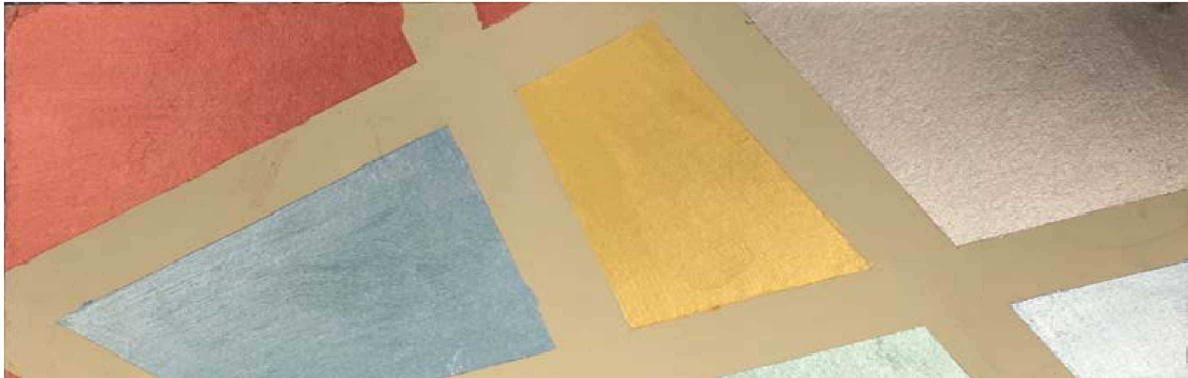

Welcome to the May 2023 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: LPS on the shelf; fluctuating capacity and the interface under the judicial spotlight;

(2) In the Property and Affairs Report: the new surety bonds structure and an update on the Powers of Attorney Bill;

(3) In the Practice and Procedure Report: reporting restrictions and the Court of Appeal, and costs in serious medical treatment cases;

(4) In the Wider Context Report: DNACPR notices and disability, litigation capacity, the new SCIE MCA database, and Ireland commences the 2015 Act;

(5) In the Scotland Report: problems of powers of attorney in different settings and a very difficult Article 5 choice.

You can find our past issues, our case summaries, and more on our dedicated sub-site here, where you can also sign up to the Mental Capacity Report.

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

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HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

Liberty Protection Safeguards: implementation delayed "beyond the life of this Parliament"

The Government announced on 5 April 2023 that it would delay the implementation of the Mental Capacity (Amendment) Act 2019 until "beyond the life of this Parliament."

We set out the announcement in full below:

> *Update on implementation of the LPS*
>
> *Yesterday you will have seen the Government has set out its plans for*

adult social care reform in its publication of the Next steps to put People at the Heart of Care.

To enable us to focus on these critical priorities, the Government has taken the difficult decision to delay the implementation of the Liberty Protection Safeguards beyond the life of this Parliament. This was one of a number of decisions taken as part of prioritising work on social care. More detail can be found on plans to reform and improve adult social care here.

We recognise that this delay will be disappointing news for the people and organisations who have worked closely with us on the development of the LPS since the Mental Capacity (Amendment) Act was introduced in 2019. We would like to thank everyone who engaged with us on the development of the policy and during the consultation on the LPS. The detailed feedback we received has been invaluable.

During the LPS consultation, we received detailed feedback from stakeholders across the health and social care, voluntary and legal sectors, and the people affected by it. Many of those who responded to the consultation expressed support for the LPS and agreed that there is a need for a more streamlined and person-centred system. Though some responses to the consultation also suggested changes to the proposals in a number of ways which have been considered during the consultation analysis phase.

Although implementation of LPS has been delayed at this time, we plan to publish a summary of responses to the consultation in due course, which will set out further information about the feedback we received at consultation. We will update you via the LPS newsletter when the summary of responses is published.

In the meantime, the Deprivation of Liberty Safeguards remain an important system for authorising deprivations of liberty, and it is vital that health and social care providers continue to make applications in line with the Mental Capacity Act 2005 to ensure that the rights of those who may lack the relevant capacity are protected.

Changes to the LPS team

In line with the decision not to move forward with the LPS at this time, some members of the LPS team will begin moving to other areas of the Department in the coming weeks. In the short term, Laura Karan and Martin Teff will remain the key points of contact for the LPS and the DoLS. We will provide further updates on the future of the LPS team as soon as practicable.

As always, please do get in touch with us at lps.cop@dhsc.gov.uk with any queries or comments.

The most immediate effect that this has is that the Liberty Protection Safeguards are not going to come into force for the foreseeable future. There are also knock-on effects, including that the new version of s.4B will not come into force to provide much-needed 'cover' in emergency situations. And, at the time of writing, it is unclear what is going to happen in relation to those parts of the updated Mental Capacity Act Code of Practice that relate to the main body of the MCA and which are badly out of date (our informal attempt to highlight the most dangerous passages in the MCA Code,

together with the DoLS Code, can be found here).[1]

As we were going to press, Helen Whateley MP and Michelle Dyson, Director General for Adult Social Care, Department of Health and Social Care, gave evidence to the Health and Social Committee, identifying that there was still a commitment to change the system, but that (in effect) it was too complex to do so at the moment. The relevant exchanges can be found from 15:49 here.

Schedule AA1 is dead; long live Schedule A1

The government's decision to dust-gather LPS on the lower priority shelf of policy will please some but frustrate most. Why the human rights of hundreds of thousands of people with disability have not been prioritised is difficult to fathom. But silver linings help to mediate the pain from change of policy. So what might DoLS 2.0 look like using a non-legislative approach (aka 'LPS')?

(i) Change the terminology!

Terminology matters. It matters to those with disability, to their family and friends, to care providers and to those practitioners responsible for acting lawfully. Neither the terms 'deprivation of liberty safeguards' nor 'liberty protection safeguards' are contained in legislation. They are in fact merely labels to describe a legal procedure. English law has always safeguarded the protection of liberty and the Mental Capacity Act 2005 already provides administrative and judicial liberty-protecting safeguards. You might say we already have "administrative LPS" (local authorities/ health boards safeguarding adults in hospitals and care homes) and "judicial LPS" (Court of Protection judges safeguarding young people and adults in any care setting).

There is no legislative reason therefore why DoLS 2.0 could not be renamed as "LPS". Potential confusion could be addressed by updating the Code of Practice. After all, the work has already been done to improve the MCA-core content in the draft version. There is already a DoLS Code which, to reflect "administrative LPS", can at the touch of the CONTROL + H button easily replace 'deprivation of liberty' with 'liberty protection'. And it would not be that difficult to add new chapters for "judicial LPS". Given how much time and effort everyone has put into LPS, the least the government could do in this Parliament is to update the Codes of Practice.

(ii) Supply the demand

DoLS was not designed for the level of demand for legal safeguards that exploded onto its scene after the *Cheshire West* decision in 2014. In justified desperation, people will rightly call for more resources to try to make it work. We need more assessors, more authorisers, more advocates, more monitors of authorisation conditions (worth having if you have none), and more COP judges to reduce delays with COPDOL11 applications. But what other enhancements could also be made to help meet the demand?

Broadly speaking, there tends to be three types of case where liberty-protecting safeguards are required: 'the classic', 'the unhappy', and 'the stable'. The classic cases are where someone is being confined somewhere they really should not even be (e.g. in a care home rather at home with a care package). The unhappy are those situations where the person is in the 'right' type of place but changes to the arrangements are

[1] Alex has also recorded a presentation about what to do now.

needed to make them happier. And the stable are those in the 'right' place with the 'right' arrangements but technically confined because "a gilded cage is still a cage".

With limited resources to supply the demand, the overriding objective in this DoLS 2.0 world we now face is, with a side-eye to the Court of Protection Rules, how to deal with all three cases justly and at proportionate cost, having regard to the MCA principles. Dealing with a case justly and at proportionate cost could be said to include, so far as is practicable:

(a) ensuring that it is dealt with expeditiously and fairly;

(b) ensuring that P's interests and position are properly considered;

(c) dealing with the case in ways which are proportionate to the nature, importance and complexity of the issues;

(d) ensuring that those involved are on an equal footing;

(e) saving expense;

(f) allotting to it an appropriate share of the supervisory body/Court of Protection resources, while taking account of the need to allot resources to other cases; and

(g) monitoring compliance with authorisation conditions, and reviewing recommendations.

After all, what is sauce for the Court of Protection goose is sauce for the supervisory body gander. For they both have the same responsibility to safeguard the protection of liberty, just in different care settings.

So what changes could be made to fulfil this new overriding objective of "administrative LPS"? The first is having the confidence to rely on good existing evidence for new authorisations. According to MCA Sch A1 para 49, an existing assessment carried out within the last 12 months can be re-used as an 'equivalent assessment' if there is no reason why it may no longer be accurate. If I had dementia last time, chances are I still have it. If this was a care home last time, we do not need a medic to confirm that this is still a care home. Indeed, there is no need to reassess any of the six DoLS criteria (so-called 'qualifying requirements') if there is an accurate existing assessment.

Being able to identify when existing evidence can be relied upon for the next authorisation may be an art, but the current legislative option to do so provides a way to avoid unnecessary cost and ensure appropriate cases are dealt with expeditiously and fairly. This would certainly reduce the need for mental health assessors and no doubt an ADASS Form 4B could be created (if Lorraine Currie has not already written one!) to capture this to run alongside the existing Form 3B. And for those supervisory bodies that do not already use Form 3B, they may now well wish to consider doing so.

(iii) Improve the forms

Speaking of forms, those used for "administrative LPS" in the new DoLS 2.0 world can no doubt be speedily simplified and updated to reflect best practice and case law developments. And some thought could be given to the authorisation itself. In times gone by, only the most senior judges (Tier 3) dealt with judicial LPS cases. Nowadays, any nominated Court of Protection judge can do so and whether a case is scrutinised by a Tier 1, 2 or 3 judge depends upon the complexity of the issues. Conversely, most supervisory bodies no doubt still use some of their most senior staff to scrutinise assessments which can cause delay. Senior staff may still be justified for the 'classic' cases,

but may not necessarily be for the 'unhappy' and 'stable' ones.

(iv) Expand the authorisers

There is nothing in law that determines who undertakes this role. Indeed, the role is not even mentioned in Schedule A1. It is the 'supervisory body' that gives a standard authorisation and it decides who does so. Clearly, they need to know their stuff to provide an appropriate level of scrutiny, and have a degree of independent thinking to reduce the risk of bias or conflict of interest. But no more than that. Advanced practitioners or best interests assessors, for example, could undertake the role. Not, of course, in relation to their own assessments but in those situations where they are able to think and act independently of the assessor.

(v) Embed periodic reviews

Changes could also be made to the standard authorisation without any legislative amendments. Its length (up to a 12-month maximum) is determined by the person's best interests. Rather than giving a shorter authorisation to ensure a BIA gets back on the scene, a longer authorisation could be given but with robust interim review arrangements. Authorisation conditions could, for example, require the managing authority to carry out a programme of care planning reviews, with recommendations targeted at the relevant health/social care professionals.

Effective monitoring of such conditions would provide the supervisory body/BIAs with greater confidence to go longer with the safeguards. Recommendations also need to be better communicated and checked because they can make a real difference. Fundamentally, a BIA may have more confidence to go long if the supervisory body's duty to monitor conditions is working effectively, there are interim reviews required, coupled with an efficient Part 8 review process to enable representatives to flag up 'problem cases' requiring attention. Such an efficient and effective use of resources could provide more people with enhanced safeguards and reduce the need for legal proceedings. All these measures are already provided for; they just are not being used.

(vi) (Avoid?) advance consent

Finally, there is much learning from the draft Code of Practice that we can apply to "administrative LPS". Whether anyone will attempt to stretch the concept of advance consent to avoid Article 5 safeguards altogethzr remains to be seen. Only a capacitous forward-thinking care home resident or mental health patient and a test case would determine whether that is actually lawful.

(vii) Empower

Most people subject to DoLS we anticipate do not choose their own representative but should be better empowered to do so where possible. The draft Code suggests that the relevant information for this decision includes, but is not limited to:

- What a deprivation of liberty means and the impact on the person;
- The role of the RPR and what is expected from the individual who undertakes the role;
- How to carry out the role, such as meeting the person regularly and challenging decision makers;
- RPR's rights for support, including from an IMCA; and
- Information on the person and RPR's rights to challenge an authorisation and how to challenge.

This is certainly too demanding and more thought needs to be given to the salient details for this relatively simple decision. More people can no doubt be better-enabled to choose their own representative. And a renewed effort should be made to improve the giving of accessible information to people about their rights and safeguards.

(viii) Consider MHA 1983 s.17(3)

A little niche, but for those liable to be detained under the Mental Health Act 1983, the draft at paragraph 22.80 highlighted how the responsible clinician "should consider first whether it is possible for that deprivation of liberty to be authorised through the use of section 17(3)". Even had LPS been implemented, the interface with the MHA would have remained. But greater clarity like this on these sorts of issues could help now.

(ix) Acute hospitals

The same is particularly true in relation to acute hospitals where a significant demand for safeguards is made in circumstances where the patient is discharged before any assessors reach the scene. The current DoLS Code importantly states (emphasis added):

> *6.3 However, an urgent authorisation should not be used where there is no expectation that a standard deprivation of liberty authorisation will be needed.*
>
> *Where, for example:*
> - *a person who lacks capacity to make decisions about their care and treatment has developed a mental disorder as a result of a physical illness, and*
> - *the physical illness requires treatment in hospital in circumstances that amount to a deprivation of liberty, and*
> - *the treatment of that physical illness is expected to lead to rapid resolution of the mental disorder such that a standard deprivation of liberty authorisation would not be required,*
>
> *it would not be appropriate to give an urgent authorisation simply to legitimise the short-term deprivation of liberty.*
>
> *6.4 Similarly, an urgent deprivation of liberty authorisation should not be given when a person is, for example, in an accident and emergency unit or a care home, and it is anticipated that within a matter of a few hours or a few days the person will no longer be in that environment.*

Perhaps a significant number of patients in these acute physical ill-health scenarios are unlikely to be deprived of their liberty because of the *Ferreira* decision, which the draft Code describes as follows (emphasis added):

> *Medical treatment for physical health problems*
>
> *12.77 A deprivation of liberty will not occur if the person is treated for a physical illness and the treatment is given under arrangements that are the same as would have been in place for a person who did not have a mental disorder. In other words, the restrictions on the person are caused by physical health problems and the treatment being provided. The root cause of any loss of liberty is the physical condition, not any restrictions imposed by others (for instance health and care professionals). This approach should be applied to any form of medical treatment for physical health problems and in whatever setting the treatment is being delivered. It should not be limited to hospital settings, but could include*

> *any setting where medical treatment is being provided."*

One can well understand why acute hospitals are routinely triggering urgent authorisations to avoid the risk of legal liability. But if staff can develop the confidence to distinguish 'a *Ferreira*' (no safeguards required) from a 'DOL' (safeguards required), [2] that would avoid unnecessary requests being made.

The way forward

In conclusion, LPS-not-to-be would have provided more people with watered down safeguards whereas the LPS-as-is (aka DoLS 2.0) provides better safeguards but the challenge is enabling more people to secure them. They provide statutory time limits to prevent arbitrary detention. Everyone is entitled to an independent periodic check, whether from a BIA or a judge. The focus now should be on how best to deal with the demand justly and at proportionate cost. We should take our steer from the factors in the Court of Protection Rules and better enhance the use of current resources, whilst justifiably demanding more from the change in government priorities.

A capacity masterclass from MacDonald J (and an updated capacity guide from us)

North Bristol NHS Trust v R [2023] EWCOP 5 (MacDonald J)

Mental capacity – assessing capacity

Summary[3]

In 2015, in *Kings College Hospital NHS Foundation Trust v C and V* [2015] EWCOP 80, MacDonald J provided both the then-authoritative summary of the principles to apply in assessing capacity, and a masterclass in the application of those principles to a complex case. In *North Bristol NHS Trust v R* [2023] EWCOP 5, MacDonald J has updated his authoritative summary to take account of the Supreme Court decision in *A Local Authority v JB* [2021] UKSC 52, and again provided a masterclass in the application of those principles.

The case concerned the question of the capacity and (if she lacked capacity in the relevant domains) the best interests of a woman as regards her birth arrangements. The woman, R, was a serving prisoner; she was a failed asylum contact and wished no contact with her mother who was understood to be present in England. She had had two previous children, both of whom had been removed from her care, one to adoption and one to placement with her mother. Little was known about the circumstances of her current pregnancy. She had had continued deterioration in the growth of her baby, and a number of other complications, which the clinicians involved considered meant that only a Caesarean section was consistent with recommended safe obstetric practice in this case. R had not said that she did not want a Caesarean section, but the clinicians were concerned as to whether she had capacity to make the decision. One doctor, a Doctor Q, considered that she had capacity to make decisions about her birth arrangements; none of the other clinicians considered this to be so. However, as MacDonald J observed at paragraph 44:

> [...] *a difficulty in this case has been in identifying whether R is suffering from*

[2] See in this regard, the 'Midnight Law' one-pager from the Faculty of Intensive Care Medicine on deprivation of liberty in intensive care.

[3] Note, we have also reported this case in 'headnoted' fashion in the first issue of the 39 Essex Chambers Mental Capacity Case Report series, available here.

an impairment of, or a disturbance, in the functioning of the mind or brain. In particular, in circumstances where those who have assessed R are (with the possible exception of Dr Q) agreed that her presentation suggests that the functioning of her mind is impaired, but where they have not been able to arrive at any formal diagnosis for a presentation variously described as "unusual" and "baffling", this case has given rise to the question of whether a formal diagnosis in respect of R is necessary in order for the terms of s.2(1) of the 2005 Act to be satisfied.

As MacDonald J had set out in the *C* case, but which usefully bear reproducing here, the 'cardinal principles' that must be followed are that

i) A person must be assumed to have capacity unless it is established that they lack capacity (Mental Capacity Act 2005 s. 1(2)). The burden of proof lies on the person or body asserting a lack of capacity, in this case the Trust, and the standard of proof is the balance of probabilities (Mental Capacity Act 2005 s. 2(4) and see KK v STC and Others [2012] EWHC 2136 (COP) at [18]);[4]

ii) Determination of capacity under Part I of the Mental Capacity Act 2005 is always 'decision specific' having regard to the clear structure provided by ss 1 to 3 of the Act (see PC v City of York Council [2014] 2 WLR 1 at [35]). Thus, capacity is required to be assessed in relation to the specific decision at the time the decision needs to be made and not to a person's capacity to make decisions generally;

iii) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success (Mental Capacity Act 2005 s. 1(3));

iv) A person is not to be treated as unable to make a decision merely because he or she makes a decision that is unwise (see Heart of England NHS Foundation Trust v JB [2014] EWHC 342 (COP) at [7]). The outcome of the decision made is not relevant to the question of whether the person taking the decision has capacity for the purposes of the Mental Capacity Act 2005 (see R v Cooper [2009] 1 WLR 1786 at [13] and York City Council v C [2014] 2 WLR 1 at [53] and [54]);[5]

v) Pursuant to s. 2(1) of the 2005 Act a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain. It does not matter whether the impairment or disturbance in the functioning of the mind or brain is permanent or temporary (Mental Capacity Act 2005 s. 2(2)). It is important to note that the question for the court is not whether the person's ability to take the decision is impaired by the impairment of, or disturbance in the functioning of, the mind or brain but rather whether the person is rendered unable to make the decision by reason thereof (see Re SB (A Patient: Capacity to Consent to Termination) [2013] EWHC 1417 (COP) at [38]);

vi) Pursuant to s. 3(1) of the 2005 Act a person is "unable to make a decision for himself" for the purposes of s.2(1) of

[4] Note that the standard of proof strictly applies only in the court setting. Outside the court setting, in the context of care and treatment, the question is whether there is a reasonable belief that the person lacks capacity to make the decision (s.5).

[5] Although, as the *Royal Bank of Scotland case* makes clear, that does not mean that the fact that the proposed decision appears unwise is irrelevant – it is a trigger to consider whether the person has capacity to make it:

> *the Act if he is unable (a) to understand the information relevant to decision, (b) to retain that information, (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate his decision whether by talking, using sign language or any other means.*
>
> *vii) An inability to undertake any one of these four aspects of the decision making process set out in s 3(1) of the 2005 Act will be sufficient for a finding of incapacity provided the inability is because of an impairment of, or a disturbance in the functioning of, the mind or brain (see RT and LT v A Local Authority [2010] EWHC 1910 (Fam) at [40]). For a person to be found to lack capacity there must be a causal connection between being unable to make a decision by reason of one or more of the functional elements set out in s. 3(1) of the Act and the diagnostic element of 'impairment of, or a disturbance in the functioning of, the mind or brain' required by s. 2(1) of the Act, i.e. for a person to lack capacity the former must result from the latter (York City Council v C [2014] 2 WLR 1 at [58] and [59]);*
>
> *viii) The information relevant to the decision includes information about the reasonably foreseeable consequences of deciding one way or another (Mental Capacity Act 2005 s. 3(4)(a));*
>
> *ix) The threshold for demonstrating capacity is not an unduly high one (see CC v KK & STCC [2012] EWHC 2136 (COP) at [69]).*

In the *North Bristol* case, MacDonald J noted (at paragraph 43) that:

> *The foregoing authorities now fall to be read in light of the judgment of the Supreme Court in A Local Authority v JB [2022] AC 1322. The Supreme Court held that in order to determine whether a person lacks capacity in relation to "a matter" for the purposes of s. 2(1) of the Mental Capacity Act 2005, the court must first identify the correct formulation of "the matter" in respect of which it is required to evaluate whether P is unable to make a decision. Once the correct formulation of "the matter" has been arrived at, it is then that the court moves to identify the "information relevant to the decision" under section 3(1) of the 2005 Act. That latter task falls, as recognised by Cobb J in Re DD, to be undertaken on the specific facts of the case. Once the information relevant to the decision has been identified, the question for the court is whether P is unable to make a decision in relation to the matter and, if so, whether that inability is because of an impairment of, or a disturbance, in the functioning of the mind or brain.*

Applying these broad principles, MacDonald J turned to the specific question before him, identifying (at paragraph 57) that there were four questions he had to address:

> *First, what is the "matter", i.e. what is the decision that R has to make. Second, what is the information relevant to that decision. Third, is R unable to make a decision on the matter. Fourth, if R is unable to make a decision on the matter, is that inability caused by a disturbance in the functioning of her mind or brain.*

As to the first question, MacDonald J considered as being too broad the formulation advanced by the Official Solicitor, namely "whether to carry her baby to the point of natural childbirth or to have the baby delivered earlier and, if so, whether to do so by induction or Caesarean section." This was because:

> *59. In this context, in circumstances where R has had continual deterioration*

> *in growth of her baby from 28 weeks and that her abdominal circumference now well below the 5th centile, indicating a growth restricted, oligohydramniotic pregnancy, **the decision R is being asked to make is whether or not to undergo the procedure clinically indicated in those circumstances.** This does not mean that the option of carrying the baby to term followed by labour either induced or natural is irrelevant. But in light of the fact that R's treating team can now offer for decision only one clinically safe course, it is relevant as information to be retained, understood, weighed or used when deciding the matter, rather than as part of the proper formulation of the matter to be decided.* (emphasis added)

Turning then to the relevant information, MacDonald J reminded himself that the task had to be undertaken by reference to the specific facts of this case because:

> 61. Human decision making is not standardised and formulaic in nature in that we do not, at least consciously, break a decision down carefully into discrete component parts before taking that decision. In addition, decisions are always taken in a context, with the concomitant potential for a myriad of other factors, beyond the core elements of the decision, to influence the decision being taken. This has the potential to make the task of creating a definitive account of the information relevant to a particular decision a challenging one. This difficulty can be addressed however, by acknowledging that in order to demonstrate capacity, a person is not required or expected to consider every last piece of information in order to make a decision about the matter, but rather to have the broad, general understanding of the kind that is expected from the population at large (see Heart of England NHS Foundation Trust v JB [2014] EWHC 342 (COP) at [25]). Within this context, the Mental Capacity Act Code of Practice at [4.16] states relevant information includes "the nature of the decision", "the reason why the decision is needed" and "the likely effects of deciding one way or another, or making no decision at all".

In the particular circumstances of R's case, this meant that:

> 62. […] *the information relevant to the decision on the matter in this case can usefully be derived from the questions that might reasonably be anticipated upon a member of the population at large being told that their doctor is recommending an elective Caesarean section and being asked whether or not they consent to that course. Namely, why do you want to do a Caesarean section, what are the alternatives, what will happen when it is done, is it safe for me, is it safe for my unborn child, how long will I take to recover and what will happen if I decide not to do it. Within this context, I am satisfied information relevant to the matter requiring decision by R in this case can be articulated as follows:*
>
> > *i) The reason why an elective Caesarean section is being proposed, including that it is the clinically recommended option in R's circumstances.*
> > *ii) What the procedure for an elective Caesarean involves, including where it will be performed and by whom; its duration, the extent of the incision; the levels of discomfort during and after the procedure; the availability of, effectiveness of and risks of anaesthesia and pain relief; and the length and completeness of recovery.*

> *iii) The benefits and risks (including the risk of complications arising out of the procedure) to R of an elective Caesarean section.*
> *iv) The benefits and risks to R's unborn child of an elective Caesarean section.*
> *v) The benefits and risks to R of choosing instead to carry the baby to term followed by natural or induced labour.*
> *vi) The benefits and risks to R's unborn baby of carrying the baby to term followed by natural or induced labour.*

At paragraph 63, MacDonald J made clear that in relation to (iv) that R's child had no separate legal identity until born, but that:

> *that legal position does not prevent the impact on the unborn child of taking or not taking a decision being information relevant to the matter requiring decision. Indeed, I consider it a safe assumption that one of the foremost pieces of information a pregnant woman would consider relevant in deciding whether to undergo any medical procedure during pregnancy is that of the potential impact on her unborn child. On the evidence of Dr Jobson, in this case R has shown some preference for having a live, healthy baby, as inferred from her showing occasional interest in the baby by asking for scan photos, wanting baby clothes and speaking about going to see the baby from time to time.*

As to the third question, on the evidence before him, MacDonald J identified, first that:

> *65. There is some difficulty in this case in establishing the extent to which the relevant information was conveyed to R. This stems from the relative brevity of each of the documents recording the outcome of the various capacity assessments that have been undertaken on R. During the course of her oral evidence, Dr Zacharia noted, "we are not good at writing capacity verbatim" and that, especially where professionals differ, it would be very helpful to have more detail.*

MacDonald J made it clear that he agreed with those sentiments, and in a passage of broader application, continued:

> *Given the number of capacity assessments that are required to be carried out on a daily basis in multiple arenas, it would obviously be too onerous to require a highly detailed analysis in the document in which the capacity decision is recorded. However, a careful and succinct account of the formulation of the matter to be decided and the formulation of the relevant information in respect of that matter, together with a careful and concise account of how the relevant information was conveyed and with what result, would seem to me to be the minimum that is required.*

On the evidence before him, MacDonald J found that:

> *68.* […] *Whilst on occasion R may be able to understand in a limited way the information conveyed to her regarding the matter on which a decision is required (as demonstrated, for example, by R being able to verbalise to Dr Jobson that a Caesarean section is cutting open her tummy to deliver the baby), she is unable to retain that information for long enough to be able to use or weigh the information and communicate a decision and, in the circumstances, is unable to make a decision about whether or not her baby should be delivered pre-term by elective Caesarean section.*

As to the fourth question, the Official Solicitor had initially argued that, in identifying the impairment of the functioning of the mind or brain under s.2(1), the court must identify the underlying condition. This was position was moderated in argument, but MacDonald J helpfully set out why a formal diagnosis is not required:

> *46. In A Local Authority v JB at [65], the Supreme Court described s.2(1) as the core determinative provision within the statutory scheme for the assessment of whether P lacks capacity. The remaining provisions of ss 2 and 3, including the specific decision making elements within the decision making process described by s.3(1), were characterised as statutory descriptions and explanations in support of the core provision in s.2(1), which requires any inability to make a decision in relation to the matter to be because of an impairment of, or a disturbance in the functioning of, the mind or brain. Within this context, the Supreme Court noted that s.2(1) constitutes the single test for capacity, albeit that the test falls to be interpreted by applying the more detailed provisions around it in ss 2 and 3 of the Act. Again, once the matter has been formulated and the information relevant to the decision identified, the question for the court is whether P is unable to make a decision in relation to the matter and, if so, whether that inability is because of an impairment of, or a disturbance, in the functioning of the mind or brain.*
>
> *47. Once the case is before the court, the overall assessment of capacity under the single test is a matter for the judgment of the court (see Re SB (A Patient: Capacity to Consent to Termination) [2013] EWHC 1417 (COP) at [38]). In this context, the question of whether any inability of R to make a decision in relation to the matter in issue is because of an impairment of, or a disturbance in, the functioning of the mind or brain is a question of fact for the court to answer based on the evidence before it. In this context, the wording of s.2(1) itself does not require a formal diagnosis before the court can be satisfied that whether any inability of R to make a decision in relation to the matter in issue is because of an impairment of, or a disturbance, in the functioning of the mind or brain. The words "impairment of, or a disturbance in" are not further defined elsewhere in the Act. In these circumstances, there is no basis for interpreting the statutory language as requiring the words "impairment of, or disturbance in" to be tied to a specific diagnosis. Indeed, it would be undesirable to do so. To introduce such a requirement would constrain the application of the Act to an undesirable degree, having regard to the complexity of the mind and brain, to the range of factors that may act to impair their functioning and, most importantly, to the intricacies of the causal nexus between a lack of ability to take a decision and the impairment in question. In PC v City of York Council McFarlane LJ (as he then was) cautioned against using s.2(1) as a means "simply to collect the mental health element" of the test for capacity and thereby risk a loss or prominence of the requirement of a causative nexus created by the words "because of" in s.2(1). Reading s.2(1) as requiring a formal diagnosis would in my judgment significantly increase that risk.*

> *48. In the foregoing circumstances, a formal diagnosis may constitute powerful evidence informing the answer to the second cardinal element of the single test of capacity, namely whether any inability of R to make a decision in relation to the matter in issue is because of an impairment of, or a disturbance, in the functioning of the mind or brain. However, I am satisfied that the court is not precluded from reaching a conclusion on that question in the absence of a formal diagnosis or, to address Mr Lawson's original proposition, in the absence of the court being able to formulate precisely the underlying condition or conditions. The question for the court remains whether, on the evidence available to it, the inability to make a decision in relation to the matter is because of an impairment of, or a disturbance in the functioning of, the mind or brain.*

MacDonald J accepted the evidence of the consultant psychiatrist involved that even though there had been no formal diagnosis, on the balance of probabilities, R had a learning disability, which amounted to an impairment that disabled R from being able to make a decision about whether or not her baby should be delivered pre-term by elective Caesarean section, by preventing her from retaining information long enough to use and weigh it to make a decision. He also noted the psychiatrist's evidence that "*in circumstances where is an element of dissociation due to past trauma, R may also be at times choosing not to retain the information*" (paragraph 71, the word 'choosing' being an interesting one here).

As he had found that R lacked capacity to make the decision, MacDonald J had then to consider what course of action was in her best interests. As with considerations of capacity, and in line with previous case-law he found that the impact on R of any adverse impact on the unborn child of taking or not taking the decision *was* a legitimate factor to be taken into account when assessing R's best interests (paragraph 79). On the evidence before him, and:

> *81.* […] *Given what I am satisfied is the would be the extremely traumatic experience for R of having to give birth to a dead child should the appreciable risk of the baby dying before natural or induced labour can occur become manifest, I am satisfied on balance that an elective Caesarean section is in R's best interests.*
>
> *82. I am further reinforced in my view that an elective Caesarean is in R's best interests by the, albeit limited, views she has expressed in respect of the same. Whilst I am satisfied that R does not have capacity to consent to an elective Caesarean section, it is relevant that she has never expressed an objection to such a procedure when it has been discussed with her. Lack of objection is not assent. However, I consider that this is nonetheless a further factor providing support for the court's conclusion as to best interests. As does the preference R has shown, on occasion for giving birth to a live, healthy baby.*

MacDonald J concluded by observing that:

> *84. As I have had cause to observe in another urgent case of this nature that came before me in the week I dealt with this matter, for the court to authorise a planned Caesarean section is a very serious interference in a woman's personal autonomy and Art 8 rights. As the Vice President noted in in Guys and St Thomas NHS Foundation Trust & Anor v R, Caesarean sections present particular challenges in circumstances where both the inviolability of a woman's*

> *body and her right to take decisions relating to her unborn child are facets of her fundamental freedoms. Against, this Parliament has conferred a jurisdiction on this court to authorise medical treatment where a person lacks capacity to decide whether to undergo that medical treatment and where the medical treatment is in the person's best interests. I am satisfied it is appropriate to exercise that jurisdiction in this case, for the reasons I have given.*

A postscript to the judgment confirmed that R had undergone an elective Caesarean section in accordance with the care plan, which proceeded smoothly. R's baby was born in good condition and was doing well for his gestation.

Comment

We have set out the reasoning of MacDonald J in some detail in relation to the elaboration of the capacity test as it applied to R because it shows (1) both the rigour of the steps required in a complex case; and (2) the consequent transparency of the decision reached. Whether or not one agrees with the outcome, it is entirely clear what MacDonald J considered to be the matter in question, what the information was that was relevant to that decision; how he reached the conclusion that R could not retain or use and weigh the information, and how that inability was caused by an impairment or disturbance in the functioning in her mind or brain. It is therefore precisely the sort of transparent and accountable, and therefore defensible, decision that we would suggest meets the demands of the CRPD (see further in this regard this article).

One point that is brought out by the transparency of the decision is that is possible and interesting to compare MacDonald J's list of relevant information with that set out in the Royal College of Gynaecologists and Obstetricians' August 2022 Planned Caesarean Birth consent guidance. The latter is said to be used for women over the age of 16 with mental capacity (and people under 16 years who are Gillick competent). MacDonald J's list was draw up for purposes of deciding whether or not R had capacity. There are strong similarities, but not a direct overlap. This may be a function of the fact that the guidance was not before MacDonald J (there is no reference to it in the judgment), but it would have been interesting to see whether MacDonald J considered that the requirements of the RCOG guidance meshed with his own analysis of the position. It is certainly the case that, more broadly, there may be an insufficiently recognised tension between supporting people to make decisions for purposes of the MCA (which pushes towards a minimalist approach to the relevant information), and complying with the requirements of securing informed consent for purposes of the law of negligence (which pushes towards a maximalist approach).

MacDonald J's clear confirmation that a formal diagnosis is not required in order to reach a conclusion that a person lacks capacity to make a decision is helpfully crisp, as are his observations about the minimum requirements for recording assessments. We have updated our guidance note on assessing and recording capacity accordingly to reflect them (as well as to make a few other updates required by the passage of time since the last update).

Fluctuating capacity – making rights real and practical, not theoretical and illusory

A Local Authority v PG & Ors [2023] EWCOP 9 (Lieven J)

Mental capacity – assessing capacity

Summary[6]

This decision provides a very clear and helpful route map through the complexities of fluctuating capacity. The case concerned a 34 year old woman, PG, who had diagnoses of an intellectual disability in the moderate range, and autism spectrum disorder. She had also recently been diagnosed as having "trauma based mental illness with Emotionally Unstable Personality Disorder traits" (impulsivity, suicidal thoughts and emotional instability). As Lieven J noted (paragraph 4):

> *The parties agree that PG lacks capacity in the following respects – to conduct these proceedings and to enter into an occupancy agreement. The parties agree that she has capacity to make decisions about where she lives. However, the parties disagree about whether PG has capacity in respect of decisions about her care, including when she is within the home, when in the community, and at times of heightened anxiety. They also disagree as to whether she has capacity as to contact with others, including at times of heightened anxiety.*

Having set out a condensed list of the circumstances which gave rise to the concern of PG's local authority, Lieven J turned to the evidence of Dr Jordan King, Highly Specialist Clinical Psychologist at the Intensive Support Team of the Adult Neurodevelopmental Services for the relevant NHS Trust, was involved in PG's care between 2018 and the middle of 2022. He gave oral evidence to the Court and was cross examined. As Lieven J noted (paragraph 19):

> *It was clear from his evidence that this is a complex case in respect of PG's capacity and that the law's desire for clear lines as to both what decisions she does and does not have capacity to make, and in what circumstances she loses capacity, does not fit with the reality of PG's presentation. It might be said there was a lack of clarity in Dr King's reports, and perhaps shifts in his oral evidence. However, in my view that was not because of any lack of expertise or careful consideration by Dr King, but rather because of the complex interactions in PG's presentation and behaviours.*

Of significance, Lieven J continued:

> *It is important to note that Dr King had seen PG at times when she was in a heightened state, after some of the incidents referred to above. Therefore, his evidence was more based on actual observations of PG at critical moments, than is often the case with experts in these cases.*

Lieven J noted (at paragraph 30) that:

> *the Court of Protection has frequently had to consider the position of a person who has "fluctuating capacity" and such cases have been treated somewhat differently.*

In the circumstances, she found that:

> *36. I am really faced with a choice between making orders that follow the line of Sir Mark Hedley in PWK, and thus taking a "longitudinal view" of PG's presentation, and which closely relates to Newton J's "macro" decisions [in CDM]; or that of Cobb J in DN and making anticipatory declarations in respect of when PG has the equivalent of a "meltdown". Having analysed the*

[6] Note, we have also reported this case in 'headnoted' fashion in the first issue of the 39 Essex Chambers Mental Capacity Case Report series, available here.

> *facts of those cases, and considered those of PG, I do not think that one or other is the correct or indeed better approach. How an individual P's capacity is analysed will turn on their presentation, and how the loss of capacity arises and manifests itself. Both the decisions in issue here are ones that arise on a regular basis and often not in planned or controlled situations. That will influence how decisions about capacity are approached.*

Importantly, Lieven J reminded herself that:

> *37. In deciding this issue I must have regard to the importance of making orders that are workable and reflect the reality of PG's "lived experience", both for the sake of PG and those caring for her. This can be analysed in various difference ways. It is a fundamental principle of the European Convention on Human Rights and the Strasbourg jurisprudence that the Rights should be interpreted in a way which makes them real and practical, not theoretical and illusory. It is a principle of statutory construction that the Court must have regard to the "mischief" of the statute. One of the mischiefs of the MCA is to seek to preserve an individual's autonomy, but in a way that ensures that when they do not have capacity, their best interests are protected.*
>
> *38. My concern about making an anticipatory declaration in a case such as this, is that it would in practice be unworkable for those caring for PG. Unlike DN, PG does not have capacity in relation to decisions around her care, both when at home and in the community. Although when calm, she does at times make capacitous decisions within the meaning of section 3(1), I accept Dr King's evidence that even when at home, when she becomes anxious and emotionally dysregulated, she loses capacity. This seems to me to be a more fundamental part of her general presentation than was the case with DN.*

Whilst Lieven J noted that, it might well be that there were times when PG's decision making was impacted by alcohol consumption, "*the evidence is clear that her decision making is impacted by her mental impairment under s.2(1) and not simply by consuming excessive alcohol*." Further:

> *41. It is not possible to disentangle the influence of alcohol from the impact of her mental impairment. If the evidence was that PG only lacked capacity at times when she is intoxicated then the position would be different, but that is not the evidence.*[7] *No party argued that the mental impairment has to be the sole cause for the person being unable to make a decision within the meaning of s.3(1).*
>
> *42. On the basis of Dr King's evidence, I conclude that the primary, though quite possibly not only reason, for PG not having capacity in relation to decisions about contact with others is her mental impairment.*

Lieven J therefore considered that the

[7] As a matter of law, a person can lack capacity for purposes of the MCA where alcohol has sufficiently impaired the functioning of their mind or brain (see paragraph 4.12 of the Code of Practice). However, a whole series of complexities would ensue in terms of seeking to establish a framework around someone with no apparent impairment, but who lacked capacity to make decisions about contact when intoxicated: not least, that such a framework could logically apply to anyone who might ever drink alcohol. In relation to addressing alcohol dependence, which raises distinct, and very difficult questions, see this guidance from Alcohol Change, and for a discussion about alcohol related brain damage and capacity, see this shedinar.

> *43. […] the appropriate approach is to take the "longitudinal view". An anticipatory order would in practice be close to impossible for care workers to operate and would relate poorly to how her capacity fluctuates. The care workers would have to exercise a complicated decision making process in order to decide whether at any individual moment PG did or did not have capacity. This might well vary depending on the individual care worker, and how much of the particular episode they had witnessed or not. The result would fail to protect her, probably have minimal benefit in protecting her autonomy and in practice make the law unworkable.*
>
> *44. In my view, the more practical and realistic approach is to make a declaration that PG lacks capacity in the two key respects, but also make clear that when being helped by the care workers they should so far as possible protect her autonomy and interfere to the minimum degree necessary to keep her safe.*

Comment

Lieven J's observation that whatever orders she had made had to be workable, not just as a matter of pragmatism, but also so as actually satisfy the ECHR, is an important one. Further, her identification of the difficulties with making anticipatory declarations in PG's case resonates with the wider difficulty of seeking such anticipatory declarations, which in practice are only really workable if they relate to (1) a very obvious one-off, for instance giving birth; or (2) a situation where there are very clear, and obvious, external triggers for a person temporarily losing capacity to make a relevant decision. It is important to remember, however, that this is a difficulty solely for the court, which is fixed with the obligation to determine, at the point of making its decision, whether the person has or lacks the relevant capacity and – if possible – whether there are specific and identifiable circumstances under which they may do so. Outside the courtroom setting, the question is always whether those concerned with carrying out acts in connection with care and treatment reasonably believe that the person lacks capacity to give the relevant consent at the point that consent is required. In this regard, the guidance note we have done about fluctuating capacity in context may be of assistance (and also contains consistent and complementary observations about the operation of the ECHR to those contained in the current judgment).

Lieven J's emphasis on the importance of care workers protecting the autonomy of PG was an important ethical corollary to her willingness to declare PG to lack capacity in the relevant domains, and must always be remembered in any case where workably securing the person's interests may push towards a more 'longitudinal' approach to capacity. It also equally, if not more, important to remember that such situations are ones crying out for working with the individual to help them set out what they would like (or would not like) at points when they may in fact lack capacity.

Grasping the nettle of the interface

Manchester University Hospital NHS Foundation Trust v JS and Manchester City Council [2023] EWCOP 12 (HHJ Burrows, sitting also as a s.9 judge)

Mental Health Act 1983 – interface with MCA

This case concerned ineligibility for detention under the Mental Capacity Act under Schedule 1A MCA, and, in particular, the extent to which the court is bound to accept conclusions of the professionals involved.

The case related to a 17-year-old referred to the judgment as 'Jane' or 'JS,' who was represented by her mother, MS, as litigation friend. JS had

diagnoses of autistic spectrum disorder, attention deficit hyperactivity disorder, a learning disability and an attachment disorder. She complex mental health needs and was agreed by all parties to be a danger to herself, and vulnerable to harm from others. There was no immediately effective plan for her care in the community.

In December 2022, JS was admitted a psychiatric inpatient in a specialist hospital for children and adolescents (the judgment records specifically that she had been admitted for the purposes of assessment and treatment of her mental disorders). She was assessed as having capacity to consent to an admission and was discharged home in January, but was quickly detained under s.136 MHA when she ran away from home and ran into traffic. She was assessed by the CAMHS gatekeeping service, but found not to be suitable for admission. She was again detained under s.136 a few days later after attempting suicide by overdose, followed by detention under s.2 MHA to a general adult acute (non-psychiatric) ward in a hospital to be treated for the physical consequences of the overdose.

Jane's s.2 MHA detention expired on 5 February, and while she had been physically fit for discharge for some time, she remained in hospital in the absence of any safe discharge destination. The court described the nature of Jane's care and treatment in hospital, which plainly amounted to a deprivation of liberty:

> 15. *A flavour of Jane's care and treatment at J6 is given in the statements and notes I read. According to one statement, there were many incidents during the currency of her s. 2 detention where she absconded or attempted to abscond. She tried to self-harm on a number of occasions, including by the use of sharp objects, attempting to swallow batteries, and claiming to have swallowed screws. She tried to lock herself in a toilet in order to carry out these acts of self-harm.*
>
> 16. *In order to try to manage Jane, the Hospital put in place a "Care Plan of Restrictions" for her. I summarise those restrictions:*
>   *(1) Jane is not to leave the ward.*
>   *(2) She is to be subject to "1:1 supervision (with a minimum of 2:1 assessed as necessary and appropriate by the ward staff during periods of escalation)".*
>   *(3) She is to be supervised when in the bathroom at all times by her care support worker and the bathroom door must not be locked.*
>   *(4) Physical restraint and oral sedative medication* ***may*** *be used (as set out in the plan) if de-escalation techniques have been attempted but are unsuccessful.*
>   *(5) Jane's room is "reviewed" by the Nurse in charge at least twice daily on shift handover "to remove any risky objects that Jane could use to cause herself or others harm"*
>   *(6) Jane's cubicle may be subject to additional searches if necessary and proportionate if there is a risk that she may have retained items she could later use to harm herself.*

The records also detailed many 'incidents' in which Jane injured herself and others, and had to be restrained to prevent harm. HHJ Burrows noted that: "*it was anticipated on the expiry of MHA detention that the MCA would be used for exactly the same care plan, with exactly the same purpose namely to treat Jane's challenging and self-injurious behaviour, largely by physical containment and the use of restraint both by physical intervention and medication*" (paragraph 22) which included a number of psychotropic

medications. HHJ Burrows observed that "[i]t seems entirely obvious to me those treating Jane considered her behaviour to be a manifestation of her mental disorder. This pharmacological treatment was intended to combat it" (paragraph 23).

There was no lawful authorisation for Jane's detention in hospital after the expiration of the s.2 MHA authorisation. The Trust took the clear view that JS did not need to be in hospital, but did not propose that she should be discharged in the absence of any safe destination. There was no option for her to either move to a Tier 4 CAMHS bed or have a community placement, and the local authority was continuing to work on a package of care to support Jane's return home (which was facilitated on 27 February, but was unsuccessful and Jane returned to hospital by 2 March, following the contested hearing). The Trust made an application to authorise JS's deprivation of liberty in hospital under the MCA, having refused to detain her under s.3 Mental Health Act 1983 (though she was subsequently detained under s.2 MHA after her March readmission which followed the contested hearing, she was again found not to be detainable under s.3 MHA).

HHJ Burrows that he had been the one to raise the concern as to whether the Court of Protection had the authority to detain Jane if she ought to be detained under the MHA; he also sat simultaneously in the High Court to cover all avenues. He also authorised Jane's detention in hospital on an interim basis pending full consideration of the issues in the case.

HHJ Burrows readily accepted evidence that Jane lacked capacity to make decisions regarding her residence and care. Similarly, in relation to best interests, HHJ Burrows accepted (with more hesitancy) that remaining where she was, despite it not being anything resembling an optimal environment, was the best available option for Jane while a robust care package to facilitate Jane's return to her mother's care was developed (it was hoped within a short timeframe after the hearing). Jane's remaining in hospital was keeping her safe in the immediate short term, and it would not assist her to return home without a care package, which would very likely result in her return to hospital quickly (which ultimately occurred even though a care package was in place). The court noted the medical evidence that the doctor with responsibility for Jane's care "*was clear that he was not treating what is usually called the 'core condition' because such treatment was simply not available, but he was treating the manifestations of that condition, namely the behaviour outlined above in the incidents I have summarised*" (paragraph 42).

The crux of the court's judgment was in relation to whether Jane was ineligible for detention under Schedule 1A MCA, specifically under 'Case E', which applies where 'P is— (a) within the scope of the Mental Health Act, but (b) not subject to any of the mental health regimes.' (Paragraph 2 Schedule 1A MCA) The definition of 'within the scope of the Mental Health Act' is set out in paragraph 12 of Schedule 1A:

> *(1) P is within the scope of the Mental Health Act if-*
>
> *(a) an application in respect of P could be made under s.2 or s.3 of the Mental Health Act, and*
>
> *(b) P could be detained in a hospital in pursuance of such an application, were one made.*

After surveying the statutory provisions of both the MCA and MHA, HHJ Burrows proceeded on the basis that Jane could only be detained under s.3 MHA as she had very recently concluded a s.2

detention. In considering whether an application for detention under the MHA 'could' be made, HHJ Burrows made clear that "*the wording of the MCA places the Court in a similar position to the AMHP when determining whether P 'could' be detained*" (paragraph 65) as it is ultimately a question for the AMHP to make the application for admission if the medical recommendations are made. HHJ Burrows also observed that "[t]o *make the decision easier for the Court of Protection, or anyone else who has to decide, it is assumed for the purposes of Schedule 1A Para 1(12)(4) [MCA] that the medical recommendations for admission under s. 3(2) of the MHA have been made*" (paragraph 67). Finally, HHJ Burrows reminded himself of the definition of 'medical treatment' under s.145(4) MHA:

> *Any reference in this Act to medical treatment, in relation to mental disorder, shall be construed as a reference to medical treatment the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms of manifestations.*

HHJ Burrows considered that in this case it was:

> *69.* [...] *immediately clear that the care plan for Jane on the ward was for medical treatment in this broad sense. It consisted in care, namely providing her with a safe place with nursing care. The purpose of that care plan, including the use of restraint both physical and chemical was to ensure that Jane did not harm herself, or that she absconded away from the care setting in order to do so.*

HHJ Burrows agreed that the treatment was not optimal, but that:

> *71* [...] *in no meaningful sense could Jane's behaviours outlined above be described as anything other than manifestations of her mental disorder. Or put another way, Jane's mental disorder causes her to abscond from safe environments, such as her home or hospital. It causes her to place herself at great risk of danger. It causes her to injure herself using sharp objects or taking overdoses. She has done this with alarming regularity. Nothing that those responsible for her care have been able to do has prevented her from doing so. However, that is what they were trying to do, and their treatment was aimed at that.*

HHJ Burrows also noted that she was plainly objecting to being a mental health patient.

He went on to consider whether Jane 'could' have been detained under s.3 MHA. He considered that the issue was not simply whether the assessing professionals thought she could be detained under s.3, but whether the court, on the basis of the evidence before it, considered that she could. Considering *GJ v The Foundation Trust, a PCT & Secretary of State for Health* [2009] EWHC 2972 (Fam), HHJ Burrows reminded himself that Charles J had found that the MCA "*decision-maker should approach paragraph 12(1)(b) by asking himself whether in his view the criteria set by, or the grounds in, section 2 or section 3 of the 1983 Act are met (and if an application was made under them a hospital would detain P)*" (paragraph 80 of *GJ*). HHJ Burrows also noted that by the terms of Schedule 1A MCA, "*the decision-making process must be predicated on there being no available alternative under the MCA*" (paragraph 87).

HHJ Burrows found that Jane was within the scope of the MHA and found that she was ineligible for detention under the MCA. He summarised the reasons for his findings thus:

> *90. Firstly, that she was accommodated at the Hospital as a place of safety because there was nowhere else for her to go and, once the physical damage*

caused by her overdose was successfully treated, she needed no in patient medical treatment. The answer to that is: of course, she did. She was a danger to herself. She needed to be nursed safely and medicated to address the effects of her mental disorder (viz. to injure herself and abscond away for safety).

91. It was submitted that although Jane suffers from a mental disorder it was not of a nature or degree to make it appropriate for her to receive medical treatment for that disorder in a hospital. This is clearly wrong. The medical treatment she did receive as a detained patient in hospital was necessary to keep her safe and to prevent her from absconding or harming herself. There was no readily available alternative when she was receiving it.

92. It is submitted that the outcome of the MHA Assessments was that inpatient care for Jane's condition was neither available nor desirable because she could be treated in the community under the MCA. This too is plainly wrong. She could only be treated in the community once a suitable package of care was available for her. Until then she could not safely leave hospital. That was the situation with which I was confronted at the first hearing. At that point hospital was the only option.

93. This is quite a familiar situation for those who practise mental health law. Patients who have been detained under the MHA (like Jane) can theoretically be discharged into the community with a suitable package of care, but only when that package is actually available. Many weeks or months can be spent putting such packages together (funding, placement, support etc) and in place. During which time patients remain detained. The whole s. 117 process is designed to speed that up so as to ensure detained patients get out and stay out of hospital. Of course, because Jane was never detained under s. 3 of the MHA, s. 117 aftercare was not available to her.

94. The hospital thought that utilising the MHA to detain Jane would be harmful to her mental health, as would her remaining in Hospital. This is an invalid argument which contains two fallacies. First, she was detained by her care plan which I have summarised above. What jurisdictional label is placed on the care plan is immaterial to its restrictive nature, whether that be MHA, MCA, "common law", the High Court's inherent jurisdiction is irrelevant to whether she was detained for treatment. That was the care plan's doing.

95. Secondly, keeping her in Hospital for a day longer than was necessary was also nothing to do with the regime she was subject to. Good clinical practice and the operation of Article 5 of the European Convention requires a patient to be detained only for so long as is necessary. The MHA does not prolong detention. In fact, as I have already said, proper use of s. 117 should reduce the overall time a patient spends in Hospital because professionals inside and out of Hospital concerned with health and social care should all work together to put together an effective discharge plan speedily.

96. There seems to be a belief, not just in this case but in others in which I have heard recently, that the decision to use the MHA should be viewed in isolation from what is available elsewhere at the time the decision to detain or not detain is taken. Ideally, a 17-year-old vulnerable young person would not be detained in a psychiatric facility, let alone a mixed adult general ward. However, where there is literally no option in which that young person will be safe, or as safe as

> *possible in the circumstances, I cannot see how the MHA decision maker can avoid the decision I have had to make in this judgment. If the patient has to be detained for treatment for their mental disorder, and there is no alternative outside the hospital setting, and no other treatment plan available, then it seems clear to me the patient should not be detained under the MCA but rather under the MHA.*

HHJ Burrows also rejected submissions that he should authorise the detention in the inherent jurisdiction in the alternative, finding that the MCA and MHA provided a legal structure for her detention.

Comment

This judgment grabs the nettle of a notoriously difficult issue under the MCA. In our view, it is also entirely correct.

The question of whether a person is detainable under the Mental Health Act is not an absolute one, but one which turns at least in part on whether the person could receive necessary care for a mental disorder outside of hospital. There are many people who are detained under s.3 Mental Health Act primarily because there are not yet any adequate arrangements for their care in the community: they 'need' to remain in hospital because there is simply nowhere else for them to receive appropriate treatment. We would further note that there are many people detained under the MHA who are being treated for symptoms of their disorder by way of medication or mental health nursing, and that 'treatment' is necessary for their health and safety.

There was no argument before the court that at the time of the hearing, Jane would be either safe or appropriately cared for if she left hospital. While the hospital was more appropriately understood as the 'least worst' option, it was plain that all other options were quite significantly worse and Jane would be at serious risk of harm if she left. The care plan cannot be properly understood as anything other than one to treat symptoms of a mental disorder, and there was no proposal to change it. While the reasons the treating doctors refused to detain Jane are not entirely known, the court's logic as to why Jane could have been detained under the MHA is difficult to dispute. It is also very helpful that HHJ Burrows made clear that it is ultimately for the court to make the decision, rather than for the clinicians.

This judgment provides a thorough and welcome analysis which will likely be of assistance to other courts struggling with issues of Schedule 1A ineligibility.

Working through fluctuating capacity in the obstetric context

Wrightington, Wigan And Lee Teaching Hospitals NHS Foundation Trust v SM [2022] EWCOP 56 (Cobb J)

Mental capacity – best interests – medical treatment

Summary[8]

SM was 16 years old and a looked-after child under s.20 Children Act 1989. She resided in a supported living accommodation, and received regular care and support. She did not have a consistent relationship with her parents. She had a history of sexual exploitation, "*and suffer*[ed] *from a complex post-traumatic stress disorder as a result of childhood trauma, anxiety and emotional dysregulation. She has had multiple*

[8] Note, although this case dates from 2022, it has only recently appeared on Bailii.

admissions to hospital as a result of her mental ill-health. She also has recorded instances of visual and auditory hallucinations, recalling a figure called 'Greg' who visits her. She is declining all psychotropic medications through fear she will become "like her brother", who it is said suffers from paranoid schizophrenia" (paragraph 8).

At the time of the judgment, SM was 39 weeks pregnant. The Trust made an application for declarations that SM lacked capacity to make decisions regarding her obstetric care and treatment; that the Trust could proceed with a care plan which included delivery by caesarean section if necessary; and that SM could be deprived of her liberty to achieve the safe delivery of her child.

SM's antenatal care had been generally good, and she had been supported by a team which specialised in providing care to women with vulnerabilities. Most of her pregnancy had been uncomplicated, but she had become distressed and afraid when thinking about giving birth. This had caused her to, at times, self-harm and punch her stomach. She was briefly detained under s.5(2) MHA after stating she was a risk to herself.

During a routine scan on 10 November, an abnormality was noticed which indicated the foetus was at risk. The strong clinical opinion was that delivery should not be delayed to avoid a risk of stillbirth. SM agreed to be induced on 11 November, but then changed her mind and refused to carry on with the induction. Twice on 12 November and once on 14 November, SM agreed to an elective caesarean section but changed her mind at the stage of anesthesia being commenced due to severe anxieties. On 15 November, SM again agreed to a caesarean section, but again became severely anxious to the extent of running away from hospital grounds.

The case was brought on an urgent basis, and it was accepted by the Trust that the matter was "*complex and finely balanced*" (paragraph 3). The Official Solicitor declined to act, as it was agreed that SM had capacity to conduct proceedings; SM instructed her own solicitors to represent her.

Cobb J considered that SM had likely lacked capacity to make a decision about her treatment at the point at which the Caesarean section would become an immediate reality though did not consider that it was an 'inevitability' that she would do so. He accepted evidence that "*when calm she is able to recall the risks and benefits of proposed treatment, at that point she is not able to comply due to her health anxieties about different procedures involved in the treatment, such as anaesthetic, procedures, needles and medication*" (paragraph 29). Cobb J likened the case to that of *Re MB* [1997] EWCA Civ 3093:

> [i]*n that case, as in this, careful scrutiny of the evidence is necessary because fear of an operation can be a reasonable reason for refusing to undergo it. However, fear induced by panic may paralyse the will and thus destroy the capacity to make a decision. That is, in my judgment, this case* (paragraph 33)

Cobb J found that, if he was wrong on the issue of whether SM lacked capacity, he would exercise the High Court's parens patriae jurisdiction to make relevant order on the basis that SM was a vulnerable child.

In relation to best interests, at the time of the hearing, the clinical team considered that the only realistic option was a Caesarean section under general anaesthetic. The judgment set out that there was some lack of clarity as to the precise extent and timing of the risk of harm to the foetus. It also set out that SM's wish was to be able to deliver her baby with the least

intervention practicable, and to be awake when her baby arrives. SM invited the court to make a decision "*to respect her autonomy and her ability today to make a capacitous decision in relation to this way forward*" (paragraph 24). She advanced as alternative submissions: (1) that she not be induced and should be allowed to go into labour naturally, with high levels of monitoring; or (2) to be vaginally induced and deliver vaginally. SM acknowledged that this had been attempted in the past and she had withdrawn her consent, but offered explanations that the process had been very painful and she had struggled to continue.

Cobb J adopted an approach which was a middle ground between the positions advanced by the respective parties: that SM should have one more opportunity for a vaginal induction, which if unsuccessful, would be followed by a Caesarean section under general anaesthetic if SM again lost capacity. Cobb J summarised his conclusion thus:

> 6. …*I am satisfied that the longer that the current situation goes on with this pregnancy at its extremely advanced stage, the greater is the risk of stillbirth of the baby, an outcome which would have a seriously deleterious effect on SM herself, particularly given her fragile mental health. I am further satisfied that ongoing distress for SM over the uncertainty of this current situation is not in her interests. I am also concerned about the situation that would arise should SM go into spontaneous labour in circumstances in which the medical support around her would not immediately be available. It is plainly in SM's best interests for a healthy baby to be born as soon as possible as the impact upon her psychological well-being, and the trauma that an unhealthy baby would create, would have a significantly detrimental and longer-term impact on both her and the baby. It is plainly in SM's best interests that she is able to exercise a high degree of autonomy over the manner in which her baby is born…I regard it as not only proportionate but also in SM's short and long-term best interests that the hospital attempts one final administration of vaginal induction of the baby. This should begin straightaway in order to give SM the best chance to deliver the baby vaginally and while she is alert and awake, something which she (and I understand this completely), wishes to achieve in her first experience of childbirth.*
>
> *7. I am satisfied, however, from all that I have heard that there have been times in the last few days when SM has lost capacity in what has been described as "the heat of the moment", when anxiety and stress has overwhelmed her, and she has not been able to make a capacitous decision in relation to the appropriateness of submitting to Caesarean section. Should that situation arise in the hours ahead and if, in the opinion of the treating clinicians, she loses capacity again, as she has in the recent past and as described in the reports before me, and if the welfare of the mother or child is compromised or is likely to be compromised such that a caesarean section is indicated as an emergency, I confirm that it is in SM's best interests for the baby to be delivered by Caesarean section performed under general anaesthetic; it will accordingly be lawful for the hospital to perform that procedure in those circumstances. I recognise that this is not what the applicant NHS Trust wishes me to order in this particular case, at least in part, because they have assembled (no small feat) a dedicated and expert team this afternoon to perform the Caesarean section. However, with warning and*

> *due notice that the process of delivery of the baby is now to begin within the next few minutes or hours in the manner in which I have described, I very much hope that the clinical team that has been assembled can, either in its current form or in a substituted form, be on stand-by over the next few hours and days in the event that a Caesarean section is required.*

The judgment included the welcome post-script that SM was induced after the hearing, safely delivered her daughter and was entirely compliant with medical advice during the delivery.

Analysis

This judgment is an interesting one on fluctuating capacity, particularly for its nuanced findings that SM likely had capacity at the time of the hearing, but repeatedly lost that capacity at the time when making a decision about a Caesarean section became an 'immediate reality.' However, as the postscript notes, on being given one further opportunity, it appears that SM had been able to make decisions despite her anxieties and the court was correct that her losing capacity was not 'inevitable.' Cobb J noted several times in the judgment that it was made on the specific facts of the case, but may be an interesting model for its careful and structured declarations on capacity and best interests in the event that SM again lost capacity to take a decision about her medical treatment (which ultimately were not required).

Short note: covert medication

A Local Authority v A & Ors (Re the Mental Capacity Act 2005) [2020] EWCOP 76 relates to the case of 'A', whose case was also discussed in the judgments of Poole J (*Re A (Covert Medication: Closed Proceedings)* [2022] EWCOP 44) and HHJ Moir (*The Local Authority v A & Ors* [2019] EWCOP 68 (18 June 2019)), which were covered in the November 2022 and December 2022 Mental Capacity Reports. A was a young woman with primary ovarian failure who was covertly medicated with hormone medication following orders to this effect by HHJ Moir in 2019. Neither A nor her mother had been told about the medication, due to concerns that her mother would seek to prevent A from taking the covertly-administered medication, which might result in either the administration of medication being ineffective and/or A ceasing to eat altogether.

This recently-reported 2020 judgment related to the decision to administer covert medication to A. The court noted that it had recently made an order that the substantive application to covertly medicate A not be served on B. The court noted its discomfort with considering such a significant application in the absence of B, who had been central in A's life. The consideration of the matter without B was supported by all other parties, including the Official Solicitor. HHJ Moir noted B's Article 6 rights and the importance of procedural fairness, but considered (at paragraph 11) that:

> *if she was aware of the plan B would seek to subvert the medical treatment. That view is based upon my knowledge of B's approach throughout these proceedings. I found in 2019 although B might say that she accepted the treatment should be undertaken that I had no confidence that she would encourage or support A to take the medication, or keep hospital appointments, and Dr X, consultant endocrinologist (to whom the judgment will refer to as Dr X), in their more recent report in, I think, March 2020, repeated their concerns about B's approach to A taking any medication. Therefore, I am satisfied that B should not be informed*

> *of the plan and therefore it is right that she should not have been notified of this hearing, or play a part within it.*

HHJ Moir identified that she would hear any opposing views to the application without B's presence, and considered that the scrutiny provided by the Official Solicitor and statutory bodies in weighing up the risks and benefits of the treatment would be appropriate. HHJ Moir considered that, 15 months after the original judgment concluding that it would be in A's best interests to have the medication, she had shown no willingness to take it; she was described as being 'completely against' the hormone medication, though willing to take other recommended medications. There had been no appeal to the court's substantive judgment that it was in A's best interests to have the medication, and further delay would only reduce the efficacy of the treatment. HHJ Moir reminded herself that the consequences of primary ovarian failure were profound, and included increased risk of death by cardiovascular disease by 30 to 40 years of age; by contrast, there were no meaningful physical risks to taking the medication. HHJ Moir accepted that there were disadvantages to A in going against her wishes and an interference with her Article 8 rights. However, HHJ Moir found that:

> *19. Balancing up the advantages and disadvantages it is clear that the advantages far outweigh the disadvantages, and the clear and significant advantages, set against the less concerning disadvantages, tell in favour of the covert medication being administered.* […]
>
> *20. Against the background of this case, it is clear that A and B would not willingly facilitate the administration of the medication for the primary ovarian failure, and that without that treatment the future for A will be significantly affected and even possibly life-limiting. If there was another way that the court could be satisfied that this treatment could be undertaken, then that would be considered. But the only mechanism by which the treatment can be administered is covertly. It is unarguable, unassailable, that the treatment is in A's best interests, and having considered the balance sheet it is difficult to see how A's best interests are not served by approving the application of the Trust, supported by the Local Authority and the Official Solicitor, that medication should be administered covertly, and in the circumstances I have set out, I am satisfied that any interference with Article 8 is justified, and is the only way forward to try to achieve what Dr X so graphically described in their oral evidence, and has set out in their written evidence, namely, that A should be given the opportunity to reach maturity and have a happy, fulfilling existence and, therefore, I am satisfied that the application should be granted.*

PROPERTY AND AFFAIRS

Powers of Attorney Bill

Continuing its rapid progress through Parliament (see our February and March 2023 reports), Stephen Metcalfe's Bill had its third reading in the House of Commons on 17 March. No amendments were proposed. It has now left the House of Commons, has had its first reading in the House of Lords and is awaiting its first substantive consideration there at second reading stage. Fulfilling a commitment made at third reading in the House of Commons, Mike Freer MP (the Parliamentary Under-Secretary of State for Justice) has placed a letter in the House of Commons library explaining the position in relation to Scottish powers of attorney, thus:

> *I can confirm that there is already legislation in place which allows for the recognition of Scottish Powers of Attorney in England and Wales. Schedule 3, Paragraph 13 of the Mental Capacity Act provides that where an individual is habitually resident in another country to which England and Wales is a connected country (this would include Scotland) then, the law applicable to the power's existence is the law of the other country (in this case Scotland). This means that if the correct process has been followed for the Power of Attorney to be created in Scotland, it would be legally recognised in England and Wales without the need for further action from either the Court of Protection or Office of the Public Guardian (OPG) for England and Wales.*

The letter goes on to note that "*despite this legislation being in place, the experience of those with Scottish Powers of Attorney continues to be that third parties, such as banks, often reject these powers.*" The Minister declined to move towards legislative amendment (although it remains possible that an amendment will be introduced by a Peer at the House of Lords stage), considering that "*this is a matter of education and awareness. We need to ensure that institutions and organisations are aware of the legal status of Scottish Powers of Attorney in England and Wales.*"

Separately, practitioners may wish to note the written exchange between Steve Reed MP and Mike Reed MP:

> *Steve Reed MP:*
>
> *To ask the Secretary of State for Justice, what steps his Department is taking to ensure that a certificate provider for a Lasting Power of Attorney application is aware their role is to ensure the donor (a) understands the information relevant to the decision, (b) can retain that information and (c) can use or weigh up that information as part of the process of making the decision.*
>
> *Mike Freer MP:*
>
> *The certificate provider is a crucial safeguard during the creation of a lasting power of attorney (LPA). They sign to state that the person making the LPA understands it, is not being pressured into making it and there is no evidence of fraud. A modernised LPA service must provide additional support to certificate providers, so they are confident and mindful of their role, including the part the functional test (understanding, retaining, weighing and communicating information relevant to the decisions made) plays in carrying out that role.*
>
> *My department is therefore considering the best way to achieve this, including potential changes to the certificate that is signed, the forms more generally and supporting guidance. Testing and iterating any changes with stakeholders and users will be critical to ensure we achieve the core aim that the certificate*

> *provider understands what they need to do and has confidence taking on the role.*

Although this exchange suggests that the Government will not amend the MCA itself in this regard, it is to be hoped that if the certificate is amended, it will make clear that the certificate provider is indeed (as the Minister appears to confirm the MoJ considers to be the case), considering the donor's capacity to grant the power. Strikingly, it might be thought, the certificate does not currently make that clear.

The new property and affairs deputyship process

A recording is now available of the webinar held on 28 February by HMCTS for legal professionals, to provide an overview on how to submit property and affairs deputyship applications using the Court of Protection online portal.

All change with security bonds!

[This is a guest post by Sheree Green of Greenchurch Legal Services Ltd]

At 2pm on Friday 31 March 2023 the Office of the Public Guardian contacted stakeholders to announce a change to the scheme for surety (security) bonds for Court of Protection deputies.

There was no fanfare, but also no forewarning, consultation or discussion, despite the OPG being fully aware that the existing contract, set up on 1 October 2016 with a single supplier – Howden UK Ltd, was always due to end in March 2023.

The OPG advise there has been a procurement exercise, which resulted in a move from the one preferred supplier to three suppliers:

- Marsh [www.arrangebonds.com]
- Howden [www.howdendeputybonds.co.uk]
- Insync Insurance Solutions Ltd [www.securitybonds.co.uk]

The Howden contract had been awarded competitively "to the provider who could provide the best value for money for clients". (It had always been possible to opt for a different bond supplier).

It is early days of course, but what are the immediate, felt consequences of the change?

Financial impact on "P"

Howden UK Limited have increased their premiums from 0.075% of the security required to 0.2%. So, a bond for £150k now costs £300 instead of £112.50, and a bond for £1.8m costs over £3k rather than around £1400. (We do not know of course whether this rise is a consequence of the change to the scheme, or a driver for the change. We might imagine that bulk purchases with a single provider could lead to reduced costs).

Marsh Ltd has its own pricing structure (which is not publicly available currently, but quotes are available on request). Insync do not currently provide bonds for deputies but interestingly do offer bonds for appointees and for attorneys.

Impact on deputies

The court tells the new deputy that they may either set up a new bond with Howden or Marsh or through a company of their choice (provided the bond meets the requirements of the OPG). Leaflets are provided and links to the relevant websites. Lay deputies will now need to check with both providers as to terms, decide which option best serves the person's best interests and then proceed with the application. Prospective lay deputies prior to 1 April 2023 found the need for surety, the cost and the

process bewildering, as their introduction to becoming a deputy. It is now more complex, and time consuming. For professional deputies, used to receiving notice of the bond having been issued, prior even to receiving the deputyship order itself, there is now a potential further few weeks' delay before we can begin work on behalf of our deputyship client.

The downsides to these changes appear to include further delay and increased costs.

And the upsides? We shall wait and see.

PRACTICE AND PROCEDURE

Short note: reporting restrictions / transparency orders – the Court of Appeal's perspective

The Court of Appeal has allowed the conjoined appeals in *Abbasi* and *Haastrup* [2023] EWCA Civ 331, (permission to appeal to the Supreme Court has been sought by the two hospital Trusts involved). For more detail, see here, but in headline terms, the implications of the judgment are as follows:

(1) as 'refined' a focus as possible is required by both the relevant parties and the court upon those individuals most clearly requiring protection;

(2) that the protection may be required to ensure the continued anonymity of the subject of the proceedings / their family; to maintain the integrity of the proceedings; or to secure against a risk of harm to a professional;

(3) that the focus may need to be refined as matters continue to unfold (and, in particular, in light of any relevant social media activity of concern);

(4) any application to continue an order restricting the identification of professionals after the end of the proceedings on the basis of continuing risk must be based upon clear evidence as to the nature of that risk; and

(5) indefinite orders restricting identification (at least in respect of securing the anonymity of professionals, rather than the person or their family) will very much be the exception rather than the norm.

Short note: the cost of getting things wrong

In *West Hertfordshire Hospitals NHS Trust v AZ* [2023] EWCOP 11, Vikram Sachdeva KC, sitting as a Deputy High Court Judge has delivered a helpful reiteration of the law on costs as it applies to the Court of Protection – the headline point being that, rightly or wrongly, the COP remains a costs free jurisdiction for welfare cases.

This costs application arose out of an out of an hours application for a caesarean section. The initial application was adjourned by Morgan J when he realised the sole urgency was that P had reached 37 weeks' gestation and was therefore considered to be at "term" rather than any medical emergency; and that no proper capacity evidence had been provided to the court, the patient's psychiatric notes being absent from the bundle and no professional involved in the case apparently having assessed the mother's capacity.

Before the application was reheard, P was considered to have regained capacity and the application was withdrawn, with the Official Solicitor's consent.

Having agreed the application to withdraw, and the usual order for 50% of her costs, the Official Solicitor subsequently made an application for costs. The basis for this was essentially that the Trust should have followed the well-known guidance of Keehan J in *NHS Trust 1 v FG* [2014] EWCOP 30 and made the application far earlier [38], that there had been no urgency justifying an out of hours hearing, and that there was incomplete capacity evidence.

DHCJ Sachdeva set out at paragraphs 44- 60 a round up of the existing law on costs in the COP. He noted that:

- The application clearly – and admittedly by the Trust – should have been made sooner, in accordance with the guidance in *FG* (paragraphs 62-66);

- The applicant trust should have contacted the Official Solicitor far earlier in order to discuss the case which may have obviated the need for an urgent hearing (paragraph 67);
- Professionals involved in the case were wrong to consider that an assessment of capacity can only be conducted on the date of the procedure – it should be done in advance and done again if, at the time of the hearing, there is reason to think the position may have changed (paragraph 69).

However, DHCJ Sachdeva noted that the original agreed order arising out of the application hearing included a "no order as to costs" provision, which he had no jurisdiction to re-open (paragraph 71). As to the subsisting period – post the initial, adjourned application, prior to the withdrawal of the application, he noted that the Trust's actions, while regrettable, were neither "significantly unreasonable" or a "blatant disregard of the processes of the MCA" (paragraph 72). He observed:

> *72. The way in which this application was approached signifies substandard practice. Whether to make an application to the Court of Protection, and the appropriate timing of an application, is not just a clinical question, but one which also involves a legal judgment. The Applicant, in identifying the need for training in this area, recognises its actions on 21 October 2022 were inappropriate.*
>
> *73. Although it is important to follow the guidance in FG, there is no suggestion in the case itself that breach of the guidance automatically justifies a costs order against an applicant. Something more is needed.*

DHCJ Sachdeva is undoubtedly correct in his analysis: the law *does* provide that there will, generally speaking, be no order as to costs in welfare proceedings, save where the parties have acted in a manner which can be construed as significantly unreasonable. The COP remains, however, beset with delay and, regrettably, poor practice from many public bodies – and private individuals. One does sometimes wonder whether more strict provisions on costs might concentrate minds and result in smoother and faster conduct of proceedings.

THE WIDER CONTEXT

Do not attempt cardiopulmonary resuscitation (DNACPR) and people with a learning disability and or autism

Depressingly, it has been necessary for the powers that be NHS England to write, again, to write to all medical practitioners to

> *We are writing to you to remind you and your systems of the importance of implementing the Universal principles for advanced care planning and ensuring that DNACPR decisions for people with a learning disability and autistic people are appropriate, are made on an individual basis and that conversations are reasonably adjusted.*
>
> *The NHS is clear that it is unacceptable that people have a DNACPR decision on their record simply because they have a learning disability, autism or both.*
>
> *The terms 'learning disability' and 'Down's syndrome' should never be a reason for DNACPR decision making, nor used to describe the underlying, or only, cause of death. Learning disability itself is not a fatal condition: death may occur as a consequence of co-occurring physical disorders and serious health events.*

In short, care planning must be done with, not to, people. If you need help implementing this principle, this video may be of assistance.

New SCIE MCA directory

The SCIE MCA directory has now been revamped and expanded, running to some 386 resources at the time of writing.

Litigation capacity before the courts

There have been two notable recent cases on capacity to conduct proceedings.

In *Cannon v Bar Standards Board* [2023] EWCA Civ 278 the Court of Appeal considered the law on capacity to conduct proceedings in an appeal brought by a disbarred barrister who argued that she had lacked capacity to participate in the hearing before the BSB which had resulted in her disbarment. In its review of the law, it expressly noted the Supreme Court decision in *JB*, discussed in the next article.

Dismissing the appeal the Court of Appeal noted, firstly, that the evidence on which the appellant sought to rely was not contemporaneous and was therefore insufficient to rebut the presumption of capacity. The Court of Appeal noted further, that the appellant's own solicitors did not raise the issue of mental capacity at the material time.

The court emphasised the difference between mental capacity and the fairness of proceedings involving a vulnerable individual. At paragraph 34 held that:

> *A person may well have vulnerabilities arising from underlying mental health conditions. Those may require adjustments to ensure that proceedings are fair. Special measures may need to be taken to accommodate a witness with vulnerabilities or who has a fear of being present at a hearing with a particular person. There may need to be an adjournment because of physical or mental conditions. In the present case, the difficulties that have been identified in relation to the appellant are ones that were relevant to the way in which the disciplinary process might need to be conducted to ensure fairness (as Dr Isaacs pointed out in his assessment of September 2019). They do not provide a sufficient basis on which to conclude that the presumption of capacity has been rebutted.....*

In *R (Philip Percival v Police and Crime Commissioner for Notts & Ors* [2022] EWHC 3544 (Admin), HHJ Richard Williams sitting as a High Court Judge considered the mental capacity of the claimant to bring judicial review proceedings against the respective Police and Crime Commissioners for Nottinghamshire and Derbyshire in 2021 and 2022.

Professor Percival had brought damages claims arising out of two incident in 2011 when he had been (a) on the first occasion, detained by officers under s.136 Mental Health Act 1983, (b) on a second occasion, been visited by a police officer and issued with a harassment warning in relation to his conduct with a former partner.

The claims were listed for trial in December 2021, but two weeks prior to the hearing, HHJ Gosnell felt himself bound to vacate the trial due to an application brought by Professor Percival himself in which he maintained that he lacked litigation capacity (paragraphs 6-7).

While these claims were stayed, and absent the appointment of any litigation friend or the provision of any further capacity evidence, Professor Percival brought two further claims for judicial review arising out of the handling of the complaints he had made about the alleged misconduct. He justified this action, advising that he "*finds the judicial review proceedings therapeutic and less daunting [than the personal injury litigation], since they are essentially a paper-based exercise and do not involve him having to relive the events in 2011, which he still finds difficult to deal with*" (paragraph 16).

Noting the perturbation of the defendants that the claimant might argue – as he did – that he lacked capacity to conduct proceedings in one set of litigation while retaining capacity in another, HHJ Richard Williams held at paragraph 18 that:

> *determining capacity is ultimately a functional test focusing on the ability of a person to make a particular decision. I note that some of the medical evidence, at least before HHJ Gosnell, did suggest that the lack of capacity in that case may have arisen as a result of Professor Percival being faced with the potential of being cross-examined about the events in 2011. In any event, I am not making any decision about Professor Percival's current capacity to litigate those proceedings, only his capacity in relation to conducting these judicial review proceedings.*

This judgment provides a helpful and accurate reminder of the specificity of the test for capacity in any domain. The fact that an individual might lack capacity to conduct one set of proceedings at one particular time should not, of course, be determinative of whether he might lack capacity to conduct proceedings of another form at a later date.

On the facts of the case, though, it is perhaps difficult to avoid the impression that HHJ Richard Williams was keen to find that Professor Percival had capacity to conduct the proceedings for what might be thought to be an extraneous reason – namely that the previous proceedings had been stalled (it appears) by difficulties in appointing the Official Solicitor as litigation friend. Had he concluded that Professor Percival lacked capacity to conduct the judicial review proceedings, these, too, would have joined the queue.

CPR Part 21: all (apparent) change, and an update to the White Book

With effect from 6 April 2023, there has been a change in how the civil courts approach questions relating to the participation of children and protected parties in proceedings (nb, this change does not relate to the Court of Protection,

nor to the family courts/Family Division of the High Court, which have their own set of Rules and Practice Directions).

CPR Practice Direction 21 has been withdrawn, and CPR Part 21 has been amended to include most, but not all, of the provisions contained in the Practice Direction, as well as a number of relatively minor changes to the rules themselves. This forms part of the rolling process being undertaken by the Civil Procedure Rules Committee ('CPRC') to comply with its statutory duty under s.2(7) Civil Procedure Act 1997 to simplify the Rules.

The explanation for the removal of PD21 can be found in the minutes of the October 2022 CRPC meeting, namely that it was considered to be "*a mix of (i) repetition, (ii) outmoded or otherwise inappropriate content and (iii) provisions that should be in the rule*[s]." This means, in turn, that Part 21 now includes elements which had previously been found in the Practice Direction and is – therefore – longer, although more succinctly expressed.

The CPRC had consulted upon its proposals in the late autumn of 2022. Only one change attracted substantive comment: one respondent raising a concern that the increase to £100,000 in the revised version of CPR r.21.11(9)(a) (control of money recovered for the benefit of a protected beneficiary) would mean that fewer claimants can apply to the Court of Protection for appointment of a Deputy. The minutes of the CPRC meeting of 2 December 2022 contains the explanation from Master Cook of the practical rationale which satisfied the CPRC that the concern was misplaced, thus:

> [t]*he purpose of this provision was to enable the court to avoid the expense of appointing a Deputy or applying to the Court of Protection where the damages awarded were modest. This sum has been fixed at £50,000 for a considerable period of time. Management by the court (Court Funds Office) is a light touch inexpensive alternative to the Court of Protection route. The increase to £100,000 gives more scope to reduce costs for protected beneficiaries and was seen as leading to fewer applications to the Court of Protection, not more.*

We would note that clearing PD21 out of the way is likely to be helpful for an entirely different reason to that which motivated the CRPC. The Civil Justice Council has convened a Working Group (on which I sit) is looking at practice and procedure around determining mental capacity in civil proceedings. Whilst work is still ongoing, one possible outcome is a recommendation will be made as to the need for a Practice Direction to amplify the provisions of Part 21 in such a way as to add value, rather than duplicate.

Linked to this, it is unfortunate that the 2023 edition of the White Book does not quite get it right in relation to litigation capacity (separately, there is a much bigger issue, for which the White Book editors can bear no responsibility, as to whether Part 21 gets it right at all in terms of the approach to take to litigation capacity).

In particular, the following paragraph (2.1.03) of the White Book contains an error we hope can be corrected in future editions:

> *In legal proceedings the burden of proof is on the person who asserts that capacity is lacking. If there is any doubt as to whether a person lacks capacity, this is to be decided on the balance of probabilities; see s.2(4) of the 2005 Act. The presumption of capacity will only be displaced on the basis of proper evidence.* ***That evidence must be current and must deal first with the "diagnostic test" of impairment or***

> ***disturbance of the functioning of the mind or brain, then secondly the "functional test" of whether the impairment renders the person unable to make the relevant decisions in litigation**. It must deal with all the factors in s.3 of the Mental Capacity Act including whether there are any practical steps which could be taken to assist the claimant in making decisions in relation to the litigation. See Fox v Wiggins [2019] EWHC 2713 (QB) and King v Wright Roofing Co Ltd [2020] EWHC 2129 (QB).*

The error, in the sentence in bold, is to follow the 'old' ordering as set out in the Mental Capacity Act Code of Practice. However, in A Local Authority v JB [2021] UKSC 52, the Supreme Court made clear that the test need to be applied in the reverse order. Following the Court of Appeal in York City Council v C [2013] EWCA Civ 478 (sometimes also called *PC v NC*), Lord Stephens identified that section 2(1) – the core determinative provision – requires the court (and hence anyone else, outside court) to address two questions. First, is the person unable to make the decision for themselves? As Lord Stephens noted:

> *67. […] The focus is on the capacity to make a specific decision so that the determination of capacity under Part 1 of the MCA 2005 is decision-specific as the Court of Appeal stated in this case at para 91. The only statutory test is in relation to the ability to decide. In the context of sexual relations, the other vocabulary that has developed around the MCA, of "person-specific", "act-specific", "situation-specific" and "issue-specific", should not be permitted to detract from that statutory test, though it may helpfully be used to identify a particular feature of the matter in respect of which a decision is to be made in an individual case.*
>
> *68. As the assessment of capacity is decision-specific, the court is required to identify the correct formulation of "the matter" in respect of which it must evaluate whether P is unable to make a decision for himself: see York City Council v C at paras 19, 35 and 40.*
>
> *69. The correct formulation of "the matter" then leads to a requirement to identify "the information relevant to the decision" under section 3(1)(a) which includes information about the reasonably foreseeable consequences of deciding one way or another or of failing to make the decision: see section 3(4).*

If the court concludes that P cannot make the decision, then the second question is whether there is a "*clear causative nexus between P's inability to make a decision for himself in relation to the matter and an impairment of, or a disturbance in the functioning of, P's mind or brain*." Lord Stephens was clear (at paragraph 78) that the two questions in s.2(1) were to be approached in the sequence set out above, i.e. starting with the functional aspect. Whilst the Supreme Court was considering the MCA in the context of its application by the Court of Protection, Lord Stephens' observations apply with equal force to its application by the civil courts, because CPR r.21.1(2)(c) expressly provides that references to a person lacking capacity are references to a person lacking capacity for those purposes applying the MCA 2005 (see also *Saulle v Nouvet* [2007] EWHC 2902 (QB).) The Court of Appeal in *Cannon v Bar Standards Board* [2023] EWCA Civ 278 (discussed above) expressly noted the observations in *JB* as to the ordering of the test at paragraph 22).

Helpfully, the recently revised certificate as to capacity to conduct proceedings has the test the right way around.

Separately, it is unfortunate that in the same

highlighted sentence, the White Book uses the term 'diagnostic' element. Although in common currency, it is misleading. As we put it in our guidance note on capacity:

> *As a judge has put it, a formal diagnosis "may constitute powerful evidence informing the answer to the second cardinal element of the single test of capacity, namely whether any inability of [P] to make a decision in relation to the matter in issue is because of an impairment of, or a disturbance, in the functioning of the mind or brain"* [see North Bristol NHS Trust v R [2023] EWCOP 5 at paragraph 48]. *However, it is entirely legitimate to reach such a conclusion in the absence either of a formal diagnosis or without being able to formulate precisely the underlying condition or conditions. To this extent, therefore, the term "diagnostic" test which is often used here is misleading.*

Using the term 'diagnostic element' also suggests that medical evidence is required, but this is incorrect. The White Book (in the same paragraph, 21.0.3) notes *Hinduja v Hinduja* [2020] EWHC 1533 (Ch) as an example of a case where medical evidence is not necessary, this is perhaps rather to understate the position. Falk J (as she then was) undertook a first principles analysis of the position, identifying that medical evidence is simply not required by the Rules.

> *37. There is no requirement in the* [Civil Procedure Rules] *to provide medical evidence. The absence of any such requirement was commented on by Chadwick LJ in Masterman-Lister at [66]. There is no reference to medical evidence in CPR 21.6. The only reference to medical evidence is in paragraph 2.2 of PD 21, which applies where CPR 21.5(3) is being relied on. That requires the grounds of belief of lack of capacity to be stated and, "if" that belief is based on medical opinion, for "any relevant document" to be attached. So the Practice Direction provides that medical evidence of lack of capacity must be attached only if (a) it is the basis of the belief, and (b) exists in documentary form. It does not require a document to be created for the purpose.*
>
> […]
>
> *50. In summary, medical evidence is not required under the rules* […]

Whilst, as set out above, Practice Direction 21 has now been removed, the reference to medical opinion (or, now, 'expert opinion') is to be found in CPR r.21.6, and is on the same basis. There may well be situations in which the court will consider that it cannot make a determination that the party lacks capacity to conduct the proceedings absent medical evidence. However, we would suggest that it is important that representatives and judges approach matters from the correct starting position (not least because it also opens the door to taking the same approach as is now taken in the Court of Protection, namely that where expertise is, in fact, required, that expertise can be obtained from an appropriately qualified professional such as a social worker who is able to speak to the individual's capacity.

Short note: cognitive impairment, parenting and care proceedings - the irrelevance of blame.

In *West Sussex County Council v K* [2022] EWFC 170, HHJ Thorp (sitting as a s.9 High Court Judge) was considering whether the threshold was crossed to justify the making of a care order. The father had died when the child was 2; the mother had suffered a sudden and catastrophic brain haemorrhage in November 2021. She had been left with minimal abilities; she required 24/7 care; she had very limited cognition and understanding; and lacked capacity to litigate or

make any decisions about her own welfare. It was agreed that was not able to make any decisions about her child's welfare, and could exercise any parental responsibility for her on a practical basis. In those circumstances, all decision-making was made by others and she has no input into it. Further, it was agreed that she does not have capacity to provide agreement under s.20 Children Act 1989 for K to stay in Local Authority accommodation.

A submission was made on behalf of the local authority that "[t]*he mother is a protected party and is incapable of any conscious thought.that could result in her being blamed for placing K at risk of future harm*." The submission was repeated by all of the other parties, who were, as HHJ Thorp identified "*quite rightly, and understandably, very concerned that some sort of blame might be attributed to the mother in this case, or that the difficulties in her care may be placed at her door. As I have indicated earlier, the Official Solicitor is particularly concerned that there should not be state intervention just because a person has a disability, and that they should not be deprived of their Article 8 rights*."

However, HHJ Thorp made clear that it was not necessary or appropriate to deal with the case with any reference to blame. He emphasised that, as the Supreme Court had made clear, such a finding was not necessary for purposes of s.31 Children Act 1989 and that

> *In my judgment, "blame" is not required. Family practitioners are well used to the fact that in the family courts, we often see parents who are not blameworthy. The fact that they are not able to provide safe and adequate care may be for a variety of reasons but should not of itself reflect blame on their part. Rather, s31 recognises that in some cases where the children's needs are not going to be met by a parent, then the state may need to intervene to ensure that those needs are met.*

The future of ageing: ethical considerations for research and innovation – Nuffield Council on Bioethics Report

In a veritable doorstop of a report published on 25 April 2023, the Nuffield Council on Bioethics sets out its findings from a two-year in-depth inquiry by an interdisciplinary working group, who benefitted from the evidence and experience shared by many contributors from across the UK and beyond. The report, T*he future of ageing: ethical considerations for research and innovation*. looks at the role that biomedical research and technological innovation has to play in responding to the needs of an ageing population. It focuses on three broad areas of research and innovation:

- Research into biological ageing
- Assistive, monitoring, and communications technologies such as health apps and smart home technologies
- Data-driven detection and diagnosis of age-related conditions.

Developments in these areas offer possible benefits in terms of supporting people to flourish in older age, but they can also raise significant ethical questions about how ageing is perceived, and how older adults are valued in our society. The report sets out to identify the values, principles and factors that are most at stake in the context of research that seeks to influence our experience of ageing, and proposes an ethical framework and toolkit to help everyone involved in conducting research relating to ageing to think through the ethical implications of their work.

The report is dedicated to Baroness Sally

Greengross. As the chair of the working group, Bella Starling, notes in her introduction, "*Sally was a member of the working group and an unerring advocate for the rights of older people, who sadly passed away in June 2022. We hope that this report bears testament to her passion and influence. It was an honour to work with her*."

The report culminates by setting out 15 recommendations to policymakers, research funders, researchers, regulators and professional bodies, health care professionals and others involved in shaping research, as follows:

> *All research stakeholders are encouraged to use the ethical framework and toolkit to guide their thinking and their processes – particularly when scrutinising funding applications and making decisions about the translation of research into An interactive tool on our website provides further prompts and support for those directly involved in research and implementation.*
>
> *The Government is urged to establish a cross-governmental strategy to support the aims of achieving five extra healthy years for all and narrowing the inequitable gap in healthy life expectancy, and to support this strategy with an intergenerational public advisory It should also ensure that any new screening or testing programmes for age-related diseases must be accompanied by properly funded services and support for those diagnosed.*
>
> *Research funders are encouraged routinely to expect meaningful collaboration between researchers and older adults in any research they fund concerned with ageing; to fund the necessary engagement infrastructure and expertise; to establish minimum demographic datasets to ensure that diversity of inclusion in studies is measured; and to take active steps to encourage partnership working between researchers and We further recommend that funders explicitly take a public health, life-course approach to research funding, recognising the importance of preventative approaches, and prioritising the needs of those who are currently most disadvantaged.*
>
> *All the UK Research and Innovation (UKRI) funding councils are encouraged to support interdisciplinary ageing research through the new Ageing Networks.*
>
> *The Health Research Authority (HRA) is encouraged to work with the National Institute for Health and Care Research (NIHR) and other partners to identify good practice in involving older adults with impaired mental capacity in research, and to support ethics committees to feel confident in reviewing such research*[9]
>
> *The Medicines and Healthcare products Regulatory Agency (MHRA) is urged to continue working with funders and others to address the challenges that may hinder older adults with multiple long-term conditions being included in research relevant to them, and if necessary to consider mandating such inclusion.*
> *The British Standards Institution (BSI) is encouraged to work with the MHRA, Innovate UK, and other stakeholders to develop accredited*

[9] This is, perhaps unsurprisingly, a recommendation that were are particularly interested in; it is very helpful that the Report also specifically singles out the NIHR INCLUDE Impaired Capacity to Consent Framework as a practical tool.

> *standards that promote ethical and inclusive research practices with respect to technologies designed to support people to live well in older age.*
>
> ***Providers of undergraduate education for health professionals and biomedical scientists*** *are urged to ensure that their students gain a rounded, interdisciplinary understanding of ageing, including the ethical considerations set out in our ethical framework and toolkit.*

It was particularly interesting reading the report, and, especially, Chapter 2 on attitudes to ageing, in light of the recent (thirteenth) session of the UN Open-Ended Working Group on Ageing for the purpose of strengthening the protection of the human rights of older persons, held between 3 and 6 April 2023 in New York. The working group is considering the existing international framework of the human rights of older persons and identifying possible gaps and how best to address them, including by considering, as appropriate, the feasibility of further instruments and measures, with a report due with its recommendations by the time of the fourteenth session. Any discussion of what is or is not (and what should be) in any such instruments or measures would be equally informed by this Report as we hope will be biomedical researchers and those commissioning and funding such research.

FCA Consumer Duty: Looking out for vulnerable customers

On 27 July 2022, the Financial Conduct Authority ("FCA") set out its final rules and guidance for a new Consumer Duty that sets higher and clearer standards of consumer protection across financial services. The new duty will need to be applied by firms to new and existing products and services open to sale (or for renewal) from 31 July 2023. For closed books, firms have until 31 July 2023 to apply the duty.

The new duty will be set out in Principle 12; and will state as follows: "A firm must act to deliver good outcomes for retail customers." Where a "retail customer" is defined as an individual who is acting for purposes which are outside their trade, business or profession.

The purpose, as set out in the proposed amendments to the FCA Handbook, is to ensure that retail customers receive a high level of protection, given: (i) they typically face a weak bargaining position in their relationships with firms; (ii) they are susceptible to cognitive and behavioural biases; (iii) they may lack experience or expertise in relation to products offered through retail market business; and (iv) there are frequently information asymmetries involved in retail market business.

Given the duty, there are a number of related obligations, including:

a. A firm must act in good faith towards retail customers;
b. A firm must avoid causing foreseeable harm to retail customers;
c. A firm must enable and support retail customers in pursuing their financial objectives.

In the guidance on those obligations, there are multiple references to retail customers with "characteristics of vulnerability".

The FCA defines "vulnerability" as "customers who, due to their personal circumstances, are especially susceptible to harm, particularly when a firm is not acting with appropriate levels of

care".[10] It goes on to advise firms to think about vulnerability as a "spectrum of risk", noting that all customers are at risk of becoming vulnerable and the risk is increased by "characteristics of vulnerability related to 4 key drivers":

- Health – health conditions or illnesses that affect ability to carry out day-to-day tasks.
- Life events – life events such as bereavement, job loss or relationship breakdown.
- Resilience – low ability to withstand financial or emotional shocks.
- Capability – low knowledge of financial matters or low confidence in managing money (financial capability). Low capability in other relevant areas such as literacy, or digital skills.

The "characteristics" associated with these drivers include "mental health condition or disability", "low mental capacity or cognitive disability" and "learning difficulties". 11 The guidance specifically flags the need for firms to consider how they can empower consumers to manage their finances or protect them from scams, particularly when someone may lack capacity or have impaired decision-making. It notes that some vulnerable consumers may need additional support in making decisions or rely on others to make decisions on their behalf.

Firms are advised to have a pre-emptive and flexible processes in place (i) to adapt to the needs of vulnerable customers (ii) for dealing with temporary vulnerability (including through third party representation). A firm should take reasonable steps to assist customers in making capacitous decisions. Firms should also build in extra time and flexibility to ensure the needs of vulnerable customers are met (as well as ensuring that they discharge their obligations in the Equality Act 2010. Firms are also advised to ensure they have adequate systems in place so that a customer's vulnerability and any third party representation can be recorded, as well as ensuring their communications are clear and provided to vulnerable customers in way they can understand (to include marketing, point of sale, post-contractual information, information about changes to the product or service, and complaints processes).

"How I should be cared for in a mental health hospital."

In 2022, NHS England commissioned the Restraint Reduction Network to create the new 'How I should be cared for in a mental health hospital' toolkit, which tells people about the different kinds of restrictive practices they might be subject to, the law, their rights, and how they should expect to be cared for while in hospital. The toolkit is now available here.

The resources are compliant with Seni's Law (2018) and were written, edited and designed by people who have been in hospital themselves and understand what it might be like.

The resources include information for people and family members on the person's rights and what to expect when they are in hospital, along with an evaluation tool to help people check if they are getting good care and if restrictive practices are being used correctly.

Children's Commissioner for England report: Children's Mental Health Services 2021-2022

A new report from the Children's Commissioner's office outlines key findings in understanding children's access to mental health services in

[10] FG21/1 "Guidance for firms on the fair treatment of vulnerable customers" February 2021, para 2.5

[11] *Ibid,* Table 1

England in financial year 2021-22, as follows:

- *Of the 1.4 million children estimated to have a mental health disorder, less than half (48%) received at least 1 contact with CYPMHS and 34% received at least 2 contacts with CYPMHS.*
- *The percentage of children who had their referrals closed before treatment has increased for the first time in years. In 2021-22, 32% of children who were referred did not receive treatment compared to lower numbers in 2020-21 (24%), 2019-20 (27%) and 2018-19 (36%). There remains wide variation across the country in how many children's referrals were closed without treatment, from as low as 5% of referrals in NHS East Sussex to 50% in NHS North Cumbria.*
- *The average waiting time between a child being referred to CYPMHS and starting treatment increased from 32 days in 2020-21 to 40 days in 2021-22. The average waiting time for children to enter treatment (defined as having two contacts with CYPMHS) varies widely by CCG from as quick as 13 days in NHS Leicester City to as long as 80 days in NHS Sunderland.*
- *Spending on children's mental health services has increased every year, after adjusting for inflation, since 2017-18. CCGs spent £927 million on CYPMHS in 2021-22, equal to 1% of the total budget allocated to them. This compares to £869 million in 2020-21 – an increase of 7% in real terms. The share of CCGs spending over 1% of their total budget increased from 30% in 2020- 21 to 45% in 2021-22.*
- *The number of children admitted to inpatient mental health wards continues to fall, as does the number of detentions of children under the Mental Health Act each year. Of the 869 detentions of children under the Mental Health Act in 2021-22, 71% were of girls.*
- *An increasing number of children, many of whom have mental health difficulties but are not admitted to hospital, are being deprived of their liberty in other settings. These children are hidden from view as they do not appear in any official statistics,* ***but research suggests that over ten times as many children are being deprived of liberty in this way in 2023 as in 2017-18.*** (emphasis added)
- *Children in inpatient mental health settings who we spoke to wanted more, earlier intervention to prevent crisis admissions – sometimes children are presenting multiple times at A&E before an inpatient admission is considered.*
- *Much more can be done to make inpatient mental health wards feel safe and familial. Children reported a huge variation in the quality of relationships they had with staff. For example, while some children felt they knew staff genuinely cared about them, one child described how staff would only refer to children by their initials, rather than their name. There appears to be a particularly acute issue with the quality of night staff.*
- *Education was viewed very positively by most of the children spoken to for this report, and highlights the importance of high-quality education in these settings for children's recovery as well as their learning.*
- *The data collected on children in inpatient settings, including demographic information and information about key safeguards for children, is patchy and makes it harder to improve quality.*

"Notices to quit" – their impact

A new report from researchers at King's College London [12] has highlighted the impact that "notices to quit" care homes can have.

The study's findings highlight:

- that 'notices to quit' may follow strained relationships between care homes and residents' families following relatives' complaints or concerns over quality of care. Notices to quit were almost always one piece of 'traumatic journeys' within a particular care home experienced by the families interviewed for this report, who felt that constructive, empathetic and person-centred communication was lacking.
- Some care home managers and LGO reports mentioned stress and pressures on staff related to high levels of contact and/or complaints and/or abusive behaviour by relatives and/or high or complex levels of care as a primary factor for serving notice. Indeed, the most common reason for care homes serving notice – according to Care Quality Commission (CQC) (the regulator) data - is the inability to cater for a resident's needs. But, various LGO reports have concluded that the circumstances under which such notices were served are not always in the best interest of a resident, the option of last resort or not in line with necessary procedures, which it viewed as often amounting to an 'injustice' towards the resident and/or the relative.
- The negative emotional impact of the circumstances before, during and after receiving or learning of (in the case of funded individuals where the notice was handed to the commissioning local authorities) such a notice on families can be immense, with some relatives reporting posttraumatic stress disorder or long-term anxiety as a result. This seemed especially the case if the care home had not followed necessary procedures and policies leading up to the notice or once notice had been served. But some of the data, particularly the LGO reports, suggest that the negative emotional impact may also affect some individuals even when procedures and policies are followed.
- Many of the study's participants felt emotionally and practically overwhelmed, especially during the window between having been served notice and having to leave the care home, struggling to secure alternative accommodation for their family members. Interview participants reported the positive effect of support, including peer (other relatives') support and legal advice, on their ability to cope with the situation. However, local authority social workers (if they were in touch with such services) were often not perceived as helpful at any stage of the notice journey, with some exceptions who said that social workers had supported them to find new placements. Exploring a legal route to challenging the notice was not an option for many relatives because of the time, stress and financial burden associated with civil proceedings.
- The majority of people interviewed, whose relative in a care home survived the notice period and moved to another care setting, perceived an improvement in their life, around quality of care and wellbeing of their relative in the new care home or other care

[12] Dr Caroline Emmer De Albuquerque Green and Professor Jill Manthorpe: 'Angry, relieved, forever traumatised': A report into the experiences of families of care home residents who were served a 'notice to quit'(March 2023).

setting (We acknowledge of course that this study is limited by not hearing from residents who were the subject of notices to leave to get their accounts). This suggests that a change in care setting may indeed be a positive solution for a care home resident and/or their families. This is perhaps unsurprising considering the conflicted relationships, which often became worse after raising concerns, between families and notice serving care homes that the participants in this study described. In cases where notice was served because care needs could no longer be safely catered for, the move may also indeed be necessary and in the resident's best interest. However, some of the LGO reports concluded that, at times, families ended up in situations in which they had to take their relatives with care needs into their own homes without having the right environment and support to do so, which resulted in stress and anxiety for families and unsafe conditions for the people they cared for.

The report sets out a series of recommendations to address the issues set out above.

Controlling or Coercive Behaviour Statutory Guidance

The statutory guidance issued under section 77 of the Serious Crime Act 2015 (the 2015 Act) has been updated. It is entitled 'Controlling or Coercive Behaviour Statutory Guidance Framework 5 April 2023' and can be found here.

The guidance was updated following the coming into force of section 68 of the Domestic Abuse Act 2021 (the 2021 Act) which amended the definition of "personally connected" in section 76 of the 2015 Act. This removed the "living together" requirement, which means that from 5 April 2023, the offence of controlling or coercive behaviour now applies to partners, ex-partners or family members, regardless of whether the victim and perpetrator live together.

The guidance is primarily aimed at police and criminal justice agencies in England and Wales involved in the investigation of criminal behaviour. Indeed any persons or agency investigating offences in relation to controlling or coercive behaviour under section 76 of the 2015 Act must have regard to this Guidance. However, the information contained in this guidance is also important to organisations and agencies in England and Wales working with victims (including children) or perpetrators of domestic abuse, this of course includes children and adult social care providers and ICBs.

The Guidance contains detail on what constitutes controlling or coercive behaviour and guidance on identifying and evidencing the offence. This is particularly useful for agencies concerned with obtaining civil injunctions in COP and inherent jurisdiction proceedings, where coercive or controlling behaviour is in issue.

The Care Act appeals process

Summary

The Claimant in *HL v SSHC* [2023] EWHC 866 (Admin) sought to judicially review the Secretary of State for Health and Social Care's decision "*not to make regulations pursuant to s 72 of the Care Act 2014 (**the CA 2014**) to make provision for appeals against decisions taken by a local authority in the exercise of its functions under Part 1 of the CA 2014*".

Part 1 of the CA 2014 places local authorities ('LAs') under a duty to meet the care needs of eligible individuals in their area who require support. This is to promote individual's well-being: s.1(1) defined as including dignity and control over day-to-day life s.1(2). LAs are required to have regard to the importance of beginning with the assumption that the individual

is best placed to judge their own wellbeing: s.1(3). The LA's duty to carry out a needs assessment is set out at s.9. Where an adult has needs, the LA must determine whether these meet the specific eligibility criteria, and if so, the LA must, pursuant to s.18 "*meet [an] adult's needs for care and support which meet the eligibility criteria where they are ordinarily resident*". S.19 empowers LAs to meet identified needs which they are not required to meet under s.18.

S.72 of the CA 2014 confers a power on the SSHC to make regulations governing appeals. No such regulations have been made, nor has s.72 been brought into force following s.127. Whether this is unlawful is the central issue in this case. Relevant context to s.72 is set out by Julian Knowles J at paragraphs 8-13 of the judgment, in particular the fact that individual care recipient may disagree about the level of care and support that is necessary. That individual can complain to the LA via its internal complaint procedure, to the Local and Social Care Ombudsman ('LGSCO') (on limited grounds), seek judicial review of the LA's decision, or bring a claim under the Human Rights Act 1998 ('HRA 1998'). The Claimant contended that there were not effective dispute resolution mechanisms as none wereare capable of reaching a decision on the merits of any dispute with the LA, the "*nub of the Claimant's complaint is that the Defendant decided in 2016 to implement an appeals system under s 72, but then on 1 December 2021 in a White Paper performed what she regards as a volte-face and decided not to implement the appeals system*" (paragraph 13).

Three main grounds of challenge were advanced on behalf of the Claimant were as follows:

- Ground 1: the Defendant breached his common law duty to consult prior to making his decision in December 2021 to 'shelve' the implementation of an independent appeals system.
- Ground 2: the failure to implement an appeals system poses a real risk of individuals being unable to have effective access to a legal remedy.
- Ground 3: the failure also amounts to an interference with the procedural guarantees to an effective remedy to which the Claimant is entitled under Article 8 of the European Convention on Human Rights ('ECHR').

Julian Knowles J reviewed relevant policy and legal context, noting the requirement on local authorities to keep care and support plans under general review annually pursuant to s.27(1) Care Act and *Care and Support Statutory Guidance* (updated 2 September 2022), and the existing routes for challenging adult social care decisions, identifying that the LGSCO is expressly precluded from questioning a decision on its merits.

A history of s. 72 of the CA 2014, set out in the judgment, covers that it was introduced following public consultation and following express recommendation of the Law Commission and a Joint Committee of Parliament. A decision was taken to implement an appeals system following a 2015 consultation. The Consultation Paper contained proposals for a three-stage appeals system. In 2016 the SSHC announced the decision to introduce the proposed system as recorded in the *Care Act Factsheet 13: Appeals Policy Proposal*. Developments from 2016 onwards culminated in the White Paper in December 2021 which concluded that an appeals system would be "*introduced immediately*." It is that decision which was the focus of this case.

The SSHC relied on the evidence of the Director of Adult Social Care Policy who noted in his witness statement at cited at paragraph 84 of the

judgment that the "*Secretary of State had to make policy decisions about which areas to prioritise early spending on*". The SSHC made the decision that other areas were to be prioritized and the appeals system was not a reform priority. The White Paper concluded:

> *The Care Act 2014 includes a provision to introduce a new system to allow the public to appeal certain social care decisions made by local authorities. While we do not intend to introduce such a system immediately, we are keeping it under ongoing review as the new reforms are implemented and will continue to gather evidence to inform future thinking.*

The court's findings on the three grounds:

The Court's findings on the three Grounds advanced were as follows.

Ground 1: That the ground of challenge concerning the duty to consult must fail (paragraph 106) This is on the basis that there was no statutory duty to consult in 2021 in this case. Julian Knowles J applied *R (Better Streets for Kensington and Chelsea) v The Royal Borough of Kensington and Chelsea* [2023] EWHC 536 (Admin), [36]-[47] and *R (Plantagenet Alliance Ltd) v The Secretary of State for Justice and others* [2014] EWHC 1662 Admin, and made the findings that:

- There could be no suggestion that the Defendant made an *unequivocal* promise to consult in relation to an appeals system under s. 72 (paragraph 116);
- That there had previously been consultations, but that these could not have given rise to an expectation of a subsequent consultation (paragraph 117).
- That the White Paper Consultation of 2021 was of a broad type - it covered some 233 organisations. The court consequently took the view that the consultation conducted met the purposes required – namely that the (a) decision-maker receives all relevant information and that it is properly tested; (b) it avoided the sense of injustice which the person who is the subject of the decision will otherwise feel; and (c) the broad and inclusive nature of the consultation was reflective of the democratic principle (paragraph 121);
- That the fact that there was a fundamental change in circumstances marked by the white paper did not require the type of consultation that the Claimant's contends for – where a change in government policy follows a full consultation, this does not require the consultation process to be repeated (paragraph 124).

Julian Knowles J concluded at paragraph 130 that the combination of the Law Commission's work and ongoing consideration, taken together, mean there had been no unfairness, let alone that of the necessary cogency that could warrant an intervention.

Ground 2: Julian Knowles J rejected the Ground 2 advanced by the Claimant, the 'access to justice' argument, his conclusion being found at paragraph 152.

His analysis began with considering one of the first cases under the access to justice head: *R v Lord Chancellor ex parte Witham* [1998] QB 575, which had identified that "*access to courts was a constitutional right at common law which could be abrogated only be a specific statutory provision in primary legislation*." He then considered *R (UNISON) v Lord Chancellor* [2017] 3 WLR 409, a a 'fees case' which was concerned with the lawfulness or policy or delegated legislation which creates an unreasonably or unacceptable impediment to effective access to justice. Julian

Knowles J noted that the policies considered in *Unison, Witham* and *R (BF (Eritrea)) v SSHD* [2021] 1 WLR 3967 prevented *any* access at all to a court or tribunal.

Measured against that yardstick, Julian Knowles J found that the Claimant had failed to fulfill the requirement per *R (A) v Secretary of State for the Home Department* [2021] 1 WLR 3931 at [80] to show that there is 'unacceptable risk' this is because:

- Parliament, by leaving it to the SSHD to bring into force and then implement an appeals system, did not consider the problem so pressing as to require the Secretary of State to implement such a system (paragraph 144);
- The Claimant was not left without remedies – including JR and HRA 1998 claims which confer broad and flexible powers on the court and the LGSCO (paragraph 145);
- That work completed by the Department "*has not uncovered that much concern about the lack of a merits appeal system"* (paragraph 146).

Thus, while Julian Knowles J accepted the general point that the Defendant acknowledged a possible need for change regarding appeals, that this fell short of showing "*there is currently a risk of an unconstitutional and unlawful denial of access to justice"*. Accordingly Ground 2 was rejected (paragraphs 150-151).

Ground 3: The Court rejected Ground 3 "*for essentially the same reasons"* at paragraph 152. Mr Justice Knowles accepted that Article 8 carries procedural weight. However, he found that there was nothing in *Kiarie v Secretary of State for the Home Department (R (Byndloss) v Secretary of State for the Home Department)* [2017] 1 WLR 2380 that assisted the Claimant's case; rather, it pointed to to states' margin of appreciation in determining how those procedural rights are to be vindicated. Finally, he concluded that service users like the Claimant can access the courts and the LGSCO, and that that legal aid is available (see paragraph 155).

For the reasons set out in relation to each ground above, the claim was dismissed.

Comment

We set out the reasoning of this judgment in some detail, both because of its importance in itself (unless people have an effective ability to challenge care decisions, then their options available to them in the name of their best interests are radically limited), but also because of the coincidence of its timing with the decision to delay LPS. It would be interesting to speculate how a judicial review to challenge the SSHC's failure to implement LPS might be run. By contrast to the Care Act, the Mental Capacity (Amendment) Act 2019 did not empower the SSHC to bring into force the new framework; rather, it simply provided for the new framework. Parliament therefore undoubtedly might be considered to have considered the problem to be "pressing," a word that the Government itself used in responding to the Law Commission's recommendations, noting that "[w]e agree in principle that the current DoLS system should be replaced as a matter of pressing urgency." [13] Given the limited scope of non-means-tested legal aid, how effective is the ability of those deprived of their liberty to access justice where either (a) they are stuck in the queue waiting for a DoLs authorisation; or (b) in the community if they are (crudely) required in many cases to pay for the privilege of being deprived of their liberty. And in relation to the equivalent of Ground 3, the

[13] 180314 Response to Law Commission on DoLS - final.pdf, at paragraph 13.

LPS engages not 'merely' Article 8, but also Article 5 procedural rights.

Assisted Decision-Making (Capacity) Act 2015 commenced

After a very protracted journey, including amendments introduced even before it had been implemented, Ireland's Assisted Decision-Making (Capacity) Act 2015 was commenced on 26 April 2023. An extremely helpful informal consolidated version of the Act, including subsequent amendments and clarifying the rather impenetrable commencement orders, has been prepared by David Leahy SC and can be found via here.

Alex has recorded a video including elephant traps and worked examples from England & Wales which may be of some assistance to those working with the 2015 Act.

SCOTLAND

Four items on the common theme of difficulties with powers of attorney

Items (a) and (b) below concern difficulties arising from the creation and registration of powers of attorney, including the drafting of power of attorney documents. Items (c) and (d) are concerned with powers of attorney that have been properly created, but where difficulties are encountered in their operation – put technically, in recognition and acceptance by third parties, often characterised in "lawyer-language" as recognition and enforcement, but of course what granters and attorneys are entitled to expect, but are too frequently discriminatorily denied, is that powers of attorney be operated without encountering unnecessary and improper obstructions from third parties. Item (c) reports two German cases which taught salutary lessons to at least two institutions guilty of such conduct, the principles established by each being directly relevant to practice here. Items (a), (b) and (d) are all matters which we shall follow, with a view to reporting further as they develop.

(a) Inadequate drafting of powers of attorney

It is a decade since it was held in *Application in respect of S*, 2013 SLT (Sh. Ct.) 65, that the power of attorney document before the court in that case was not fit for purpose, and that it was accordingly necessary to grant a guardianship order. The deficiencies in the drafting of the power of attorney document appear to have defeated what must be presumed to have been the intentions of both granter and attorney in creating the document and accepting appointment. That case concerned a power of attorney document granted in 1998. One might have hoped that any further such issues coming to light might also relate to documents granted some considerable time ago, but one would be disappointed. It appears that issues continuing to arise because of inadequate drafting of power of attorney documents where joint attorneys are appointed, to the extent that the Public Guardian recently presented to Paisley Sheriff Court an application under section 3(3) of the Adults with Incapacity (Scotland) Act 2000 seeking the court's directions as to the proper interpretation of a power of attorney document which appointed two attorneys without any provision at all as to the extent to which they were required to act jointly, or alternatively could act individually, nor as to whether one was authorised to continue to act alone if the other should for any reason cease acting. One has to record considerable surprise that these most fundamental points were not addressed in the document: and even greater surprise that, that application having been withdrawn because it was ascertained that the granter still had adequate capacity – if so minded – to address the deficiencies, the Public Guardian was able to identify another power of attorney document with similar deficiencies which, we understand, is likely to be the subject of a similar application by her in the near future.

Section 62 of the 2000 Act applies only to joint guardians, not to joint attorneys. A joint guardian may act individually subject to consulting the other guardian, unless consultation would be impracticable in the circumstances, or the joint guardians agree that consultation is not necessary (sections 62(6) and (7) read together). Where there are joint guardians, a third party in good faith is entitled to rely on the authority of any one or more of them (section 62(9)). Joint guardians are liable for any loss or injury caused to the adult arising out of that guardian's own acts or omissions, or that guardian's failure to take reasonable steps to ensure that a joint guardian does not breach any duty of care or fiduciary duty owed to the granter (section 62(6)). Joint attorneys may however seek directions from the sheriff under section 3 of the

2000 Act, notwithstanding that section 62(8) explicitly provides that in the case of joint guardians only.

What is the minimum necessary for a power of attorney document? Styles are of course only a starting-point, which might be useful for guidance, but in every case the drafter takes responsibility for the document actually produced in that case. I still have my own bank of standard styles as I held them at the point when I ceased practising in 2016. Drafting power of attorney documents involves a substantial range of knowledge and skills, and I still hold 23 styles of power of attorney documents. For the minimum necessary, there are the styles relevant for granters whose ability to exercise their legal capacity is dependent upon substantial support, and thus – in any draft document – simple language. For appointment of joint attorneys, I started with this:

> *They must consult with each other, but either may act alone if the other agrees [# optional but they may only act jointly in # specify]. If for any reason one of them ceases to act as my attorney, the other may act alone in all matters.*

There can of course be several combinations of one or more attorney and one or more substitutes. Still taking the relatively simple situation of two attorneys and one substitute, but with more comprehensive drafting, my styles include one with the following three clauses:

> ***One*** *I hereby nominate and appoint my #, #, residing at #, and #, #, residing at # (hereinafter called "my First Attorneys") to be my true and lawful attorneys with the powers aftermentioned.*
>
> ***Two*** *I hereby nominate and appoint as my substitute attorney to act as my attorney in the event of either or both of my First Attorneys for any reason not taking up office as my attorney or at any time and for any reason ceasing to act as my attorney, #, residing at # (hereinafter called "my Substitute Attorney") with the powers aftermentioned, declaring (a) for so long as my First Attorneys are my joint attorneys, or either one of my First Attorneys together with my Substitute Attorney are my joint attorneys, such joint attorneys shall act in consultation with each other but either may act alone if and to the extent that the other has so agreed, except that they may only competently act jointly in entering any contract or executing any document relating to heritable property, in any acts or decisions concerning any gift, renunciation, lending or borrowing, in commencing and/or pursuing any judicial or other proceedings, and in making any appointment and/or authorising any remuneration or reimbursement in terms of the powers set forth in paragraphs # of the Schedule hereto, (b) that if any one of my First Attorneys or my Substitute Attorney shall be or become my sole attorney, such sole attorney may act alone in all matters and the foregoing provision (a) shall not apply.*
>
> ***Six*** *I provide and declare that all acts and deeds done or granted by my Attorneys and all decisions made by them in virtue of the powers hereby conferred shall be as valid and binding as if done, granted or made by myself; that in matters where my Attorneys are required to consult with each other the acts, deeds and decisions of each shall be so valid and binding in questions with third parties whether or not they have so consulted, and third parties shall not require to enquire as to whether they have so consulted; that except where in terms hereof anything requires to be done, executed or decided by more than one Attorney, third parties may accept without further enquiry a statement by*

> *an Attorney that that Attorney is at the time my sole Attorney or that that Attorney has been authorised by any other Attorney to act alone in the matter in question; and that persons paying money or transferring property to either of my Attorneys shall not be concerned with or be bound to see to the application thereof; and I bind myself to ratify, approve of and confirm all that my Attorneys shall do or cause to be done in virtue of the powers herein contained.*

(b) McFadyen case

In January, Sheriff Fife at Edinburgh Sheriff Court issued a judgment not yet posted on the scotcourts website at time of writing. We understand that it is likely to be published on the scotcourts website in the near future, following which we shall report on it. It is understood that interesting features include a general practitioner confirming to a certifier that an adult had capacity to grant a power of attorney document that was promptly registered, but the GP changed his mind about that a week later; and also that of the three joint attorneys appointed, only one accepted appointment, two others having accepted appointment under a previous power of attorney, but not the document in question. Those features have been described to me, but cannot be verified until the judgment becomes available.

(c) Powers of Attorney Bill

I commented in the March Report on aspects of the Powers of Attorney Bill, a UK Bill. I understand that the Bill has now completed its passage through the House of Commons with relevant provisions still limited to addressing difficulties about operability of English powers of attorney elsewhere in the UK, for which there is no evidence, but not equivalent difficulties with the operability of *inter* alia Scottish powers of attorney when presented in England & Wales, or to branches in Scotland of institutions headquartered in England & Wales, for which there is ample evidence. It is understood that attempts may be made in the House of Lords to remedy this imbalance by amending relevant provisions to apply equally across the United Kingdom.

(d) Enforcement of powers of attorney – two German examples

It is not only within the United Kingdom, nor only in relation to cross-border use of powers of attorney, that difficulties are encountered. Whether in a cross-border situation or not, standard advice where difficulties are encountered in having powers of attorney accepted and operated is that one should threaten enforcement action in which an award of expenses will be sought against the relevant third party. Occasionally, even that threat does not achieve prompt compliance. It is reassuring, and helpful to practice here, to note that in two such situations arising in Germany the courts there have granted the desired order, with expenses awarded against the recalcitrant third party.

In a case before Detmold Regional Court (LG Detmold, Urt. v. 14.1.2015 – 10 S 110/14), a bank refused to make a transfer instructed by the attorney, and demanded a certificate of appointment as guardian of the adult. The court held that this demand was unlawful, because the power of attorney authorised the attorney to act in the matter. By refusing to comply as instructed, the bank had made itself liable to compensate the attorney for the costs incurred for legal representation and for the proceedings, and awarded those costs against the bank.

In a case in Hamburg Regional Court LG Hamburg, Beschl. v. 30.08.2017 – 301 T 280/17), a granter suffered from progressive cancer and was living in a hospice, unable to get out of

bed. For that reason she had appointed her daughter as attorney to act for her in her financial affairs. It is understood that the mother's relevant capacity was not impaired, so that (in our terminology) this was a general power of attorney rather than a continuing one, but the practical issue was the same. The bank refused to act on the power of attorney and demanded a bank mandate. The daughter sought appointment as her mother's financial guardian. The court held that although there were no grounds in law to appoint the daughter as guardian, because of the existence of the power of attorney, it nevertheless appointed her to resolve the matter and, again, held that the bank was liable to bear the costs of those proceedings.

For forwarding these cases, and for permitting me to base my description of them on her helpful translation, I am grateful to Désirée Wollenschläger, Legal Advisor to the Central Authority for Germany, one of the colleagues in my work for the Hague Conference.

Adrian D Ward

Diagnosis alone not relevant

Even in proceedings under the 2000 Act, one may come across the fallacy that existence of a mental disorder of itself justifies an assumption, or even a finding, of relevant incapacity. A diagnosis of mental disorder, by itself, is no more relevant than a diagnosis of a broken leg. There must be evidence of resulting incapacity. Acting for an adult in respect of whom a guardianship order was sought, and who opposed the application, I have successfully pointed out that medical reports were fundamentally flawed in that after narrating the adult's mental disorder, in support of their "opinion that the condition mentioned in Part C [the mental disorder] has impaired the capacity of the adult named in Part A to make decisions about or to act …" (the wording in the prescribed form of certificate) has merely given more information about the mental disorder without linking that to any clear finding of incapacity.

This misapprehension arises in many other situations. A timely reminder of the underlying fallacy has been given in the opinion, delivered by the Lord Justice Clerk, in a decision of the Second Division of the Inner House issued on 14th March 2023 in an appeal by Dr Mina Mohiul Maqsud Chowdhury (Appellant) against the General Medical Council (Respondents). A Panel of the Medical Practitioners Tribunal Service had found that Dr Chowdhury's fitness to practise was impaired, and that his name be erased from the medical register. Dr Chowdhury submitted that that decision should be quashed, and a new Tribunal appointed to re-examine the facts, on the basis that a diagnosis of autism spectrum disorder had been made only between the impairment decision and the sanctions hearing, and that the diagnosis was likely to have had a material bearing on the Tribunal's assessment of fact, and its decision on impairment.

Tshe issue here was the impact of the diagnosis on Dr Chowdhury's conduct in relation to the findings in fact of the Tribunal, rather than an issue of capacity in terms of the 2000 Act, but the general point of principle (I would suggest) about linkage between diagnosis and a finding central to the outcome of proceedings is the same. Relevant for the purposes of this Report is paragraph [37] of Lady Dorrian's opinion. It speaks for itself. It reads:

> *"There is a clear flaw at the centre of the appellant's approach in this case. That is that the primary focus has been on the mere diagnosis itself, rather than on the manner in which certain features of the condition affect the appellant in specific*

ways related to the subject matter, conduct and outcome of the proceedings. The diagnosis itself, and a recital of common characteristics which may be, or even are, found in the appellant does not advance the issue. It is always important to bear in mind that the new evidence must be examined in the context of the whole proceedings, and the evidence led during the original process. To succeed with an appeal on the basis that this constitutes fresh evidence it is vital to link it closely to the conduct and outcome of the proceedings in a way which might persuade the court that it could have a material effect on the decision. A proper and detailed analysis from the viewpoint of the appellant should be the start of this, which may or may not lead to a detailed analysis of parts of the transcripts. This is necessary not only because of the need to establish materiality, but because, as Lord Reed noted in Rankin v Jack (para 40) a step in assessing whether the grounds advanced have merit is to examine the cogency of the evidence advanced. In short, the diagnosis would not be capable of impacting on the original decision unless it manifested itself in ways which influenced or contributed to that decision."

Adrian D Ward

Where the law, human rights and practical realities of the forensic psychiatric estate collide

Note by Sheriff Paul Reid, Advocate in respect of the Summary Complaint brought by the Procurator Fiscal of Perth against ZA

On 14th February 2023, Sheriff Paul Reid (Sheriffdom of Tayside, Central and Fife) issued a Note[14] sharing what had been learned from the management of a case involving a remand prisoner, ZA. The reason for doing so was that it is illustrative of existing tensions in Scotland between legal and human rights – in this case, Article 5 ECHR (the right to liberty) – and current demands upon the forensic psychiatric estate, particularly involving women[15]. Its highlighting of the fact that there may not always be a legal basis to continue to detain remand prisoners experiencing mental ill-health, and therefore provide safeguards for such prisoners, is worrying.

The facts

In August 2021 ZA had been charged with a number of racially motivated offences. She had been on bail until December 2022. Concerns over ZA's mental health seem to have arisen around December 2022 and at the end of January 2023 she was remanded in custody, although it is unclear why bail was revoked, and has been in custody ever since.

A reading of the full facts and chronology of the hearings relating to ZA, as presented in the Note, is recommended. In summary, a Specialist Registrar in Forensic Psychiatry who examined her in prison determined that ZA lacked capacity to discuss legal matters, it was in her best interests that her mental health be assessed in a psychiatric hospital and that she was unable to instruct her solicitor or effectively participate in court proceedings. However, it also became clear that there was no possibility of a suitable bed becoming available in the near future.

By the beginning of February 2023 things had come to a head. ZA's notional trial date was imminent but she remained in prison and unassessed and had by then been in custody for 40 days which is the statutory maximum days on

[14] [2023] SC per 11.

[15] Para 1.

remand in summary proceedings before the trial must start[16].

The court therefore had three options:

(a) Start the trial

This was not possible as ZA was not present and had by then been assessed as unfit to participate in 4 proceedings.

(b) Refuse to extend the time limit

This would result in ZA being released, potentially exposing her and others to risk of harm.

(c) Extend the 40 day limit for detention

Whilst this appeared to be the 'least bad option' it was highly problematic. As mentioned, ZA had already been in custody for the maximum period she could be detained pre-trial and no hospital bed was likely to become available in the near future. The court could not lawfully permit ZA's continued detention if it became arbitrary within the meaning of Article 5 ECHR.

The court authorised the detention for seven days then, in light of there being limited information as to what would happen if ZA's was extended again, for a further seven days (at the request of the Crown) until 14 February so that there could be a hearing at which a fuller explanation could be offered about the available options for managing ZA if her detention then ended. In fact, on the same day as this last extension, the court was informed that a bed would become available shortly and the necessary order was therefore made to accommodate this.

The Scottish Ministers did subsequently present a fuller explanation of the practical, including structural, issues and concerns involved here. This highlights wider challenges that had also been raised by both the recent Independent Forensic Mental Health Review (the Barron Review)[17] and Scottish Mental Health Law Review (the Scott Review)[18] about mental health provision in Scotland. The local Health Board had responsibility for ZA's care and the Scottish Ministers 'were coordinating efforts at a national level to address what appeared to be a structural issue'[19].

The Legal and Human Rights Framework

The Law: Assessment Orders, remand and avoiding arbitrary detention

Under the Criminal Procedure (Scotland) Act 1995 the Crown must apply for an assessment order (which lasts for a period of 28 days) where it appears that the person charged with an offence has a mental disorder[20]. The Scottish Ministers may apply for an Assessment Order where a person is remanded in custody[21]. Section 52D of the Act sets out the criteria for granting an assessment order, the granting of which is in the discretion of the court. The court may itself also grant such an order where it would have done so had an application been made by the Crown or Ministers[22]. Where a suitable bed is available section 52D also allows for a person to be held for up to seven days in prison pending their removal to hospital.

However, as already mentioned, the statutory maximum days a person may be held on remand in summary proceedings before the trial must start is 40 although this period may be extended

[16] s 147 Criminal Procedure (Scotland) Act 1995.
[17] Independent Forensic Mental Health Review, Final Report, February 2021.
[18] Scottish Mental Health Law Review (Scott Review), Final Report, September 2022.
[19] Sheriff Reid's Note, para 8.
[20] s 52B Criminal Procedure (Scotland) Act 1995.
[21] s 52C Criminal Procedure (Scotland) Act 1995.
[22] s 52E Criminal Procedure (Scotland) Act 1995.

under section 147(2) of the Criminal Procedure (Scotland) Act 1995 as the sheriff thinks fit if cause is shown. That being said, any decision must, of course, be in accordance with the European Convention on Human Rights (ECHR) and Human Rights Act 1998[23].

Human Rights: what is arbitrary detention violating Article 5 ECHR?

As Sheriff Reid states in his Note, Article 5 ECHR is relevant here and, in particular, its requirement that detention is not arbitrary[24] and there must be a correlation between the ground for detention [25] and place and conditions of detention[26]. Moreover, where there is an interim detention measure pending transfer to a more appropriate place of detention then such transfer should occur speedily to an appropriately resourced setting[27]. However, he also notes that ECHR jurisprudence acknowledges that whilst significant delay in admission to an appropriate setting will clearly impact on the prospects of effective treatment there may be delays in the transfer, although these should not be unreasonable[28].

Importantly, Sheriff Reid mentions that where a structural lack of capacity has already been identified then delays of, for example, six[29] or eight [30] months would not be considered reasonable and would be incompatible with Article 5. Equally importantly, he points out that the notion of arbitrariness encompasses whether detention is indeed necessary to achieve the stated aim, detention being a serious and last resort only measure[31]. Alternative, less severe, measures should therefore also be considered[32].

Applying these frameworks to ZA and the wider problem in Scotland

It appeared to be generally agreed that it was not in ZA's or the wider public's interests that she simply be released, unsupported and unmonitored, from prison. However, Sheriff Reid was not at all comfortable with a number of aspects of this case:

1. He was unhappy with the suggestion made to him that he could effectively avoid the potential arbitrariness of detention issue by remanding ZA in custody consecutively on the various charges against her.

> *I am not satisfied that such a course would be compatible with the prohibition on arbitrary detention enshrined in Art.5. Indeed, it strikes me as the very definition of arbitrary (being entirely dependent upon the happenstance of another complaint being before the court). I did not consider this option to be one that was lawfully available.*[33]

2. He was clear that there needs to be a tangible appropriate hospital bed available if the requirements of section 52D and Article 5 ECHR are to be complied with.[34]

3. He had adopted the course of extending the time limit under s.147(2) of the Criminal Procedure (Scotland) Act 1995. However, this was not without misgivings about for how long

[23] ss 3 and 6 Human Rights Act 1998.
[24] *McKay v UK* (2006) 44 EHRR 41 at para 30; *Brand v Netherlands* (2004) 17 BHRC 398 at para 58.
[25] Article 5(1) (e) ECHR and in this case governed by *Winterwerp v Netherlands* (1979) 2 EHRR 387).
[26] *Ashingdane v UK* (1985) 7 EHRR 528 at para 44.
[27] *Bouamar v Belgium* (1988) 11 EHRR 1 at para 50.
[28] *Johnston v UK* (1997) 27 EHRR 296 at para 63; *Brand, op cit,* at paras 64-65.
[29] *Brand, op cit.*
[30] *Mocarska v Poland* [2008] MHLR 228.
[31] *Saadi v UK* (2008) 47 EHRR 17 at para 70.
[32] Sheriff Reid's Note, para 16,
[33] Ibid, para 19.
[34] Op cit, para 20.

that could be done before any detention would constitute arbitrary detention thus rendering it unlawful. He had been satisfied that the line of arbitrariness had not at that stage been crossed as Article 5 ECHR requirements were being met (see above). That being said, he nevertheless had concerns over the lack of sense of urgency in finding a suitable bed apparently until the 40-day limit arrived, and it was only when the court had ultimately made it clear that it might not be able or willing to extend the detention further that a bed miraculously seemed to appear. The absence of an available bed meant that the section 52D provision allowing for a person to be held for up to seven days in prison pending their removal to hospital (see above) was not engaged but the spirit of that provision should have been respected and finding such a bed made a priority. He was also unhappy that the manner in which ZA's case had been managed meant that there was no consideration of alternatives, including community-based ones, to an Assessment Order.

> *That made it very difficult to be satisfied that detention was a last resort or to be satisfied that there were no less severe measures, which would be adequate, available (Saadi, above).*[35]

In sum, Sheriff Reid considered that these concerns:

"…took this case much closer to the line of arbitrariness that it would otherwise have been. Had a bed not become available, I would have been unlikely to have further extended the accused's detention."[36]

Noting that until the Scottish Ministers address and resolve the identified issues this problem is likely to continue he therefore provides some observations[37] which might assist in the meantime when similar cases are faced. Rather than attempt to summarise them, I set them out here verbatim:

> *"a. In principle, and subject to regular and informed oversight by the court, the continued detention of a person in custody whilst they await the making of an assessment order can be compatible with the Convention.*
>
> *b. Where the sole reason for not making an assessment order is the lack of an appropriate bed, the Crown ought ordinarily to notify the relevant Health 18 Board(s) (namely, the Board responsible for healthcare in the prison and the Board where the accused would ordinarily reside if at liberty) and the Scottish Ministers.*
>
> *c. Before granting, or when reviewing, the detention of an accused in custody where an assessment order cannot be made due to lack of an appropriate bed, the court should ordinarily expect to be satisfied as to the steps taken to find a bed, whether community-based alternatives to an assessment order could be appropriate and, if so, whether they are available, the timescale within which a bed is likely to become available and the accused's current condition.*
>
> *d. Given an assessment order should be completed within 28 days, the court would not normally allow more than 28 days to pass at any one time without the case calling before the court (although as this case has shown, it was only shorter periods which were sought and granted).*
>
> *e. Whilst input from the relevant Health Board(s), and potentially the Ministers, may be necessary, it should not be*

[35] Op cit, para 23.
[36] Op cit, para 23.
[37] Op cit, para 24.

> *necessary for those parties to appear (and incur the associated time and cost commitment). The Crown ought to be able to liaise with those parties and present the necessary information to the court.*
>
> *f. A compatibility issue should not be expected to arise before the normal period of detention has expired. Where that period has been reached, however, an application under s.147(2) may well raise a question as to whether how a public authority (namely, the court) proposes to act is unlawful under the HRA. Accordingly, before moving such an application, the Crown ought to consider the need to lodge a compatibility minute. Were an application under s.147(2) to be opposed, a compatibility minute would ordinarily be necessary."*

He accepts that this may require a case to call more often than normal but the need to avoid detention becoming arbitrary is essential.[38]

Conclusion

As already mentioned, the ZA case is not an isolated one. It illustrates a wider problem of the stretched forensic mental health services across Scotland and their ability to provide appropriate and human rights-based support and safeguards for persons with mental disability. Attention has already been drawn to this by the Barron and Scott Reviews[39] and the Scottish Government and Health Boards are admittedly apparently endeavouring to address it. They must certainly do this expeditiously. Although the risk of harm to the remand prisoner and/or to others is an important consideration the deprivation of a person's liberty is a serious matter. The decision to detain a person must be a last resort, must not be taken lightly and must be proportionate and non-discriminatory. A person experiencing mental ill-health should not be left waiting indefinitely or for extended periods of time in detention waiting for assessment and appropriate support.

Whilst the matter is being resolved, Sheriff Reid's observations, which could be considered to be guidance, are helpful. I would also suggest that it would be useful if the Mental Welfare Commission for Scotland both highlights this issue and provides guidance. It would also be beneficial to consider, alongside the Article 5 ECHR issues already mentioned, a remand prisoner's right to freedom from inhuman and degrading treatment in Article 3 ECHR[40] and right to enjoy ECHR rights without discrimination as required by Article 14 ECHR. Further, whilst UN Convention on the Rights of Persons with Disabilities (CRPD) rights are not directly enforceable at national level in Scotland yet the Scottish Government is currently obliged not to act contrary to the UK's international obligations, including those as a CRPD state party, and has expressed a commitment to give legal effect nationally to the CRPD amongst other international human rights treaties. Consideration of the CRPD requirements relating to equality and non-discrimination (Article 5), liberty (Article 14), freedom from torture or cruel, inhuman or degrading treatment or punishment (Article 15) and socio-economic rights underpinning access to support and alternatives to detention should also be taken into account.

Jill Stavert

[38] Op cit, para 25.
[39] See, for example, Chapters 3 and 10 of the Scott Review Final Report.
[40] *MS v UK* [2012] MHLO 46.

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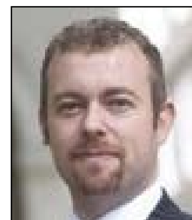

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Conferences

Members of the Court of Protection team regularly present at seminars and webinars arranged both by Chambers and by others.

Parishil Patel KC is speaking on Safeguarding Protected Parties from financial and relationship abuse at Irwin Mitchell's national Court of Protection conference on 29 June 2023 in Birmingham. For more details, and to book your free ticket, see here.

Alex is also doing a regular series of 'shedinars,' including capacity fundamentals and 'in conversation with' those who can bring light to bear upon capacity in practice. They can be found on his website.

Advertising conferences and training events

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

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

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