 1, Tier 2 and Tier 3 categories of judge following widening of the pool of judges who may be judges of the Court of Protection by virtue of changes made by the Crime and Courts Act 2013;
 - In Part 13 (hearings), making amendments to allow communication of information about proceedings to third parties for specified purposes (for example, research), and for the court to be able to do this on its own initiative. There is also an important amendment to Rule 95 clarifying that the court can admit, accept and act upon such information, whether oral or written, from P, any protected party or any person who lacks competence to give evidence, as the court considers sufficient, although not given on oath and whether or not it would be admissible in a court of law apart from this rule. This amendment picks up – belatedly – the decision of McFarlane J (as he then was) in *Enfield LBC v SA* [\[2010\] EWHC 196 \(Admin\)](#) and the ‘work around’ he gave there as to the admissibility of evidence from P;
 - Replacing Part 17, with details of how litigation friends and ‘Rule 3A’ representatives are to be appointed and how their appointment is to be brought to an end. It should be noted here that the new rule 144 ends the anomaly in the rules that existed previously that required P, in essence, to prove that they had litigation capacity: all P has to do now is to make an application;
 - in Part 19 (costs), making amendments to ensure that where provisions of the Civil Procedure Rules are incorporated by

reference, they do not include the Jackson reforms insofar as they relate (e.g.) to costs budgeting;

- in Part 20 (appeals), which will come into force on 6th April, making provision for appeals within the Court of Protection between the different tiers of judge, and revised provision about appeals to the Court of Appeal; and
- in Part 21 (enforcement), making amendments to ensure that where provisions of the Civil Procedure Rules are incorporated by reference, they are the provisions following recent amendment.

New forms are in train to pick up these changes, and we will provide updates as and when we can.

The ad hoc Committee very deliberately did not seek in this tranche to tackle some of the other thorny questions that face the Court, for instance relating to transparency, expert evidence and the extent to which a regime akin to the Public Law Outline should be imported. This first tranche, however, will start the Court of Protection on a new trajectory that is orientated more clearly around P.

What to tell the press

A Healthcare Trust v P [2015] EWCOP 15 (Newton J)

Media – Court reporting

Summary

This judgment addresses the question of what information can be provided to the press in a public medical treatment case in which an application for a reporting restrictions order

(RRO) is sought but has not yet been granted. The RRO application had been made by the applicant Trust but information identifying P had not been included because of objection by P's family. The Trust, the Official Solicitor and the Press Association agreed that identifying information should have been included and that the press would not therefore have been able lawfully to report P's name prior to the RRO application being determined. P's family argued that there was a lacuna in the relevant Rules and Practice Direction which meant that P could be identified by virtue of notification of the RRO being given to the press.

The court held that information identifying P should be provided to the press when applying for an RRO and that this did not lead to any real risk that P might wrongly be identified to the public before that application was determined. The Press Association informed the court that there was a contract in place with subscribers to the service alerting the national news media to applications (the Injunctions Alert Service) such that disclosure of otherwise confidential information was permitted only on the basis that it would not be published. The system was *"intended to provide a convenient and safe vehicle for potential applicants to notify the media of their applications, serve the relevant documentation and enable the subscribing members to make a properly informed decision about whether they wished to challenge any particular application."*

Under PD13A, there is no obligation to serve a draft order when notifying the press, and P's family relied on this as indicating that P's identity should not be disclosed to the press. The court held that it was nevertheless *'incumbent on the applicant to indicate clearly in the application and in the submissions the burden of the order being*

sought. Notice of course should indicate the categories of persons (if there are many, as for example with health professionals) whose identity would be kept confidential under the proposed order, if the applicant wishes to apply for an order restraining the media from communicating with those persons.’ The court further held that P’s identity should be given to the press. First, the wording of the Rules and Practice Direction suggested that withholding information would be exceptional and would not occur without a decision of the court. Secondly, the court (and the family) could trust the media and could be satisfied that the contractual arrangements in place were adequate to prevent erroneous publication. Thirdly, even if there were a rogue journalist or news organisation, making known P’s identity would be likely to amount to either statutory or common law contempt of court. Fourthly, media organisations in receipt of an RRO application and details of P’s identity would be under an equitable duty to keep treat the information as confidential.

Comment

This judgment clarifies a matter that can be of concern to families and healthcare providers in medical treatment cases, which are routinely held in public, and where applications for RROs are almost always made. The judgment casts some light on, but does not determine, what the position is as regards statutory and common law contempt of court in private Court of Protection cases where notification of the fact of proceedings and P’s identity is given to a third party, for example a journalist or an MP, or is posted online. The judgment should also be read alongside the provisions in the new iteration of Rule 91 and the accompanying PD (yet to be published, but which will be out by 1 July) as to communication of information about

proceedings. The issue of media access is also likely to be considered further by the ad hoc Rules Committee when it reconvenes to undertake tranche 2 of its work.

Practice Direction on Contempt of Court

The Lord Chief Justice issued on 26 March a [Practice Direction](#) on Contempt of Court which applies to all proceedings for committal for contempt of court, including contempt in the face of the court, including those before the Court of Protection. The Practice Direction emphasises the importance of open justice, and sets down the steps required to ensure that proceedings take place in public, save where exceptional circumstances dictate to the contrary, and that, in all cases, the outcome is made known in a public judgment. The Practice Direction is said to supplement Practice Directions made to accompany (inter alia) the COPR (i.e. PD21A). We suggest that it also supersedes the Practice Guidance issued by the President of the Court of Protection in 2013 available [here](#) (with a supplement [here](#)).²

² We also note that the Court of Appeal has noted that care must be taken to delineate between Practice Directions and Practice Guidance issued by the President. In *Re R (A Child)* (a decision of 24 March 2015 as yet only available in summary form on Lawtel), the Court of Appeal (considering Practice Guidance issued by the President as to transparency in the Family court), noted that it was “*dangerous for the Court of Appeal to be invited to afford that guidance greater technical status than it had.*”

Vulnerable witnesses and children working group

A working group under Hayden and Russell JJ has now [reported](#) with a number of detailed recommendations as to how the Family Division and Family Court can better address the needs of both vulnerable witnesses and children. The report makes extremely interesting reading, and we strongly suggest that many of the recommendations are ones that are likely also to be of equal – if not greater – relevance to the Court of Protection. Pending further Court of Protection-specific guidance/Rules, can we plug again the excellent [Advocates Gateway](#) and the toolkits therein, which provide detailed and practical assistance for those who need to question witnesses with a range of difficulties and/or specific requirements as regards communication.

Short Note: the presumption of litigation capacity at work

In *Waghorn v Plymouth City Council* (unreported, Lawtel 4 March 2015), Cobb J emphasised the importance of the presumption of capacity to litigate in civil proceedings. Striking out an appeal purportedly brought by a son as litigation friend for his mother against the decision of a valuation tribunal, Cobb J noted that there had to be evidence that an individual lacked capacity and that the process had to be carefully considered (applying [Folks v Faizey](#)). Perhaps unsurprisingly, he was unimpressed by a medical report that was over ten years old (and a certificate of suitability that was more than three years old), especially where there was evidence that the mother had recently executed a lasting power of attorney.

It is perhaps worth noting in this context that the rather different position in the Court of Protection – that P requires a litigation friend unless the court orders otherwise – is to be made more nuanced as of July, when the amendments to Part 17 (discussed above) mean that P no longer has to adduce evidence to prove either that they have regained or have always had capacity to conduct the proceedings. The scales are therefore perhaps to be rather less tilted against P as regards the operation of the statutory presumption of capacity than they have been to date.

Short Note: Capacity to litigate vs competence to give evidence

In the civil case of *Milroy v BT* [\[2015\] EWHC 532 \(QB\)](#), William Davis J has emphasised the difference between the capacity to conduct proceedings and competence to give evidence.

There was evidence in personal injury proceedings from a clinical psychologist and consultant neuropsychiatrist that William Davis J held was clearly sufficient to justify the appointment of the claimant's wife as his litigation friend. Counsel for BT argued that the same evidence demonstrated that the claimant was not capable when he made his witness statement of understanding the questions which must have been put to him for the statement to be taken and/or of giving a rational account of himself. William Davis J disagreed, holding that:

“8. [...] Mr Milroy undoubtedly would have considerable difficulty in dealing with the process of giving evidence in court and unassisted the evidence he gave in that context would be highly problematic. If these were criminal proceedings and he was required to give evidence, he would be the

kind of witness for whom an intermediary to assist him would be essential. However, there is nothing in the evidence of Lorna Morris and/or Dr Bodani to indicate that Mr Milroy is or was incompetent to give an account of working practices at BT, of the training he received and insofar as he could recall them of the circumstances in which he came to be injured. He required the right circumstances and time to reflect on what he was saying. I am entitled to infer and I do infer that his solicitors approached the taking of his witness statement with the content of Lorna Morris's report very much in mind.

9. His mild reduction in memory functioning is a matter to which regard must be had when assessing the reliability of Mr Milroy's evidence. In his closing submissions Mr Daniels submitted that the evidence of Mr Milroy 'must be approached with considerable caution' because of the issues surrounding capacity. That is putting it too high. I shall not ignore the medical evidence when assessing the evidence of Mr Milroy. Equally it does not provide a basis for significant caveats to be placed upon that evidence.

William Davis also found that Mr Milroy was not in a position to give oral evidence was (a) not an issue going to admissibility; and (b) (on the facts of the case) was of limited effect as regards the weight that was to be placed upon his evidence.

This case serves as a useful reminder of a distinction that is all too easily overlooked in the Court of Protection, where the assumption is that P, because they lack capacity to conduct the proceedings, will also lack competence to give evidence. Whilst the Court of Protection is entirely able to admit, accept and act upon information from P even if they lack competence

to give evidence³ we suggest that Articles 6 and 8 of the ECHR (let alone the operation of the Equality Act 2010 and Articles 12 and 13 of the CRPD) compel a more careful consideration of whether or not P is not, in fact, able to give evidence as to the factual matters before the court – including, crucially, their own capacity to make the decisions in question.

Funding under duress

(1) *MG and (2) JG v (1) JF and (2) JFG* [2015] EWHC 564 (Fam) (Family Division (Mostyn J))

COP jurisdiction and powers – interface with personal injury proceedings

Summary

This case concerned an application for a costs allowance under Schedule 1 to the Children Act 1989 to fund representation and experts' fees in a private children dispute. MG and JG, a same-sex couple, decided in 2005 that they wanted a child. In 2006, MG was impregnated artificially with JF's sperm. The child, JFG, was born in 2007. It was agreed that JF would be named on the birth certificate and that JG would be a "legal step-parent" with the idea that all three (MG, JG and JF) would have equal legal parenting rights. In October 2012, serious difficulties arose in relation to the contact of JF to JFG. Conflict erupted on many fronts and contact completely broke down. MG and JG later separated. JF issued an application for a contact order and the case was due to be set down for a five day final hearing.

³ See in this regard the express provision to be made in the new iteration of Rule 95, which picks up the decision of McFarlane J (as he then was) in *Enfield LBC v SA* [2010] EWHC 196 (Admin) and the 'work around' he gave there as to the admissibility of evidence from P.

Mostyn J was clearly of the view that it was impossible to expect MG and JG to be able to represent themselves having regard to the factual and legal issues in the case. However, the Legal Aid, Sentencing and Punishment of Offenders Act 2012 (“LASPO”) had removed legal aid from private law children proceedings save in those exceptional cases where domestic violence is a central feature. Thus, MG and JG were no longer eligible for legal aid funding. JF was of reasonable means and privately paying for legal representation. JFG, aged 7, was represented in the proceedings by a guardian and funded by legal aid.

Although MG and JG were not entitled to an order for costs, they were entitled by operation of the provisions of Schedule 1 to the Children Act 1989 to seek an order for costs funding from JF. Mostyn J ordered that JF should pay 80% of each of the claims of MG and JG for legal representation and that in future JF should pay 80% of all professional costs in respect of therapeutic work. MG and JG would each pay 10% of such costs. Whereas MG and JG could not reasonably or realistically be expected to contribute more given their means, Mostyn J was satisfied that JF could bear the costs without undue hardship.

In respect of the expert evidence, Mostyn J ordered that the fees should be paid for in their entirety by JFG and that such fees were a reasonable charge on the legal aid certificate. Although the normal rule is that the cost is to be apportioned equally, MG and JG did not have the means to contribute and JF was already shouldering a great burden of the costs. Therefore, it was just and reasonable that JFG bear the costs of the expert evidence, whether or not he was legally aided, because these fees were being incurred primarily for his benefit.

Comment

Mostyn J recognised that ordering JF to pay over £20,000 plus 80% of the cost of future therapeutic work could be said to be “*grossly unfair*”. However, it was deemed to be necessary because “*that is where the government has left him.*” Mostyn J endorsed previous judicial criticisms of the Government’s legal aid cuts and described it as “*a sorry state of affairs.*”

It is easy to imagine similar concerns arising in COP cases. Mostyn J’s remarks are reminiscent of Baker J in the COP case of *A Local Authority v M, E and A* [2014] EWCOP 33 to the effect that “*[o]ne lesson of this case is that, if parties such as E and A are to be unrepresented in hearings of this kind, be it in the Court of Protection or in the Family Court, the hearings will often take very considerably longer than if they were represented. Denying legal aid in such cases, is thus, a false economy.*”

The position in relation to COP cases is even more parlous, however, because there is no equivalent in the COPR to Schedule 1 to the Children Act, and the COP therefore does not have the power to direct that a party to the proceedings pay all or part of the costs of any of the other parties to secure representation. Ps may be in a special position: it is, for instance, absolutely clear that the Official Solicitor cannot be compelled to act as litigation friend unless he is put in funds to instruct solicitors (and continues to be put in such funds: *Bradbury v Paterson* [2014] EWHC 3992 (QB)), and the position in medical treatment cases is that the OS will not act unless the NHS Trust making the application agrees to pay half of his costs, although this simply reflects custom and practice: see *An NHS Trust v D* [2012] EWHC 886 (COP)). Family members and others who may be parties to proceedings, however, enjoy no such privileged position; we will wait with interest to

see how the Court of Protection will proceed in a case where it is clear that the lack of representation of such a party due to non-availability of legal aid will give rise to a real risk of a breach of their rights under Articles 6 and/or 8 ECHR.

As regards expert evidence, in the Court of Protection, like the Family Court, the normal rule for funding expert evidence is that costs are shared equally between the instructing parties: see COP Rule 131(5). However, where some parties are family members acting in person, it is conceivable that the COP may order expert evidence to be funded by one party, either a party with means or P where P is being publicly funded. For more detail in this regard, interested readers are referred to *JG v The Lord Chancellor & Ors* [2014] EWCA Civ 656 and the discussion at paragraphs 6.92-6.103 and 13.68-13.73 of the LAG [Court of Protection Handbook](#).

Justice in trouble – the Justice Select Committee reports upon LASPO

In a highly critical [report](#), published on 12 March 2015, the House of Commons Justice Committee considers the impact of the reforms to civil legal aid introduced by Part 1 of LASPO, which came into force on 1 April 2013. The reforms were introduced as part of the Government's programme of spending cuts to achieve significant savings to the legal aid budget.

The Ministry of Justice (MOJ)'s four stated objectives for the reforms were to:

- discourage unnecessary and adversarial litigation at public expense;
- target legal aid to those who need it most;

- make significant savings in the costs of the scheme; and
- deliver better overall value for money to the taxpayer.

The report concludes that the MOJ has only succeeded in one of its four stated objectives - making significant savings in the costs of the scheme - and that the 'faulty implementation' of the legal aid changes has harmed access to justice for some litigants. The report concedes that 'at best' the changes appear to have had effect in discouraging unnecessary and adversarial litigation at public expense [182].

The report proceeds over 183 paragraphs and 54 conclusions and recommendations to criticize the Government for its failure "*in its haste to implement the changes*" to carry out adequate research into the legal aid system before introducing the reforms [11]

The Committee cautions that the underspend in the civil legal aid budget should have rung alarm bells in the MOJ and blames the MOJ for not ensuring that those eligible for legal aid are able to access it. It highlights the lack of public information about the extent and availability of legal aid, including information about the Civil Legal Advice telephone gateway for debt advice. It recommends the MOJ undertakes a public campaign to combat the impression that legal aid is almost non-existent and to provide information on accessing the gateway for advice. It also recommends that the MOJ and the Legal Aid Agency improve their communication with the providers on eligibility for and scope of legal aid criteria.

The report is particularly critical of the 'wholly inadequate' implementation of the exceptional cases scheme. It concludes that the exceptional

cases funding scheme has not done the job Parliament intended, namely protecting access to justice for the most vulnerable people in our society [45].

“The number of exceptional cases funding applications granted has been far below the Ministry of Justice’s estimate. We have heard details of cases where the refusal of exceptional cases funding to vulnerable litigants is surprising on the facts before us. We conclude therefore that the low number of grants together with details of cases refused exceptional cases funding means that the scheme is not acting as a safety net.” [33]

Putting this in context, the latest figures from the Legal Aid Agency show that only 151 of the 2,090 applications for exceptional cases funding made between April 2013 and September 2014 were granted. [37]

Criticism is made first of the poor quality of decision-making in exceptional funding cases and secondly of the formal Guidance for failing to give sufficient weight to access to justice in the decision making process. It notes that the legality of the Lord Chancellor’s Guidance has been successfully challenged in courts (*R (Gudanaviciene) v The Lord Chancellor* [2014] EWCA Civ 1622). The report recommends that immediate steps be taken by all agencies involved to ensure the exceptional cases funding scheme is properly managed and provides the robust safety net envisaged by Parliament.

The report highlights the rise in the number of litigants in person due to the unavailability of Legal Aid and the knock on effect on the courts’ resources and proceedings. The National Audit Office found in its report that the increases in litigants in person had led to an estimated £3.4 million additional costs for the MOJ in the family

courts alone. There were no figures available for the effect on the civil courts. The report welcomes the steps taken by the MOJ to increase funding and support to assist litigants in person, but doubts whether these steps will be sufficient to reduce the pressure on the courts. The report recommends the development of a one-stop legal helpline able to divert inquirers to other services, or to assist with their enquiries [121]

The report also expresses concern about the failure by the Legal Aid Agency to differentiate cases involving adults lacking capacity, who require the assistance of a litigation friend, from other cases. The report notes that such cases by their very nature, concern some of the most vulnerable people in our society, whose impaired understanding means they are barred by the law from conducting litigation without assistance [110]. The Official Solicitor, as litigation friend of last resort will generally only consent to act as litigation friend if he is satisfied that his costs of so doing will be met. He cannot be compelled to act without proper funding for the costs of instructing legal representatives, or in cases in which he acts as ‘in-house’ solicitor, for those legal costs. Where a funding source is no longer in place the Official Solicitor or any other litigation friend is entitled to seek to withdraw from the proceedings (as recently confirmed in *Bradbury & Ors v Paterson & Ors* [2014] EWHC 3992 (QB)). This means in effect that the litigation cannot progress unless and until a way is found to represent the incapacitated person’s interests in the proceedings.

The Report recommends at paragraph 110 that

“The Legal Aid agency adopt a policy that ensures the Official Solicitor is able to properly represent people without litigation capacity given the consequences for access to justice

for highly vulnerable individuals if he cannot do so.

Beverley Taylor

However, the Report does not then go on to suggest the sort of policy the Legal Aid Agency should consider or how such a policy would apply to any other litigation friends.

The Committee reports 'deep concern' that the Governments failed to carry out research into the sufficiency and sustainability of the legal aid market which may have led to the existence of a substantial number of 'advice deserts' [88]. It urges the Ministry to carry out immediate research into the geographical distribution of legal aid providers to ensure sufficient provision to protect access to justice.

The report also raises a number of serious concerns about the operation of the changes on the number of mediations, the representation of separated and trafficked children and of cases involving domestic violence. It recommends that the MOJ review the impact on children's rights of the legal aid changes and considers how to ensure that children are able to access legal assistance [62]. The Committee also recommends that the Legal Aid Agency be given discretion to grant legal aid in appropriate cases involving domestic violence and that that the Government should fund all Mediation Information and Assessment Meetings for a year [158].

Finally the report acknowledges that there is no realistic early prospect of substantially increased funding for legal aid in the civil courts. In the Committee's view this makes it all the more important that the recommendations contained in the report and highlighted above are implemented. In the longer term, it recommends that proper research in the costs and effects of the scheme should inform a more fundamental review of the policy [183].

The Care Act and capacity: Editorial

As our local authority readers will be all too aware, the majority of Part 1 of the Care Act 2014 came into effect on 1 April. The purpose of this Editorial note is identify a number of that our experiences training and advising upon the Act in the period leading up to its implementation have highlighted to us.

Capacity to participate in an individual's pathway through assessment and care planning has – rightly – been emphasised in the Act and, in particular, the Guidance. Further, the introduction of duties relating to the provision of advocacy to support the unbefriended individual in that process where they would have substantial difficulties is to be welcomed (although with the obvious caveat that it is far from clear where these advocates are to be found).

However, there remains a fundamental confusion amongst many between:

1. Public law decisions as to how assessed care needs are to be met, which are, ultimately 'capacity-blind'; and
2. Choices that have to be made between care options that are actually available where the individual in question is not able to make those choices, and a decision must be made on their behalf and in their best interests.

This confusion continues to bedevil too many decisions – an obvious example being planning at the point of discharge from hospital where we have (with respect) seen one too many 'best interests meetings' that are no such thing.

We very much hope that the decision of the Court of Appeal in the appeal against the judgment of Eleanor King J in [ACCG v MN](#) [2013] EWHC 3859 (COP) will provide an opportunity to set this abiding confusion to rest.

A further area where capacity and the Care Act do not necessarily co-exist in happy union is in relation to safeguarding and the duties imposed thereunder. We do not revisit here what Alex at least considers the deeply misguided failure of the Government to include a power of entry to accompany the s.42 duty (a power which is in place in Scotland and will be in place in Wales), but rather would want to emphasise the following points⁴ that seem to us absolutely vital if local authorities are to avoid the 'car-crashes' of cases such as [Somerset v MK](#) [2014] EWCOP B25; [Milton Keynes Council v RR](#) [2014] EWCOP B19 and [2014] EWCOP 34 and [Essex CC v RF](#) [2015] EWCOP 1 where safeguarding concerns raised in relation to those who may lack capacity to take material decisions:

1. There will be some circumstances in which a local authority can only discharge its obligations to a person at risk of abuse or neglect in its area by way of an application to the Court of Protection for what will amount, in essence, to an "adult care order";
2. Where such an "adult care order" is required, the local authority must – save in the case of the utmost urgency – make sure that it comes to court armed with the evidence to allow the court to make any relevant findings of fact necessary to justify the substantial interferences with the rights of the individual

⁴ Drawn in part from an article co-written by Alex and Kelly Stricklin-Coutinho that will be published in a future edition of the *Journal of Adult Protection*.

(and, in some cases, that of their family) under Articles 8 and – potentially – 5 ECHR that will almost inevitably arise in consequence;

3. Even if there is no equivalent to the s.31 Children Act 1989 threshold in the Court of Protection, it is (at a minimum) good practice for local authorities to proceed as if there were in the collation of their evidence and the preparation of their case. In other words, adopting the rigour that is (or should be) adopted in relation to cases involving children will go some substantial way to ensuring that adult protection cases are formulated and prepared in the correct fashion.

We note in this regard that, as of July and the coming into force of the new Rule 87A proceedings once issued can only be withdrawn with the permission of the Court. This Rule will serve, in part, to identify the clear division of responsibilities between the public authority applicant and the Court of Protection in cases where the public authority can only discharge its obligations to the individual in question with the assistance of the Court (see, by analogy, the discussion of the respective roles of the local authority and the Family Court in relation to proceedings in relation to children in *Re W (Care Proceedings: Function of Ct and LA)* [\[2013\] EWCA Civ 1227](#) [2014] 2 FLR 431.

The emphasis upon empowerment as the first principle of safeguarding in the Statutory Guidance may serve, we hope, further to embed the message of cases such as *Re M (Best Interests: Deprivation of Liberty)* [\[2013\] EWHC 3456 \(COP\)](#) that mere fact of incapacity should not automatically mean that safety becomes the dominant concern. That is fundamentally to subvert (or should that be pervert?) both the

MCA 2005 and the principles underpinning safeguarding. We hope that those on Safeguarding Adults Boards will be astute in their strategic oversight role to press home this message to their partners.

Chair for the National Mental Capacity Forum

A recruitment campaign is now underway to find a new Chair for the National Mental Capacity Forum (NMCF).

The Chair will provide leadership for the NMCF and represent the views of the varied Mental Capacity Act (MCA) stakeholders. He or she will provide direction so that members of the Forum work together to drive significant improvements in awareness among other key stakeholders and the general public. The successful candidate will be expected to commit up to 10 days each year to attend meetings which will be held in London and will be expected to read and consider papers outside meetings. More details can be found [here](#).

The deadline for applications is Tuesday 14 April 2015.

[Editorial Note: the creation of the forum is a response to the House of Lords Select Committee recommendation that a body be created to champion the MCA; as will be seen from the report of the debate in the House of Lords upon the Select Committee's report that follows immediately below, it is clear that Lord Hardie, the chair, does not regard it as an entirely satisfactory response].

The Select Committee report – one year on

Lord Hardie, the Chair of the (now dissolved) House of Lords Select Committee that [reported](#) on the MCA 2005 in March 2014, led a [debate](#) in the House of Lords on 10 March on the Report and its consequences. As with the debate on DOLS on 16 March (covered in our Health, Welfare and Deprivation of Liberty Newsletter), the contributions of the peers was of universally high quality (and not just because they name-checked 39 Essex Chambers!). We do not attempt to summarise the debate here, but would urge those who wish to understand why the MCA matters, and why implementation remains so difficult, to read it for themselves. We note, though, that Lord Hardie (rightly, in our view) emphasised that it was a “grave disappointment” that the Government did not accept the Committee’s key recommendation that responsibility for oversight of the MCA’s implementation be given to a single independent body. As Lord Hardie noted:

“The reasons for rejecting our recommendation seem to be related in part to the breadth of sectors covered by the Act and the associated difficulty of the task in designing a single body, coupled with a fear that such a body would result in people involved in the Act failing to accept personal responsibility for its implementation. I note that in their response the Government do not suggest that the task is impossible. Many tasks are difficult but well worth the effort if they achieve a successful outcome. In this case a successful outcome would be the restoration to many thousands of vulnerable people rights conferred on them 10 years ago, but denied to them because of failures of professionals in different sectors to implement this Act.”

Lord Hardie was underwhelmed by the creation of the Forum (as welcome as it was a first step) because “*it is not a solution to the widespread problems, across all sectors, of failure to implement the Act, and to give vulnerable people the voice and empowerment that Parliament conferred upon them in 2005. In short, it will not bring about the quiet revolution in public attitudes and practice promised 10 years ago. That will only be realised if the Select Committee’s recommendation is implemented in full.*”

We cover the position in relation to deprivation of liberty in the coverage of the DOLS debate.

The patient as agent: the Supreme Court and informed consent

Montgomery v Lanarkshire Health Board [\[2015\] UKSC 11](#) (Supreme Court (Lord Neuberger, President, Lady Hale, Deputy President, Lord Kerr, Lord Clarke, Lord Wilson, Lord Reed, Lord Hodge))

Other proceedings – civil – mental capacity – medical treatment

Summary

This Supreme Court judgment is required reading for all medical professionals, because the Supreme Court has made clear that the doctrine of informed consent is now part of English (and Scottish) law.

The issue arose in the context of whether a doctor was negligent in not informing a pregnant diabetic woman that there was a 9-10% risk of shoulder dystocia during vaginal delivery (the baby’s shoulders being too wide to pass through the mother’s pelvis). The doctor’s policy was not routinely to advise diabetic women about shoulder dystocia as, in her view, the risk of a

grave problem for the baby was very small, but if advised of the risks of shoulder dystocia women would opt for a caesarean section, which was not in the maternal interest.

In the Court of Session (this being a Scottish case), the woman's claim for damages on behalf of her son for the injuries he suffered as a result of shoulder dystocia during his birth was rejected, on the grounds that the doctor was not negligent, and on the basis that any negligence did not cause the injuries as the woman would have not elected to have a caesarean section even had she been told of the risks. In relation to the question of whether the doctor had been negligent, the Court of Session had applied the decision of the House of Lords in *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871, holding that whether a doctor's omission to warn a patient of risks of treatment was a breach of her duty of care was normally to be determined by the application of the "Bolam test" (*Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 i.e., whether the omission was accepted as proper by a responsible body of medical opinion, which could not be rejected as irrational. Expert evidence was before the Court of Session advanced on behalf of the Health Board was to the effect that the doctor's policy was proper.

The decision of the Court of Session was upheld by the Inner House. Mrs Montgomery appealed to the Supreme Court.

Lords Kerr and Reed gave the lead judgment (Lords Neuberger, Clarke, Wilson and Hodge agreeing with them), and undertook a comprehensive review of the jurisprudence both in England and elsewhere. Their conclusions were that *Sidaway* reflected a paradigm of the doctor-patient relationship that had ceased to

reflect the reality and complexity of the way in which healthcare services are provided, or the way in which the providers and recipients of such services view their relationship:

"75. [...] One development which is particularly significant in the present context is that patients are now widely regarded as persons holding rights, rather than as the passive recipients of the care of the medical profession. They are also widely treated as consumers exercising choices: a viewpoint which has underpinned some of the developments in the provision of healthcare services. In addition, a wider range of healthcare professionals now provide treatment and advice of one kind or another to members of the public, either as individuals, or as members of a team drawn from different professional backgrounds (with the consequence that, although this judgment is concerned particularly with doctors, it is also relevant, mutatis mutandis, to other healthcare providers). The treatment which they can offer is now understood to depend not only upon their clinical judgment, but upon bureaucratic decisions as to such matters as resource allocation, cost-containment and hospital administration: decisions which are taken by non-medical professionals. Such decisions are generally understood within a framework of institutional rather than personal responsibilities, and are in principle susceptible to challenge under public law rather than, or in addition to, the law of delict or tort.

76. Other changes in society, and in the provision of healthcare services, should also be borne in mind. One which is particularly relevant in the present context is that it has become far easier, and far more common, for members of the public to obtain information about symptoms, investigations, treatment options, risks and side-effects via such media as the internet (where, although the

information available is of variable quality, reliable sources of information can readily be found), patient support groups, and leaflets issued by healthcare institutions. The labelling of pharmaceutical products and the provision of information sheets is a further example, which is of particular significance because it is required by laws premised on the ability of the citizen to comprehend the information provided. It would therefore be a mistake to view patients as uninformed, incapable of understanding medical matters, or wholly dependent upon a flow of information from doctors. The idea that patients were medically uninformed and incapable of understanding medical matters was always a questionable generalisation, as Lord Diplock implicitly acknowledged by making an exception for highly educated men of experience. To make it the default assumption on which the law is to be based is now manifestly untenable.”

The judicial tour d’horizon continued with a review of the developments brought about under the stimulus of the HRA 1998 and the Oviedo Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine. As they noted:

“82. In the law of negligence, this approach entails a duty on the part of doctors to take reasonable care to ensure that a patient is aware of material risks of injury that are inherent in treatment. This can be understood, within the traditional framework of negligence, as a duty of care to avoid exposing a person to a risk of injury which she would otherwise have avoided, but it is also the counterpart of the patient’s entitlement to decide whether or not to incur that risk. The existence of that entitlement, and the fact that its exercise does not depend exclusively on medical considerations, are important. They

point to a fundamental distinction between, on the one hand, the doctor’s role when considering possible investigatory or treatment options and, on the other, her role in discussing with the patient any recommended treatment and possible alternatives, and the risks of injury which may be involved.

83. The former role is an exercise of professional skill and judgment: what risks of injury are involved in an operation, for example, is a matter falling within the expertise of members of the medical profession. But it is a non sequitur to conclude that the question whether a risk of injury, or the availability of an alternative form of treatment, ought to be discussed with the patient is also a matter of purely professional judgment. The doctor’s advisory role cannot be regarded as solely an exercise of medical skill without leaving out of account the patient’s entitlement to decide on the risks to her health which she is willing to run (a decision which may be influenced by non-medical considerations). Responsibility for determining the nature and extent of a person’s rights rests with the courts, not with the medical professions.

84. Furthermore, because the extent to which a doctor may be inclined to discuss risks with a patient is not determined by medical learning or experience, the application of the Bolam test to this question is liable to result in the sanctioning of differences in practice which are attributable not to divergent schools of thought in medical science, but merely to divergent attitudes among doctors as to the degree of respect owed to their patients.”

Lords Reed and Kerr therefore held that the decision in *Sidaway* was unsatisfactory (and acknowledged that the courts in England and Wales had in reality departed from it). They

held that the correct position in relation to the risks of injury involved in treatment is that:

“87. [...] An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient’s position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.

88. The doctor is however entitled to withhold from the patient information as to a risk if he reasonably considers that its disclosure would be seriously detrimental to the patient’s health. The doctor is also excused from conferring with the patient in circumstances of necessity, as for example where the patient requires treatment urgently but is unconscious or otherwise unable to make a decision. It is unnecessary for the purposes of this case to consider in detail the scope of those exceptions.”

At paragraphs 89-91, their Lordships noted that three further points arose in consequence:

1. The assessment of whether a risk is material cannot be reduced to percentages. The significance of a given risk is likely to reflect a variety of factors besides its magnitude: for example, the nature of the risk, the effect which its occurrence would have upon the life of the patient, the importance to the patient of the benefits sought to be achieved by the

treatment, the alternatives available, and the risks involved in those alternatives. The assessment is therefore fact-sensitive, and sensitive also to the characteristics of the patient.

2. The doctor’s advisory role involves dialogue, the aim of which is to ensure that the patient understands the seriousness of her condition, and the anticipated benefits and risks of the proposed treatment and any reasonable alternatives, so that she is then in a position to make an informed decision. This role will only be performed effectively if the information provided is comprehensible. The doctor’s duty is not therefore fulfilled by bombarding the patient with technical information which she cannot reasonably be expected to grasp, let alone by routinely demanding her signature on a consent form.
3. It is important that the therapeutic exception should not be abused. It is a limited exception to the general principle that the patient should make the decision whether to undergo a proposed course of treatment: it is not intended to subvert that principle by enabling the doctor to prevent the patient from making an informed choice where she is liable to make a choice which the doctor considers to be contrary to her best interests.

Lords Kerr and Reed noted that there would be arguments against the approach that they set out: (1) that some patients would rather trust their doctors than be informed of all the ways in which their treatment might go wrong; (2) that it is impossible to discuss the risks associated with a medical procedure within the time typically available for a healthcare consultation; (3) that the requirements imposed are liable to result in defensive practices and an increase in litigation;

and (4) that the outcome of such litigation may be less predictable. However, they rejected these arguments:

*“85. The first of these points has been addressed in para 85 above. In relation to the second, the guidance issued by the General Medical Council has long required a broadly similar approach. It is nevertheless necessary to impose legal obligations, so that even those doctors who have less skill or inclination for communication, or who are more hurried, are obliged to pause and engage in the discussion which the law requires. This may not be welcomed by some healthcare providers; but the reasoning of the House of Lords in *Donoghue v Stevenson* [1932] AC 562 was no doubt received in a similar way by the manufacturers of bottled drinks. The approach which we have described has long been operated in other jurisdictions, where healthcare practice presumably adjusted to its requirements. In relation to the third point, in so far as the law contributes to the incidence of litigation, an approach which results in patients being aware that the outcome of treatment is uncertain and potentially dangerous, and in their taking responsibility for the ultimate choice to undergo that treatment, may be less likely to encourage recriminations and litigation, in the event of an adverse outcome, than an approach which requires patients to rely on their doctors to determine whether a risk inherent in a particular form of treatment should be incurred. In relation to the fourth point, we would accept that a departure from the Bolam test will reduce the predictability of the outcome of litigation, given the difficulty of overcoming that test in contested proceedings. It appears to us however that a degree of unpredictability can be tolerated as the consequence of protecting patients from exposure to risks of injury which they would otherwise have chosen to avoid. The more fundamental response to such points,*

however, is that respect for the dignity of patients requires no less.”

Applying this approach, Lords Kerr and Reed held that Mrs Montgomery should have been told of the risks of shoulder dystocia, and, further, that had she been told that she would probably have elected to have had a caesarean section. Her appeal therefore succeeded.

Lady Hale, expressing her complete agreement with Lords Kerr and Reed, added what she described as a footnote in relation to the particular issue of pregnancy and childbirth. She noted that it appeared that the doctor’s approach to disclosure was based, at least in part, upon a value judgment as to whether a caesarean section is the maternal interest and that:

*“115. [...] once the argument departs from purely medical considerations and involves value judgments of this sort, it becomes clear, as Lord Kerr and Lord Reed conclude at para 85, that the Bolam test, of conduct supported by a responsible body of medical opinion, becomes quite inapposite. A patient is entitled to take into account her own values, her own assessment of the comparative merits of giving birth in the “natural” and traditional way and of giving birth by caesarean section, whatever medical opinion may say, alongside the medical evaluation of the risks to herself and her baby. She may place great value on giving birth in the natural way and be prepared to take the risks to herself and her baby which this entails. The medical profession must respect her choice, unless she lacks the legal capacity to decide (*St George’s Healthcare NHS Trust v S* [1999] Fam 26). There is no good reason why the same should not apply in reverse, if she is prepared to forgo the joys of natural childbirth in order to avoid some not insignificant risks to herself or her baby. She cannot force her doctor to offer treatment which he or she considers futile or*

inappropriate. But she is at least entitled to the information which will enable her to take a proper part in that decision.”

Comment

In some ways, this case does no more than recognise social and, indeed, professional realities and to remove what had become an increasingly obvious tension between those realities and the venerable decision in *Sidaway*. However, the ringing terms in which Lords Kerr and Reed identified the basis upon which doctors are required to engage with their patients (and the counter-arguments that they set down to the propositions that ‘doctor knows best’ as regards disclosure) make clear that we are indeed a world where both doctor and patient are active agents.

As regards the question of how clinicians are to engage in discussions with those of impaired capacity, we suggest that

1. What is required of the patient remains as set out clearly by Peter Jackson J in [Re JB](#) [2014] EWHC 342 (COP), namely that they should understand the nature, purpose and effects of the proposed treatment, the last of these entailing an understanding of the benefits and risks of deciding to have or not to have the proposed treatment, or of not making a decision. Further, and crucially, as Peter Jackson J made clear, what is required is a broad, general understanding of the kind that is expected from the population at large;
2. What is required of the doctor is as set out in *Montgomery*, with a particular emphasis upon the injunction of Lords Kerr and Reed in *Montgomery* against bombarding the patient with technical information which

she cannot reasonably be expected to understand. How the information is to be made comprehensible is self-evidently a task that must be calibrated to the patient in question. If not, the doctor will not be able to say that they have complied with the injunction in s.1(2) MCA 2005 to take all practicable steps to enable the person to take the decision.

Short Note: Capacity and Housing

R (MT) v Oxford City Council [2015] EWHC 795 (Admin) (as yet only available on Lawtel) concerned an incapacitated adult who had sought housing from his local council pursuant to its obligations under the Housing Act 1996, rather than under community care legislation. The adult lived with his father, who was his financial deputy and who provided care to him. His father, it was proposed, would continue to provide care for him if he lived in his own property. The Council refused his application to go on the general housing register on the basis that he lacked capacity to make the application or to take up any offer of housing that was made. The Council relied on the 22 year old case of *R v Oldham Metropolitan Borough Council ex parte Garlick* [1993] AC 509 in support of its position. Unsurprisingly, the claimant argued that things had moved on in respect of the treatment of mentally incapacitated adults, and that the Council’s approach offended against Article 14 ECHR.

The Claimant’s application for judicial review was dismissed, the court considering that it was bound by the decision in *Garlick*, and holding that there was no discrimination since the Claimant could have accommodation provided to him under s.21 NAA 1948 if he satisfied that statutory test.

Comment

This judgment is peculiar and unsatisfactory in a number of respects. First, it does not address the various ways in which accommodation and care (whether together or separately) might be provided to an incapacitated adult, but seems to proceed on the basis that s.21 NAA 1948 was the only relevant community care provision. It is not clear that the court has fully understood the relevant legislation and the obligations of the relevant statutory bodies towards the Claimant. Secondly, there is little analysis of the Claimant's submissions as to the effect of the MCA 2005 on the position, or the discrimination point. The editors understand that permission to appeal has been sought. This may raise further complexities, since by the time of any appeal, the new regime under the Care Act 2014 will be in force.

End of Life Care

The Health Select Committee has published its [report](#) looking at the state of end of life care following the Neuberger review of the Liverpool Care Pathway. Various of the Committee's recommendations relate directly to the MCA 2005, with a particular focus on advance care planning and advance decision-making.

The Committee found that “[t]oo often [...] staff feel that they lack the confidence, skills and training needed to raise end of life issues with patients, let alone understand the mechanisms available to patients and carers under the Mental Capacity Act 2005 which allow people to make their wishes clear.”

Specific recommendations include:

- Further consideration by the Government about raising awareness of mechanisms available under the MCA 2005 to make ones wishes about end of life care clear, including ADRTs.
- Training for all staff who provide palliative and end of life care to people with life-limiting conditions about advance care planning.
- A review of the cost of making an LPA, and the simplification of the LPA process.

No Right Ignored Consultation

The Department of Health has issued a [consultation paper](#) this month entitled “*No voice unheard, no right ignored - a consultation for people with learning disabilities, autism and mental health conditions.*” The consultation runs until 29 May 2015. A summary of the responses to the consultation will be made available and placed on the consultations website at www.gov.uk after the responses have been considered.

The scope of the consultation primarily focuses on:

- The assessment and treatment in mental health hospitals for people of all ages with learning disability or autism;
- Adult care and support, primarily for those with learning disability but also for adults with autism;
- All those to whom the Mental Health Act currently applies (including children and young people).

The paper does not cover further proposals for children and young people to prepare for adulthood because DH considers the legal framework in part three of the Children and Families Act 2014 combined with the Care Act 2014 already exists to support successful transition to adult services. Nor does it seek to make any proposals for further changes to the Mental Capacity Act 2005.

The consultation is termed an 'exploratory consultation'. It sets out the case for change and seeks views on which of the proposed ideas and measures contained in the consultation document would be likely to have most impact. The next Government will determine in the context of a spending review what happens as a result of the consultation.

DH believes that all people should have the right to the same life chances, to make choices and be in control of their own life as far as possible. However evidence and data collected by DH show that it is proving hard to make this happen for everyone:

"We know that some people still have concerns about how much people are listened to, People have told us that the default is set the wrong way round. Statutory agencies and professional should have to justify why, against the wishes of individuals or families, they are doing things like sending people away or keeping them away from their communities, home, families or friends, whether to an inpatient or residential care setting." (2.6)

The consultation sets out a series of measure that could both strengthen the rights of people to live independently and to be included in their community and make choices about their own lives.

Many of the suggestions and measures are designed to help people exercise their rights and choices. For example, by providing individuals and their family/carer or nominated advocate with clear, easy read or accessible information by a named professional setting out a personalised summary of their rights; by simplifying the Mental Health Act (MHA) criteria for detention so that there is one set of criteria for detention for both assessment and treatment under the MHA.

Other measures are aimed at enabling people to make decisions for themselves (where they have capacity to do so) and to challenge others. A welcome example of this is the proposal that Local Authorities and NHS bodies have to seek explicit and documented approval or consent from a person to admit them to an inpatient or residential care settings, and giving individuals, or their families or advocates the right to subsequently change their mind and to request a move, transfer or discharge.

A more controversial proposal is that restricted patients be discharged from hospital onto a new type of order which could contain conditions imposed by the Secretary of State for Justice or a Tribunal and which would authorise deprivation of liberty in the community.

The paper also includes proposals to give individuals with learning disability and/or autism in certain circumstances the right to have a personal health budget.

The paper contains an interesting proposal to change the definition of 'mental disorder' contained in the MHA. The paper proposes three possible options (paragraphs 3.8) for change designed to ensure that the MHA is applied to people with learning disability and/ or autism

appropriately and asks consultees to select which one of the options they prefer.

This is a wide-ranging paper with laudable aims. DH seeks responses from individuals, health and social care bodies, organisations, charities, professional bodies, the police and emergency services and any other party with an interest in improving the rights, health and wellbeing of people of all ages with disability. The consultation will only be useful and effective if people read and respond to it.

Beverley Taylor

Indirect payments and mental capacity

Following a [research project](#) into how 'indirect payments' for those lacking the relevant mental capacity are working in practice, a new web guide to such payments has been developed and is available [here](#).

Mental Health Act 1983 reference guide

The new reference guide to accompany the Mental Health Act 1983 is now available [here](#). It has very much less detail about (in particular) Schedule 1A to the MCA than does the new [Code of Practice](#).

New neglect/ill-treatment offences

The provisions of the Courts and Criminal Justice Act 2015 providing for care worker/care provider offences of ill-treatment or willful neglect (covered [here](#)) will come into effect to cover offences committed on or after 13 April 2015.

Dementia challenge website

DH has launched a beta version of its [Dementia Challenge](#) website which, as yet, is distinctly underpopulated, but may in time provide a useful gateway into resources to assist in the still woefully inadequate understanding of dementia and its challenges for the delivery of dignified care and treatment.

Guardians for missing persons

Although not, strictly, a matter relating to capacity, we note that it is overwhelmingly likely that the next government will introduce a new legal role and status of guardian of the property and affairs of a missing person.

As outlined in the consultation response [here](#), the key features of the proposed scheme will be:

- a guardian will be required to act in the best interests of the missing person and in this respect will be subject to duties similar to those of a trustee;
- the guardian will be supervised by the Office of the Public Guardian and will be required to file accounts in much the same way as a Deputy appointed under the Mental Capacity Act 2005;
- a guardian will be appointed by a court on application by a person with a sufficient interest in the property and affairs of the missing person;
- the appointment will be for a period of up to 4 years with the possibility of applying for an extension for up to another 4 years.

Which court will have the responsibility for appointing and scrutinising such guardians has yet to be determined (and we do not understand that it will necessarily be the Court of Protection, as suggested in some coverage of this).

Book Review: *Judicial Review: Law and Practice* (2nd edition)

Judicial Review: Law and Practice (2nd Edition):
General Editors: The Hon Mrs Justice Patterson DBE and Sam Karim (Jordans, 2015, £89).⁵

We make short note of the second edition of this book because of the very useful chapter (written by Simon Burrows) that it includes on judicial review and mental health, which also includes coverage of the issues that arise in relation to judicial review and the MCA 2005.

The book is the second edition of a practitioners guide to judicial review. It covers, in the first half, the principles and procedures relating to judicial review applications before in the second half turning to the questions that arise in specific contexts.

It is a very comprehensive work, but I am duty bound to say that it is let down by the fact that there appears to have been something of a delay between the submission of the text and publication because there is – for instance – no reference in the chapter on community care to the Care Act (which was passed into law in May 2014), and there are, in general, very few references to cases decided after the early part of 2014. In such fast-moving areas of the law, it is

⁵ Full disclosure: Alex is very grateful to Jordans for providing him with a copy of this for purposes of this (unpaid) review. We are always open to reviewing books in the area of mental capacity law and policy (broadly defined) – contact one of us with your suggestions and, ideally, a copy of the book!

inevitable that there will always be points in which matters move on between writing and publication, but the gap here is particularly unfortunate.

That having been said, however, the chapter on mental health and mental capacity is less affected than others (and the decision in *ACCG v MN*, outlining the division between the COP and Admin Court will hopefully be out by the time of the third edition!), and the book in general, clear, straightforward and helpful. It would make a useful reference work for those who do not necessarily have to engage with the Administrative Court on a day to day basis but need to have an understanding of the approach that will be taken.

Alex Ruck Keene

The International Protection of Adults

Alex hopes that readers will forgive the shameless plug for the book that he has written, together with Adrian, Richard Frimston and Claire van Overdijk, on the International Protection of Adults. Available [now](#) from Oxford University Press, the book represents the first comprehensive attempt to address questions of capacity across borders.

As OUP note, increasing numbers of people have connections with one country, but live and work in another, frequently owning property or investments in several countries. People with lifelong or subsequently developed impairments of capacity move cross-border or have property or family interests or connections spread across different jurisdictions. This new work fills a gap in a specialist market for a detailed work advising lawyers on all the considerations in these situations.

The book provides a clear, comprehensive, and unique overview of all relevant capacity and private international law issues, and the existing solutions in common law and civil law jurisdictions and under Hague Convention XXXV (or, as practitioners before the COP know it better, the 2000 Convention). It sets out the existing law of various important jurisdictions, including detailed chapters on the constituent parts of the UK, Ireland, Jersey, the Isle of Man and the states parties to the Convention; and shorter chapters on 26 Non-Hague states and those within federal states, including coverage of the United States, several Australian and Canadian states, and a number of other Commonwealth jurisdictions. Containing a number of helpful case studies and flowcharts, the book draws upon the expertise of the editors in their respective fields, together with detailed contributions from expert practitioners and academics from each relevant jurisdiction.

Deprivation of liberty update: *Stankov v Bulgaria*

Introduction

Things rarely stand still for long in mental health and capacity law and rights. During March, for example, the European Court of Human Rights (the Court) delivered its judgment in [Stankov v Bulgaria](#) (Application no. 25820/07) which appears to reinforce the fact that guardians, even where they are family members, cannot consent to a deprivation of liberty of a person with incapacity in the absence of specific powers to do so and real and effective means to challenge such deprivation of liberty through the courts. A brief summary of the case follows although readers are referred to the case itself for more detail (the transcript is only available in French at the moment).

Facts of the case

Mr Stankov was declared by a court to be partially incapacitated on the basis that he suffered from schizophrenia which caused a personality change and inability to handle his own affairs. His mother was appointed his guardian.

Shortly after this he was placed at his mother's instigation and with her agreement in two successive state-run social care homes for persons with mental disorder. There was no judicial authorisation and it appears to have been a contractual arrangement.

It was clear that Mr Stankov did not wish to be placed in these homes.

He subsequently applied to court to have his legal capacity restored on the basis that he was able to handle his own affairs. This was refused.

Mr Stankov argued that his being placed in the social care homes was a breach of his Article 5(1) ECHR right to liberty and the lack of ability to challenge the legality of such deprivation of liberty was a violation of his Article 5(4) ECHR (adequate procedural safeguards) right. The Court agreed with him⁶.

Court's findings

1. There had been a deprivation of liberty engaging Article 5 ECHR

This was on the following basis:

1. The objective element of deprivation of liberty was present in that Mr Stankov had been under the constant control of staff at the homes and was not free to leave without permission at any time⁷. This follows Strasbourg jurisprudence (in other words, *Bournewood*⁸ and related Strasbourg jurisprudence) through to the UK Supreme Court's *Cheshire West*⁹ ruling which has particular relevance to cases such as this.

⁶ Violations of Articles 5(5) (the right to compensation), 6(1) (right to a fair trial), 3 (inhuman or degrading treatment) and 13 (in conjunction with Article 3) (the right to effective remedy) were also found. However, Articles 5(1) and (4) are only considered here owing to their relevance to the recent Scottish Law Commission [Report on Adults with Incapacity](#).

⁷ Para 87

⁸ *HL v UK* (2005) 40 EHRR 32.

⁹ *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.

It also noted that such deprivation of liberty was for an indefinite period of time given that no end date had been set¹⁰.

2. There was no valid consent provided to the deprivation of liberty (which would have taken it outside the ambit of Article 5¹¹). Mr Stankov had not personally consented to his being placed in the homes. However, his mother, as his guardian, had instigated and consented to it on his behalf¹². The Court was clearly uncomfortable with this. It observed that there are situations where the will of a person with incapacity may be validly replaced by that of third party acting as a protective measure and that sometimes it is difficult to ascertain the real wishes and preferences of such a person. However, it reiterated its comments in *Shtukaturv*¹³ and *Stanev*¹⁴ that an incapacitated person who has been deprived of their liberty may nevertheless still be capable of understanding their situation¹⁵. Indeed, the Court noted that domestic legislation gave some weight to the views of the applicant in such situations, that Mr Stankov appeared to understand his situation and that it was pretty clear that he disagreed with his placement given repeated attempts to leave the first home and expressed wish to leave the second¹⁶. It should also noted (see below) that the Court was not prepared to infer that the assessment of Mr Stankov's capacity and

¹⁰ Para 89.

¹¹ *Storck v Germany* (2005) 43 EHRR 96, paras 76-77; *JE v DE* [2006] EWHC 3459(Fam), per Munby J at para 77; *Stanev v Bulgaria* (2012) 55 EHRR 22, para 117

¹² Para 85, noting also *Stanev*, para 122 and *DD v Lithuania* [2012] ECHR 254, para 151).

¹³ *Shtukaturv v Russia* (2008) ECHR 223, para 108.

¹⁴ *Stanev*, para 130.

¹⁵ Para 89.

¹⁶ Paras 89-90.

granting of guardianship was for the purposes of depriving him of his liberty.

2. Deprivation of liberty was unlawful under Article 5(1)

For the deprivation of liberty to be lawful it had to be justified under the permitted exception, subject to appropriate safeguards, in Article 5(1)(e) permitting detention of persons of 'unsound mind'. In light of the fact that Mr Stankov had been medically assessed for the purpose of exercising his legal capacity and not specifically for whether he suffered from a mental disorder warranting detention the Court felt that the detention was unjustified¹⁷.

3. Inadequate procedural safeguards for compliance with Article 5(4)

The Court noted the requirement to be able to apply to a court to test the lawfulness of the detention¹⁸ and found that in Mr Stankov's case there was a breach of Article 5(4)¹⁹. Strangely, it did not mention *MH v UK*²⁰ which provides for enhanced procedural safeguards in the case of persons with incapacity in order to comply with Article 5(4)²¹ but it is clear that it expected there to be a real and effective ability to challenge the lawfulness of the detention.

Importantly, the Court noted that there been no court authorisation of the placement, only of the partial denial of legal capacity, and no subsequent periodic judicial review ability of such placements (indeed, Bulgarian law does not

¹⁷ Paras 92-105.

¹⁸ *Stanev*, paras 168-171.

¹⁹ Paras 111-115.

²⁰ (2013) ECHR 1008.

²¹ See "Deprivation of liberty, adults with incapacity and Scotland: the ongoing debate", *Mental Capacity Law Newsletter*, [March 2015](#).

recognise such placements as a deprivation of liberty)²². Although it was also argued on behalf of the Bulgarian Government that it was open to Mr Stankov to apply for termination of the contract authorising his placement the Court remarked that it was unclear how such a request would be interpreted by the domestic authorities²³. Moreover, as in *Stanev*²⁴, it was noted that the Article 5(4) requirement were not met where the only person who was permitted under domestic law to challenge the legality of the guardianship was the guardian themselves²⁵.

Conclusion and implications for Scotland

In the [March 2015](#) issue of this newsletter, it was mooted whether the Scottish Law Commission's recommendations²⁶ to amend the Adults with Incapacity (Scotland) Act 2000 would be entirely Article 5(4) compatible. This is in light of developing ECHR case law, some of which is subsequent to the report, that appears to require enhanced procedural safeguards in the case of persons with incapacity and it was commented in the March issue that it is difficult to envisage how this can be effectively achieved otherwise than through automatic judicial review.

The Scottish Law Commission recommends provisions allowing for the prevention of and adult with incapacity from going out of hospital and for welfare guardians and attorneys to authorise a significant restriction of liberty for an adults with incapacity without automatic judicial review. The *Stankov* ruling seems to strengthen the case for such automatic judicial review.

²² Para 112.

²³ Para 113.

²⁴ Paras 174-177.

²⁵ Para 114.

²⁶ Scottish Law Commission (2014) [Report on Adults with Incapacity](#), Report No.240, Edinburgh: The Stationery Office (the Report)

What is also notable is the lack of weight given by the Court to the exercise of legal capacity relative to the requirements of Article 12 of the UN Convention on the Rights of Persons with Disabilities (CRPD) as interpreted in the Committee on the Rights of Persons with Disabilities General Comment²⁷. Indeed, although the Convention is mentioned generally and Article 14 CRPD (the right to liberty) specifically as relevant international texts, as has generally been the case in Strasbourg judgments to date, there is no active use of the CRPD by the Court. However, as the situation currently stands in Scotland, by virtue of the Human Rights Act 1998 and Scotland Act 1998 it is the ECHR and its interpretation by the Court that takes precedence.

Readers may also want to note the comments made in the Health, Welfare and Deprivation of Liberty Newsletter as regards the implications of this decision for the position in England and Wales.

Jill Stavert

Essex Autonomy Project: now going UK-wide

As many readers will be aware, in 2014 an Essex Autonomy Project (“EAP”) research team, with support from the Arts and Humanities Research Council, provided technical research support to the UK Ministry of Justice in developing a formal Opinion as to whether the Mental Capacity Act 2005 is compliant with the United Nations Convention on the Rights of Persons with Disabilities. The 2005 Act of course applies only

²⁷ Committee on the Rights of Persons with Disabilities, General Comment No. 1(2014) *Article 12: Equal recognition before the Law*, adopted 11 April 2014.

to England & Wales, but the UK Government remains responsible in such international matters (even when they impact directly upon devolved topics²⁸) for the whole United Kingdom. The omission of Scotland and Northern Ireland from this exercise, and the lack of any similar exercise for those jurisdictions, was discussed with concern between Professor Wayne Martin of Essex University, who led the EAP project, and Adrian at an event in London on 9th February 2015 in connection with the book “International Protection of Adults” (see [cross-reference]). It was agreed that it was important to move rapidly to make good this omission, and that an extension of the EAP project would be the best vehicle for doing so. Jill was rapidly drawn in to enlist the involvement of her Centre for Mental Health and Incapacity Law Policy and Practice at Edinburgh Napier University, as was Alex, in respect of his considerable involvement in the original EAP project and his membership of the Mental Health and Disability Committees of both the English & Welsh and the Scottish Law Societies. Adrian’s firm of TC Young LLP is also a sponsor of the project, and a first meeting of the core team who hope to drive this forward took place at TC Young’s Edinburgh office on 30th March 2015. As regards Scottish input, attendees included Sandra McDonald, Public Guardian, Colin McKay, Chief Executive of the Mental Welfare Commission, and Amy Woodhouse of Mental Health Foundation. Subject to funding, it is anticipated that the project will formally commence on 1st July 2015 and last for about 11 months. The purpose is to be able to offer further technical research support to HM Government, in parallel with and supplementary to the input of others, including Scottish Government and the UK human rights bodies. We shall keep readers advised of developments.

²⁸ See the item at page 8 on the constitutional implications of draft Scotland Clauses,

Adrian D Ward

Adult incapacity: specialist sheriffs?

[Last month](#) we reported on the major address given by the Lord President, Lord Gill, to the Holyrood Digital Justice Conference on 28th January 2015, in which he set out the timetable for reform of the justice system following upon the Courts Reform (Scotland) Act 2014 and announced the appointment of Sheriff Principal Mhairi Stephen QC as President of the new Sheriffs Principal Appeal Court. We provided a link to the full text of Lord Gill’s speech. We did however comment with disappointment that the adult incapacity jurisdiction was not mentioned in the passages referring to the advantages of specialisation.

In the February Newsletter we reported on, and commended, the initiatives by Sheriff Principal Stephen in her own sheriffdom – Edinburgh – effectively introducing an element of specialisation there, and issuing a new Practice Note.

In recent correspondence with Adrian, Lord Gill has now indicated that he is “persuaded that the use of nominated specialist sheriffs in adult incapacity cases is sound in principle”. It is understood that he is ascertaining from Sheriffs Principal whether they would support the idea and, if so, whether they would consider that it would be practicable in the circumstances of their individual sheriffdoms. We shall report further on the Lord President’s initiative, whenever further information becomes available.

Adrian D Ward

Scope of section 3(3) challenged

Section 3(3) of the Adults with Incapacity (Scotland) Act 2000 allows any party claiming an interest in the property, financial affairs or personal welfare of an adult to apply to the sheriff for an order giving directions to any person exercising any functions under the Act. According to the Scottish Law Commission (Report No 151 on Incapable Adults, September 1995, Recommendation 30) the purpose of this provision included conferring upon the court power “to give directions to a continuing or welfare attorney as to the exercise of his or her functions”. There have been unreported cases in which such exercise of the courts’ power has been sought. This is however one of the most wide-ranging standalone procedures in the Act. Persons exercising functions may seek directions as to how they themselves should proceed, as occurred in *B’s Guardian, Minuter* (Edinburgh Sheriff Court, 21st July 2010, see 2010 GWD 33-690) in which a guardian sought directions as to whether he could apply to be appointed sole executor dative of an estate in which the adult had been appointed sole executor. The Public Guardian has used the procedure several times for directions as to whether she should or should not register (typically) a revocation of a power of attorney and/or a fresh power of attorney (thus both of these in *Public Guardian, Applicant*, 2011 SLT (Sh Ct) 66). At least one such case went to appeal: in *Application by the Public Guardian re DC*, the sheriff at Glasgow directed the Public Guardian not to register a revocation on 14th August 2012, and that decision was upheld by the Sheriff Principal on appeal on 6th December 2012. The same *DC* subsequently raised proceedings in the Court of Session on which we reported at [insert link], in which one of the issues raised was whether it was competent for a sheriff to direct the Public Guardian not to carry out a registration

function which appeared to be mandatory (if relevant criteria were met) in terms of the Act: however, even in that comprehensively argued case there was no suggestion that the scope of section 3(3) was limited to Part 6 procedures. That however seems to have been the view of a sheriff who, on 29th January 2015, refused to warrant an application under section 3(3) for certain directions to be given to a continuing attorney. The relevant terms of the sheriff’s Interlocutor were: “refuses to warrant said application in respect that there is no process in this court to allow such a minute to be lodged”. Of course, the application was a standalone application as envisaged by section 3(3), not a minute. The sheriff does not appear to have taken account of the actual wording of section 3(3), nor of its intended purpose, nor of the previous history of use of the procedure.

An appeal against the refusal to warrant was lodged. The attorney took the action which the application sought to have him directed to take. The appeal was withdrawn.

Adrian D Ward

Evidence needed – mental health officer reports

In [July](#), [August](#), [October](#) and [November](#) last year we narrated concerns and developments over delays in provision of mental health officer reports, under the heading “Damaging Illegality of Scottish Social Work Authorities”. Welfare guardianship applications, and applications for intervention orders with welfare powers, cannot proceed unless lodged in court with the required reports, which include a report from the mental health officer (“MHO”). At time of passing of the Adults with Incapacity (Scotland) Act 2000 the Scottish Parliament was alert to the risk that delays in preparation of MHO reports could

obstruct the process and could indeed in some cases be significantly damaging to vulnerable people. A specific time limit of 21 days for preparation of such reports was accordingly inserted in section 57(4) of the Act, which requires applicants (other than the local authority) to give notice to the Chief Social Work Officer of intention to apply for such an order, and requires the report to be prepared “within 21 days of the date of the notice”.

In July we narrated the creeping disregard by local authorities of this statutory obligation; an apparent pretence that the obligation was to allocate the matter to an MHO rather than to produce the report; slippage in even doing that; and ultimately a policy of intimating delays (in one case) of 10-12 weeks from date of intimation for the preparation of a report “to be allocated”. One solicitor has subsequently reported a six month delay in preparation of a report. Other feedback, all of it unfortunately negative, was reported in August; then in October we reported the Parliamentary Question by Michael McMahon MSP, chair of the Parliament’s Cross-Party Disability Group, as to what proportion of reports are provided within the required timescale, and the entirely unhelpful written Answer that: “This information is not collected centrally”. In November we pointed out that the proposals in the recent Scottish Law Commission Report on Adults with Incapacity, and in the current Mental Health Bill, would if implemented both increase MHO workloads and worsen the situation.

Since then the Mental Health and Disability Sub-Committee (“MHDC”) of the Law Society of Scotland has been pursuing these concerns, and had a helpful meeting on 18th March with the Mental Welfare Commission (“MWC”) and the Care Inspectorate. There was a shared general impression that, while there are variations from area to area, demands upon MHOs are

outstripping currently available resources. MWC has for some time been concerned with the issue of MHO recruitment and retention, and has been highlighting those concerns to government, the Care Inspectorate and SSSC. It has called for a national strategy to address the issues.

At the meeting the Care Inspectorate advised that they were undertaking a scoping exercise to establish the extent of the problem. This will include meetings with Link Inspectors, the Chief Social Work Officer and other stakeholders, including the Law Society. While no timescale for this could be provided, once completed the Care Inspectorate intend to submit a proposal to Scottish Ministers and seek authority to proceed with a full project. The meeting identified deviances both in local authority practice and in practice of individual MHOs, some – for example – seeking medical reports before preparing their own report. There were potential time and cost implications here, particularly in legally aided situations.

Some of the delays seem to be organisational and procedural, such as delays in passing information internally. Delays appear to be longest in relation to younger people, people with learning disabilities, and people in the community. Amending the 2000 Act might alleviate some issues, but that will not happen in the current parliamentary term.

The Care Inspectorate in particular highlighted the difficulty of gathering relevant data, and this is where readers of the Newsletter can assist. Practitioners in the field are requested to send to Alison Hempsey, a member of MHDC, at amh@tcyoung.co.uk a list of dates of receipt of all recent MHO reports with, against each, the local authority and the number of days since the section 57(4) intimation: for example “31st March

2015 – Glasgow – 20 days”. Ideally this should cover six months to 31st March 2015. If the period is shorter, it is still essential that all reports received within that period (whether timeous or not) are included.

Further comment is optional but would be helpful. Descriptions of the impact of delays in some individual cases, anonymised, could be particularly helpful. Other general comments could cover experience of trends, for example as regards delays or as regards quality of reporting.

We shall keep readers advised of developments as they occur.

Adrian D Ward

Constitutional implications of draft Scotland Clauses

The Political and Constitutional Reform Committee of the UK Parliament has published a personal submission by Adrian, the main terms of which are as follows:

“A significant omission from the constitutional provisions of the draft clauses is the lack of any equivalent to the Sewel Convention in relation to International Instruments which have direct implications for devolved areas of Scots private law.

A current example which causes concern is the UN Convention on the Rights of Persons with Disabilities. This potentially has a direct impact upon the Adults with Incapacity (Scotland) Act 2000 (asp4), which happens to have been the first piece of major policy legislation by the Scottish Parliament. The terms of the Convention, and even more so the interpretation of those terms by the UN Committee on the Rights of Persons with Disabilities, are highly controversial. However,

so far as can be ascertained, there was no meaningful consultation in Scotland either as regards the terms of the Convention, or as to the decision to ratify without reservations. It is reasonable to anticipate that if there had been proper consultation, then at least in relation to Scotland’s adult incapacity regime there would have been some reservations similar to those made by other states with broadly similar approaches.

There is in fact a converse consequence of this lack of engagement, which is that Scottish experience is not fed back into deliberations at international level. That is particularly relevant in relation to the Convention and statute mentioned above. Scotland’s incapacity legislation is seen to be world-leading. Thus I personally have been drawn into consultation and advice to the Nordic countries; as the only British member of a Council of Europe Expert Working Party; and more recently in advice in the Netherlands. These examples all reflect invitations personally to visit the states and organisations mentioned. Scotland was in fact the first jurisdiction in the world in respect of which the Hague Convention on the International Protection of Adults was ratified (it has not yet been ratified in respect of England and Wales). Thus not only has Scotland been denied engagement in the processes of drafting and implementing such International Instruments, but those processes have also failed to benefit from such input and experience as could be made available from Scotland.”

Adrian D Ward

G v West Lothian Council

Adult incapacity and mental health litigation concerning JG (an adult with severe debilitating dementia and osteoporosis, and significant mobility difficulties) generated three appeals to the Sheriff Principal at Edinburgh during 2013 and

2014, and now an interesting and carefully researched, but controversial, case commentary by Alan Eccles and Lindsay Watson (“E and W”) at 2015 SLT (News) 35.

The first appeal was determined by Sheriff Principal Stephen on 21st November 2013. She was not satisfied that the procedure adopted under which the Chief Social Work Officer of West Lothian Council (“CSWO”) was appointed interim guardian to *JG* on 28th August 2013 had been procedurally fair. She recalled that appointment and appointed *JG*’s son, BG, as interim guardian.

The second appeal was an appeal against a decision of the Mental Health Tribunal to make a compulsory treatment order (“CTO”) in respect of *JG*. That appeal was heard and determined by Sheriff Principal Stephen on 1st August 2014. *JG* had suffered serious fractures, resulting in lengthy in-patient hospital treatment, after suffering falls at home in late 2013. Having been taken home by BG against medical advice, she again suffered falls there, in consequence of which a short-term detention certificate was issued, followed by the CTO. The Sheriff Principal refused that appeal.

The third appeal, noted at 2014 GWD 40-730, was an appeal by BG against an appointment on 16th May 2014 of the CSWO as interim guardian for a period of six months. A major source of conflict throughout was what the Sheriff Principal described as a “fundamental disagreement” between social work and health professionals on the one hand, in whose opinion *JG* – by the time of the third appeal – received round the clock specialised in-patient nursing care, and BG who believed that *JG* should nevertheless be cared for in her own home on the basis of her previously strongly expressed preference to be cared for at home. The Sheriff Principal further described as a

“particularly difficult matter” BG’s unwillingness to accept that physical chastisement of an adult with severe debilitating dementia was not conducive to the adult’s welfare.

For a full account of relevant facts and history, and of the arguments and considerations in the third appeal, see the Sheriff Principal’s Judgment [here](#) and the article by E and W. We would regard two aspects of the decision and discussion thereof in the article as uncontroversial.

Firstly, the Sheriff Principal made it clear that interim guardianship is not something lesser than so-called “full” guardianship: “It is incorrect to equate interim guardianship with an interim protective order designed to maintain the status quo pending court proceedings”. The only difference between an interim appointment and a “full” appointment is that the interim appointment is made (usually) for a shorter period and pending final determination. However, during the interim period, as E and W put it, “the granting of an interim guardianship has the nature and quality of a ‘full’ guardianship – the proposed interim guardian must be suitable and the intervention must be necessary to achieve the benefit sought”.

Secondly, the Sheriff Principal also commented on the provisions of section 49 of the Adults with Incapacity (Scotland) Act 2000 which deal with the status of Part 5 authority to treat (under section 47) in circumstances where it is known that there is an application for an intervention or guardianship order. Under section 49, in that situation and pending final determination of the application for the intervention or guardianship order, treatment authorised by section 47 may only be given if it is authorised by any other enactment or rule of law “for the preservation of the life of the adult or the prevention of serious deterioration in his medical condition”. In the

appeal, BG had argued that there was no urgency or necessity to make an interim guardianship order because JG could receive necessary medical care and treatment either under ad hoc intervention orders, other procedures such as CTO, or to the extent permitted by section 49. The Sheriff Principal dismissed those proposals as being “unworkable and disproportionate” compared with covering the matter by an interim appointment of a guardian. Section 49 could not be relied upon as giving JG the level of care which she required, nor a desirable level of legal certainty in that regard. In such circumstances, as E and W put it, “a more permanent or at least stable/predictable intervention, such as guardianship, is desirable (subject to ensuring the adult’s freedoms are respected and skills and abilities are supported and encouraged)”.

Where we part company with E and W is in their acceptance of Sheriff Principal Stephen’s view as to the way in which the principles in section 1 of the 2000 Act should be applied. The Sheriff Principal saw the principles as essentially a hierarchy, in the order stated in the Act. The Sheriff Principal thus considered as being “the essential principle” the principle in section 1(2) that there should be no intervention unless the person responsible for authorising or effecting it “is satisfied that the intervention will benefit the adult and that such benefit cannot reasonably be achieved without the intervention”. The Sheriff Principal then went on to say: “*This is indeed the core principle namely that it is the welfare of the adult and the benefit to the adult which is the overarching principle. The court then has to consider the least restrictive option and take into account the present and past wishes and feelings of the adult and the views of the nearest relative and the primary carer of the adult in so far as it is reasonable and practicable to do so. The sheriff also requires to take into account the views of any other person who appears to the sheriff to have*

an interest in the welfare of the adult”. In their commentary, E and W put “then” in italics. They refer to other occasions on which they have suggested that “undue weight has arguably been given to notions of the (past) intentions and wishes of an adult to the extent that the fundamental tenets of section 1 appear to be substantially or even completely relegated in their importance”. They suggest that there is a detectable move away, in certain situations, from “benefit” having an “essential” position.

We would disagree with this approach for the following reasons.

Firstly, it is incompatible with the suggestion – for example in *Adults with Incapacity Legislation* (Ward) page 13 – that: “With due caution, “benefit” can reasonably be interpreted as encompassing overcoming the limitations created by incapacity, so as to permit something which the adult could reasonably be expected to have chosen to do if capable, even though of a gratuitous or unselfish nature”. Cited in support of that proposition are the provisions of section 66 of the 2000 Act regarding gifts from the estate of an adult under guardianship; section 51(4) regarding participation in research from which the adult will not benefit directly; and the commentary in the official Explanatory Notes to the original Act upon what is now section 30(2), qualifying the provision of section 30(1) that “any funds used by the withdrawer must be applied only for the benefit of the adult”. We would suggest that one cannot make proper judgements in accordance with the principles as a whole in such matters, in individual cases, as to what might “benefit” that particular adult without knowing as much as possible about relevant past and present wishes and feelings of the adult.

Secondly, and more fundamentally, to regard “benefit” as a “gateway” without reference to the other principles, and particularly the extent to which they are designed to ensure that account is taken of the individuality of the particular adult, comes dangerously close to equating “benefit” with the “best interests” test now so clearly (and in our view correctly) rejected by the UN Committee on the Rights of Persons with Disabilities. Moreover, a “best interests” test was explicitly rejected by the Scottish Law Commission in its Report No 151 on Incapable Adults, in which the principles were formulated: “Our general principles do not rely on the concept of the best interests of the incapable adult ... We consider that “best interests” by itself is too vague and would require to be supplemented by further factors which have to be taken into account”. Those “further factors” are of course those which the ensuing principles in section 1 are designed to elicit.

Arguably, the requirements of the UN Convention on the Rights of Persons with Disabilities, and more importantly the interests of justice and of respect for the individuality of any adult the subject of proposed intervention under the Act, are better served by the developing importance accorded by the suggestion first proposed by HH Judge Hazel Marshall in the English case of *Re S and S (Protected Persons)* [2008] COPLR Con Vol 1074 that there should be a rebuttable presumption in favour of following the known will and preferences of the adult. That approach appears to be gaining growing support in England.

A “best interests” approach, and likewise a similar approach based on “benefit” viewed in isolation, is to be contrasted with the “constructing decisions” approach advocated in Chapter 15 of *Adult Incapacity* (Ward, 2003), which (put briefly) advocates the construction of decisions using as

much as possible as can be derived from adults themselves or from all that is known about them, in each individual case.

Adrian D Ward

In brief

1. With effect from 1st April 2015 the Scottish Court Service and the Scottish Tribunals Service have merged to create a new entity, the Scottish Courts and Tribunals Service.
2. The Special Case on powers of attorney, covered [here](#) has now been reported as *Great Stuart Trustees Limited v Public Guardian*, 2015 SLT 115.
3. George Kappler and Charlie Burns both retired from the Mental Welfare Commission for Scotland on 27th March 2015. This will be covered further in May.
4. The Centre for Mental Health and Incapacity Law, Rights and Policy held a very successful seminar on 23rd March entitled *Children and Young Persons and Mental Health* – speakers Dr Lesley-Anne Barnes Macfarlane, Edinburgh Napier University, Dr Ama Addo, Consultant, Child & Adolescent and Intellectual Disabilities Psychiatry at Yorkhill Hospital Glasgow and May Dunsmuir, President, Additional Support Needs Tribunal for Scotland and In-House Convener, Mental Health Tribunal for Scotland.

Adrian D Ward and Jill Stavert

Conferences at which editors/contributors are speaking

Socio-Legal Studies Association

Alex is presenting a paper on “(Re)presenting P before the Court of Protection” and Jill a paper on “Addressing the *Bournewood* gap in Scotland” at the SLSA 2015 Annual Conference at the University of Warwick 1-2 April.

Commonwealth Legal Education Association

Jill will be presenting (with Rebecca McGregor) a paper on “Access to equal recognition before the law for persons with mental disabilities through supported decision making in Scotland” at the Commonwealth Legal Education Association 2015 conference in Glasgow 9-10 April.

Elderly Care Conference 2015

Alex will be speaking at Browne Jacobson’s Annual Elderly Care Conference in Manchester on 20 April. For full details, see [here](#).

Medical Issues and the Mental Capacity Act 2005

Tor will be speaking at a conference arranged by Clarke Willmott on 24 April, her topic being “The Court of Protection and medical treatment disputes: avoiding court and what happens if you can't.” Full details of the conference are available [here](#).

‘In Whose Best Interests?’ Determining best interests in health and social care

Alex will be giving the keynote speech at this inaugural conference on 2 July, arranged by the University of Worcester in association with the Worcester Medico-Legal Society. For full details, including as to how to submit papers, see [here](#).

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Annabel Lee
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Guest contributor

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Scottish contributors

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Advertising conferences and training events

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

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

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Victoria regularly appears in the Court of Protection, instructed by the Official Solicitor, family members, and statutory bodies, in welfare, financial and medical cases. She previously lectured in Medical Ethics at King's College London and was Assistant Director of the Nuffield Council on Bioethics. Together with Alex, she co-edits the Court of Protection Law Reports for Jordans. She is a contributing editor to Clayton and Tomlinson 'The Law of Human Rights', a contributor to 'Assessment of Mental Capacity' (Law Society/BMA 2009), and a contributor to Heywood and Massey Court of Protection Practice (Sweet and Maxwell). **To view full CV click here.**



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



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



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



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