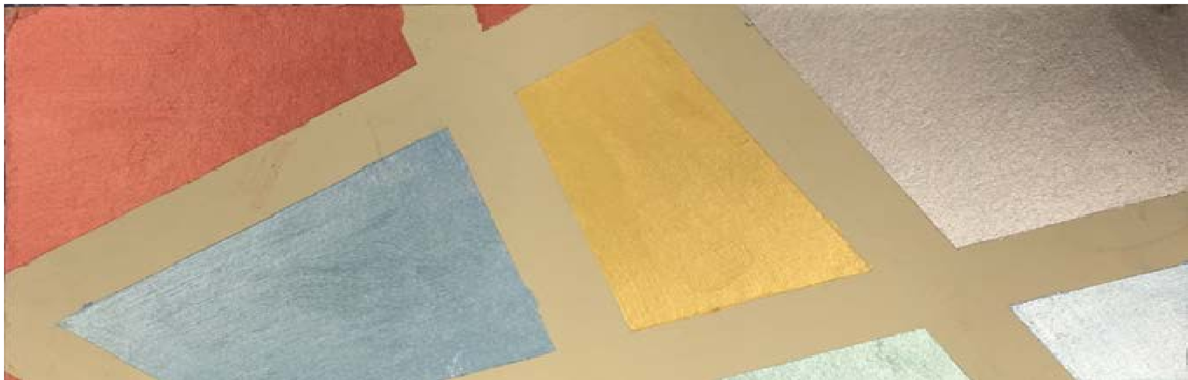

Welcome to the July 2023 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: an Anglo-Welsh LPS update and cases covering contingency planning, executive capacity, decision-specificity and restraining the detained patient;

(2) In the Property and Affairs Report: Hayden J takes on common LPA problems, an MOJ toolkit and a rather startling assertion about the position of professional solicitor deputies;

(3) In the Practice and Procedure Report: habitual residence under the spotlight, contempt and the Court of Appeal and the most recent Court of Protection statistics;

(4) In the Wider Context Report: the LGSCO ombudsman and deprivation of liberty, Article 2 and DoLs, visiting in care homes, and a report from our new Irish correspondents;

(5) In the Scotland Report: AWI masterclasses and the Scottish Government respondents to the Scott Report.

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

LPS UPDATES

The DHSC and MOJ

The Joint Committee on Human Rights *wrote* on 28 May 2023 to the Minister of State for Social Care to express its view that the "delay [to implementation] is deeply concerning, given the serious problems with the DoLS system that we reported on last year," and to ask three questions. The Minister, Helen Whately MP, has responded by letter dated 14 May 2023 (published by the JCHR on 23 May 2023). The letter is available on the JCHR website *here*, but as it requires a bit of navigation to get to it, we reproduce the material parts.

The decision to delay implementation of the Liberty Protection Safeguards (LPS) was taken after careful consideration of any implications it may have. I know that many people and organisations did an incredible amount of work in preparing for the introduction of these safeguards and the decision to delay their implementation beyond the lifetime of this Parliament was not taken lightly.

As you are aware, the Deprivation of Liberty safeguards (DoLS) set out in the Mental Capacity Act 2005 (MCA), is the system that provides for the lawful deprivation of liberty, of adults who lack the relevant capacity in hospitals and care homes, in accordance with article 5 of the European Convention on Human Rights. It is important that everyone concerned upholds this system. I do, however, recognise the challenges facing this system following the Supreme Court judgment in 2014 in the 'Cheshire West' case which increased the number of people considered as deprived of their liberty. The introduction of LPS was intended to address these challenges and although the Government has decided that now is not the right time to introduce this reform, I understand these challenges continue to pose practical problems for those affected by and applying the DoLS including those highlighted in your letter. I have responded to each of your points in turn.

Does the Government still believe that the system of DoLS is in need of reform? If so, given the delay in the implementation of the LPS, are any reforms of the system currently planned in the interim?

The Government still accepts the need for change and we are pleased that we have made progress towards introducing the LPS. There was clear support for implementing the LPS to replace DoLS at consultation, which will be a matter for a future government to consider.

The decision to delay the implementation of the LPS will enable us to focus on our priority of ensuring that everyone can access the right care, in the right place, at the right time. To achieve this goal, we are providing an historic funding uplift to the sector and taking forward the reforms set out in the Next Steps to Put People at the Heart of Care plan, which include investment in the workforce, technology and support for unpaid carers. Although these wider reforms will not alter the DoLS system, they will improve the lives of people who draw on, work in or provide care and support.

With respect to plans to reform DoLS in the interim, we recognise the importance of updates to the Mental Capacity Act Code of Practice (MCA Code) being taken forward irrespective of LPS to ensure all those practicing in this space have accurate and up-to-date guidance. Since the MCA came into force in 2007, the MCA Code has played an important role in shaping the practical application of the MCA. The Department of Health and Social Care and the Ministry of Justice (MoJ) intend to work together to consider the feedback and publish a response to the 2022 consultation on changes to the MCA Code, with the aim of publishing a revised MCA Code that supports

understanding and the application of the MCA which is essential to the application of DoLS. Further details on the timing of this work will be shared with the sector in due course.

Finally, I recently met with the Chief Executive of Social Work England and our officials continue to work together on launching a consultation on refreshed standards for Best Interest Assessor Training to ensure the ongoing quality of all those carrying out this important role under DoLS.

What steps are being taken to address the delays to the processing and completion of DoLS applications, with the aim of ensuring that no one is unlawfully deprived of their liberty in a care setting?

The Government has made it clear that all individuals and bodies with legal duties under the DoLS must continue to apply these important safeguards to ensure the rights of people without the relevant mental capacity are protected.

Local authorities have a duty to make sure that they are processing all cases under DoLS and receive specific funding to process cases in the NHS through the Local Government Community Voices Grant. Annual data on the DoLS clearly shows wide variation in how local authorities are processing and completing their DoLS applications. Many local authorities already use a prioritisation tool to manage DoLS cases, such as that developed by ADASS following the Cheshire West ruling in 2014.

The Government has made available up to £7.5 billion of additional funding over two years to support adult social care and discharge – with up to £2.8 billion available in 2023/24 and up to £4.7 billion in 2024/25. Local authorities have flexibility about how to use this funding to meet local needs.

Will the availability of non-means-tested legal aid be extended to include those who may be subject to deprivation of liberty in care settings without an authorisation in place?

From 15 March 2022 to 7 June 2022, the Government consulted on detailed policy proposals published under the Legal Aid Means Test Review. The MoJ published the Government Response to the consultation exercise on 25 May 2023 which set out the detailed policy decisions underpinning the new means-testing arrangements.

As part of the recent Legal Aid Means Test Review covering England and Wales, the Government considered whether certain specified civil legal aid proceedings should no longer be subject to means testing arrangements. These proposals did not extend to the removal of legal aid means testing for individuals subject to deprivation of liberty in care settings where no authorisation was in place or in cases where the Court of Protection needs to make a deprivation of liberty order, and, therefore, this position remains unchanged. However, if the application to the Court of Protection is made on behalf of an under 18-year-old, the applicant will benefit from the decision to introduce non-means tested civil legal aid representation for all under 18s.

What steps are being taken to ensure that those involved in making DoLS decisions receive adequate human rights training, and fully understand the operation of DoLS?

It is vital that those involved in DoLS decisions receive the right training. Training and learning on DoLS, which is free to access, is available through Health Education England's e-learning for health platform as well as the Social Care Institute for Excellence's website.

It is also essential that all those involved in DoLS decisions have sufficient understanding of the MCA which underpins the safeguards. In addition to updating the MCA Code, the Government continues to support the National Mental Capacity

Forum whose purpose is to raise awareness and understanding of the MCA across the health and social care sectors. The Department has sponsored this Forum jointly with the MoJ since 2015, bringing together stakeholders from a range of sectors where the MCA applies. Furthermore, MoJ continue to deliver wider MCA-awareness raising work on aspects of the MCA that do not directly relate to DoLS but are important for the proper application of the MCA which underpins the DoLS. This includes the publication of an MCA toolkit this month which provides guidance on the MCA and the legal steps for parents and carer to access funds on a young person's behalf.

I appreciate all the ongoing efforts of the sector to ensure the rights of those deprived of their liberty are upheld and I welcome the Committee's ongoing interest in this important issue.

In the most recent DOLS Newsletter published on 20 June 2023, the DoLS and Mental Capacity team at the DHSC made clear that:

> *remain committed to publishing a response to the consultation, which we hope to publish later this year. This response will summarise the valuable feedback we received, including the main themes we identified during our analysis of the responses.*
>
> *We would also like to take this opportunity to update you on the work to review and update the Mental Capacity Act 2005 Code of Practice (MCA Code) jointly with the Ministry of Justice (MoJ). We would like to assure you that both MoJ and DHSC remain committed to updating the MCA Code, to ensure that changes in case law and good practice since its publication in 2007 are incorporated, and to reflect the feedback stakeholders have provided both before and during consultation.*
>
> *As such, we are currently planning to work with the MoJ to revise the MCA Code, considering references on the Deprivation of Liberty Safeguards (DoLS) where appropriate, with the aim of ensuring all those who work with the Act and those who are affected by it have up-to-date statutory guidance. We will continue to work closely with stakeholders and further details on this work will be shared with you in due course.*[1]

The newsletter continues:

> *The Deprivation of Liberty Safeguards remain an important system for authorising deprivations of liberty. It is vital that health and social care providers continue to make applications in line with the Mental Capacity Act (MCA) 2005, and that Supervisory Bodies continue to fulfil their responsibilities with respect to authorising DoLS applications under the MCA to ensure that the rights of those who lack the relevant capacity are protected.*

Editorially, we are duty bound to note that unfortunate that neither in the letter from the Care Minister nor the DHSC Newsletter is it made clear **how** supervisory bodies can discharge their obligations (or public bodies make necessary applications to court) when it is clearly proving impossible for them to do with the resources currently available to them.

Welsh Government

A Welsh Government consultation was held

[1] Whilst we wait for the revised Code, it may be worth remembering that there is an unofficial update prepared by Alex and others at 39 Essex Chambers highlighting the passages that are dangerous in the current Code. It also worth reading the update carefully – it does not sound as if there is the intention to update the DOLS code, as opposed to the main Code.

between 17 March 2022 and 14 July 2022 on four sets of draft Regulations to support the implementation of the LPS in Wales The Welsh Government also consulted on supporting Impact Assessments, and a draft National Minimum Data Set for the LPS.

A summary of the consultation responses was published on 14 June 2023. The introduction sets out a number of key messages that were repeated across responses in relation to more than one of the consultation questions. These included:

- *The need for further clarification on how the Regulations will work in practice and concerns that the Regulations are not supporting the intended reforms, particularly around reducing bureaucracy; embedding the principles of the MCA across care, support and treatment planning; and supporting the rights of the person.*
- *Questions around cross-border issues and associated practicalities around implementation, workforce, and monitoring and reporting.*
- *Concern that the Regulatory Impact Assessment underestimates costs associated with undertaking assessments, determinations and pre-authorisation reviews; the role of the AMCP; the role of the IMCA; plans for monitoring and reporting; and plans for workforce development and training.*
- *Concern over the definition of a deprivation of liberty included in the draft Mental Capacity Act Code of Practice (published for consultation by the UK Government, alongside draft Regulations for England) and associated impacts on the implementation of the safeguards in Wales.*
- *Welsh Language: Support for the active offer and the needing to strengthen commitments regarding preferred language, and build workforce capacity.*

Picking up for present purposes on the penultimate bullet point, it is interesting to note (from page 59), under the heading "Concerns regarding the Code of Practice and how this is does not protect the rights of the cared for person" the following:

- *Specific concerns raised in relation to the definition of a deprivation, set out in Chapter 12 of the Code of Practice.*
- *The rights of the person and service users can only be protected when there is a clear definition of what is classed as a deprivation of liberty. Respondents "not convinced we have achieved that within the proposed legislation".*
- *The Acid Test appears to be altered which questions if the safeguards will be at a level required or as Cheshire West intended.*
- *The new interpretation*[2] *of the Acid Test takes many vulnerable people who lack capacity out of the reach of Article 5, yet still allows for intensely restrictive care with no right to*

[2] It is nerdily important to point out that a Code of Practice cannot create law, as opposed to amplifying what the law is (and, here, the law relating to deprivation of liberty is as set down by the courts). Although it is perhaps telling here that the Michelle Dyson, Director General for Adult Social Care at the Department of Health and Social Care, told the Joint Committee on Human Rights in May 2022: "We are looking at a new definition of what should constitute a deprivation of liberty – we have consulted on that and will wait to see what comes back…."

appeal or independent scrutiny.

- *Concerns raised that some people will not come under LPS (whereas they would come under DoLS). This means they will not be offered the same right to appeal and have their case heard in court.*
- *Concerns raised in relation to people who may not meet the "threshold" which would result in a deprivation of liberty being authorised. Greater clarity needed on this as there may still be restrictive practice taking place.*

Whilst we wait for further news from DHSC as to how they intend to proceed in England & Wales – including the equivalent summary of consultation responses (and a response to the letter from the Joint Committee on Human Rights), it is perhaps worth setting out the concluding section of the Welsh Government consultation response document in full:

> *107. The UK Government has recently announced their decision not to implement the LPS within this Parliament. Welsh Government has issued a Written Statement expressing disappointment at this decision.*
>
> *108. The consultation responses from stakeholders in Wales on the draft Regulations and supporting impact assessments have provided a wealth of information that will help inform future policy decisions, when any planned implementation of the LPS is confirmed by the UK Government. It may be necessary to undertake a further consultation on the Regulations following any decision by UK Government to progress with the LPS in the future.*
>
> *109. We all share the goal to continue to integrate and embed the principles of the Mental Capacity Act 2005 and the Mental Capacity (Amendment) Act 2019 into everyday care, support or treatment arrangements to avoid unnecessary duplication and bureaucracy for individuals and their families, and equally for practitioners, enabling them to share and use information legally and appropriately. Despite the recent decision of the UK Government, this remains our goal and our ambition for the people of Wales. As highlighted in the recent Written Statement, the views and the work of everyone who helped us develop and shape the consultation products, as well as everyone who offered views on the consultation, are not wasted. They have been recorded and retained to support us to protect and enhance people's rights.*
>
> *110. It has been widely recognised that there are number of challenges associated with the current DoLS system, particularly in light of the increases in the number of DoLS applications – which have been seen across England and Wales.*
>
> *111. In light of the UK Government decision, we will need to consider how we strengthen the current DoLS system in Wales and continue to protect and promote the human rights of those people who lack mental capacity. Stakeholders in Wales have provided significant evidence and support to help us shape the LPS for Wales. Welsh Government will be re-engaging with stakeholders so that we can listen and hear what we can do now to address some of the current challenges within DoLS. This will support the current application of DoLS, and strengthen the position that Wales will be in to transition to the LPS in the future.*
>
> *112. It is imperative that the momentum generated through the contributions of stakeholders in Wales is not lost. Welsh Government will continue to work with*

> *stakeholders to improve services for those who lack mental capacity, whilst preparing for any future decision by UK Government to implement the necessary reforms identified in the Mental Capacity (Amendment) Act 2019.*

KEY RECENT CASES

Contingency planning (1)

The Shrewsbury and Telford Hospital NHS Trust v T and Midlands Partnership NHS Foundation Trust [2023] EWCOP 20 (Lieven J)

Best interests – medical treatment – practice and procedure (Court of Protection) – other

Summary[3]

This judgment (which Lieven J notes was prepared approximately nine months after the application was determined) related to an application by the applicant Trust on 1 August 2022 for an anticipatory declaration in respect of the obstetric care for 'T.' T was 39 weeks pregnant, and had a diagnosis of Persistent Delusion Disorder. She had been detained under s.2 Mental Health Act 1983 approximately two and a half months prior to the application, and was recorded as not being compliant with medication. T was described as having "*something of a chaotic lifestyle*" (paragraph 4), but on 14 July 2022, had been assessed by her treating obstetrician as having capacity to make decisions about her obstetric care.

However, "*[i]n late July, T called her midwife and sounded very distressed, angry and delusional*" (paragraph 6). T's obstetrician reconsidered her view on capacity, and felt that T had fluctuating capacity, and specifically, "*may lose capacity due to the stress and pain of labour and the effects of drugs, which may cause her to have delusional thoughts which mean she cannot discuss her delivery options and obstetric care at the time. T has been known to focus on her delusional thoughts to the extent that it is not possible to discuss her pregnancy, and if this were to occur during labour it could place her and her baby at significant risk of harm*" (paragraph 7).

T's obstetrician felt that there was a small risk that she would become so focused on delusional thoughts during labour that she would be unable to make decisions regarding her care. T's midwife took the same view.

Lieven J criticised the timing of the Trust's application at paragraph 10:

> *…it is of some note that the first time that the Official Solicitor was notified of the intention to make an application was Tuesday 26 July and she was sent the Application bundle on Friday 29 July. At that stage the plan was to induce labour on Tuesday 2 August, i.e. 2 working days after the bundle was sent. This was in circumstances where the Trust had been aware of T's mental health condition since at least 19 May. As Ms Watson pointed out, the need for the application should have been apparent since at least 24 June when T's midwife was unable to complete a full antenatal check.*

When the Official Solicitor's representative spoke to T on 29 July, he found her "very lucid" (paragraph 11). When the matter was heard in court, *"the Midlands Partnership Trust, which was responsible for T's mental health care, had declined to carry out a capacity assessment*" (paragraph 12). T was supported to make an advance statement of her wishes and feelings on

[3] Steph David, having been involved in the case, has not contributed to this summary.

31 July 2022.

Citing University Lincolnshire Hospitals NHS Trust v CD [2019] EWCOP 24, Lieven J considered that there was 'no doubt' the court "*has the power to make anticipatory declarations where P has fluctuating capacity, and there is a real risk that they will lose capacity in respect of an important decision, pursuant to s.15(1)(c) Mental Capacity Act 2005 ("MCA")*" (paragraph 14). Lieven J also noted that, as per NHS Trust 1 and NHS Trust 2 v FG [2014] EWCOP 30, "*there is very clear guidance from the court about the timing of applications concerning obstetric care where capacity is an issue*" (paragraph 16). The guidance in *FG* "*states that an application should be made "at the earliest opportunity" … and no later than four weeks before the expected delivery date.*" Lieven J echoed Keehan J's observations in *FG* "*that a late application '…seriously undermines the role that the Official Solicitor can and should properly play in the proceedings' and prevents the court from giving directions for further evidence, if necessary*" (paragraph 17).

Lieven J stated that the application should have been made much earlier to allow consideration by the Official Solicitor and court. She also stated that T's entering into an 'advanced declaration about medical treatment' was "*a far more appropriate way to deal with a potential loss of capacity, rather than engaging the Court in making an invasive and draconian order. Such an approach protects the woman's autonomy, in a way that an anticipatory declaration does not* do" (paragraph 23). The court also sounded a note of caution about anticipatory declarations more generally *'unless the evidence clearly supports it.'* [24]

> *24.* […] *In the present case the Court did not have evidence that T did not have capacity at the time of the hearing and was in reality doing no more than speculating as to whether she might lose it. The evidence was that there was nothing more than a "small risk" that she might lose capacity, and in my judgment that is insufficient to justify an anticipatory declaration in a case such as this. There is a serious risk in a case such as this that a woman's autonomy will be overridden at such an important time, because of an assumption that she has lost capacity.*
>
> *25. In this case there are other ways of managing the situation, apart from taking the draconian and properly exceptional step, of making an anticipatory declaration in respect of a woman who at the present time has capacity. Firstly, she could be invited to enter into an advance statement of her wishes and feelings in respect of her obstetric care during birth. It was clear that T was prepared to enter into such an advanced declaration. Secondly, if there was a true emergency, then the clinicians can use the doctrine of necessity to protect the mother. There needs to be some caution about turning what are in truth medical decisions into legal ones.*

Comment

The observations about the impact of T's entering into an 'advanced declaration about medical treatment' perhaps need a little unpacking. A person may create an Advance[4] Decision to Refuse Treatment (ADRT) if the requirements are met, but this can only relate to a refusal of treatment.[5] An advance statement,

[4] Pedantically, it is 'Advance' not 'Advanced,' both because it is happening in advance, and also because there may not be very anything 'advanced' all about the decision.

[5] And an interesting question (as yet untested question) arises as to whether a woman can refuse a Caesarean section by way of an ADRT. Logic suggests that she

as T was supported to make in July 2022, can cover both 'negatives' and 'positives.' A clear and specific statement of T's wishes and feelings at a time when she had capacity would clearly be of considerable relevance for any best interests decisions which would need to be taken if T were to lose capacity in the future.

However, it appears that the Trust's concern was that it might need to force treatment on T in an emergency situation for her own safety and that of her child. While it is not explicit from the judgment, it would appear likely that the Trust anticipated that some restraint or deprivation of liberty might be required, and was seeking the declarations for this purpose. Despite the Government's assertion that this is already the law,[6] no court has ever held, and we strongly doubt, that an advance statement could serve as valid consent to confinement, occurring in the indefinite future, on unknown facts and on the assumption that T would lose capacity.

We would also consider that the criticisms given of the timing of the application perhaps give short shrift to the Trust's need to respond to the factual picture as it emerged. While it appeared that T was having difficulties with her mental state, the Trust had considered her capacity in an assessment on 14 July and concluded that she had capacity. It would be difficult to see on what basis the Trust would have made an application in respect of a person who it had assessed as having capacity, and surely an application is not warranted in any case where there is some concern regarding the mental health of an expectant mother, or a reluctance to engage in all care interventions. Even by the time of the application, the Trust did not consider there was an overwhelming risk T would lose capacity, but only a 'small risk,' which the court did not consider warranted an anticipatory declaration. However, we would note in *Glass v United Kingdom* [2004] ECHR 103, an Article 8 ECHR violation was found where a Trust had treated a patient without consent on an emergency basis without seeking a court order to do so. At paragraph 79, the ECtHR considered that the "*onus was on the Trust to take the initiative and to defuse the situation in anticipation of a further emergency*." Trusts thus find themselves in the unenviable position of being criticised for bringing applications where there is only a small risk the emergency may occur, or being criticised for waiting too long by applying once it is relatively clear a court order is required.

Contingency planning (2)

Somerset NHS Foundation Trust v Amira [2023] EWCOP 25 (Mostyn J)

Best interests – medical treatment – mental capacity – litigation – medical treatment

Summary

This judgment concerned an application made on 26 May 2023 by the applicant trust for anticipatory declarations that in the event 'Amira' lost capacity during the delivery of her child it would be in her best interests to implement an obstetric care plan with progressively more invasive interventions. Amira was 25 and was pregnant with her first child. The matter was heard on 8 June 2023, which was Amira's due

must be able to, even if the consequences may prove challenging.

[6] See pages 64-5 of the January 2021 White Paper Reforming the Mental Health Act (publishing.service.gov.uk), and also paragraphs 12.55-12.71 of the draft Code of Practice to the Mental Capacity Act 2005 published in 2021. The draft Mental Health Bill put before Parliament in 2022 made no reference to advance consent (nor did the accompanying impact assessment or explanatory notes). The report of the Joint Committee convened to consider the draft bill did not address the issue of advance consent.

date.

Amira had a diagnosis of hebephrenic schizophrenia, which appears to have been responsive to medication, but prone to relapse if she ceased taking that medication. She had been transferred from prison to hospital in January 2023 with an index offence of ABH against her mother. She had previously been a psychiatric inpatient for approximately two years between 2020 and 2022.

While Amira was considered to have capacity when the application was made, *"it was apprehended that as the delivery approached she would lose capacity*" both to make treatment decisions and to conduct litigation (paragraph 3). Amira had made a good recovery since her January 2023 admission, and her mental state had improved considerably until two days prior to the 8 June 2023 hearing. From 6 June 2023, Amira had begun to experience paranoia, anxiety and distress, and had been unable to understand information put to her about her obstetric treatment. Treating clinicians considered that her deteriorating mental state was partly due to being told the local authority's plan for her child (which would presumably have been to apply for her child to be taken into care). Amira's capacity was assessed on 7 June 2023, and the Trust's evidence was that she had lost capacity by that time. The application was reconstituted to seek declarations of current incapacity and orders on that basis, rather than anticipatory declarations.

The Trust's obstetric care plan had been written with Amira's involvement at a time she was considered to have capacity. It set out options for delivery in Amira's order of preference, with the final option being an emergency caesarean section if required.

The Official Solicitor submitted that the Trust should have brought its application at the earliest opportunity after 8 March 2023, arguing that if it had been made in a timely manner, Amira would have had capacity to conduct these proceedings herself. The court noted that had this been the case, she would also have not lacked substantive capacity, and in the view of the court, "*there would not have been any valid issue for the Court of Protection to decide*" (paragraph 17).

After surveying existing case law on anticipatory declarations, Mostyn J set out his own perspective on their lawfulness; as Amira had been found to currently lack capacity by the time of the court's consideration, this discussion was obiter dicta (i.e. it did not form a part of the actual, binding, decision).

Mostyn J considered that ss.4A(3) and (4) MCA only permit a deprivation of liberty where an order has been made under s.16(2)(a) and a "declaration under s.15 will not suffice" (paragraph 25). Mostyn J considered that in any event, the proposed anticipatory declarations "*do not state how, or by whom, the future loss of capacity foreshadowed in each of these declarations is to be determined. This seems to me to be a fundamental flaw in the logos of the concept*" (paragraph 26). Mostyn J considered that Part 1 MCA did not permit anticipatory declarations, but applied only to people who lacked capacity at the time the decision was to be taken. He considered that that ss.5 and 6 MCA "*put on a statutory footing the common law doctrine of necessity as it applies to the care or treatment of persons who are believed to lack capacity*" (paragraph 30). He concluded that in emergency situations "*<u>and only in such an emergency situation</u>, Part 1 of the Act will apply to someone who may yet be shown not to lack capacity at the time that the act in question was done in relation to his or her care or treatment. But that is the only circumstance where someone who is in fact capacitous falls within the terms of Part 1 of the Act*" (paragraph 31, emphasis in the original).

Mostyn J went on to consider the powers of the Court of Protection under s.15 MCA. In further obiter observations, Mostyn J made clear his view that the court was not able to make a best interests declaration in the event of future incapacity, and that the High Court had no power to authorise the deprivation of liberty of a capacitous person. Mostyn J made clear that he considered that anticipatory declarations were unworkable in practice, as there was no clear line as to when a person could be said to have lost capacity. He observed that, to the extent that the obstetric team had clear evidence that Amira had lost capacity during labour by receiving the contemporaneous opinion of her treating psychiatrist, "*such an opinion would unquestionably satisfy the terms of s. 5(1) and 6 (and if the restraint amounted to a deprivation of liberty, s.4B also) thereby giving the obstetric team a complete defence to any later complaint by Amira that she had been the victim of battery or trespass to the person*" (paragraph 40). The court stated that it was "*at a loss as to why the ss 4B, 5 and 6 route to obtain immunity from a later complaint by P about an act done in connection with her care or treatment is not routinely used. It is specifically legislated for in the Act. In contrast, the device of a proleptic declaration under s. 15(1)(c) is in my judgment directly contrary not only to the wording of the Act, but also to its essential scheme*" (paragraph 41).

Mostyn J returned to the application before him, which was grounded in the Trust's evidence that by the time of the hearing, Amira had lost capacity to make decisions about her treatment (which was not challenged by the Official Solicitor).

Mostyn J concluded that Amira lacked capacity for the purposes of a s.15 MCA declaration, but before doing so, observed (again obiter) that the court may not have power to authorise a deprivation of liberty if it is making interim orders pursuant to s.48 MCA, but considered (at paragraph 52) that:

> *…In my opinion, in an emergency, provided that the court is satisfied that there is reason to believe that P lacks capacity, the court can lawfully authorise a temporary deprivation of liberty under the inherent jurisdiction to endure for a very short period until the question of capacity can be finally determined, and, if capacity is found to have been lost, an order made under s.16(2)(a), which in turn triggers s.4A(3) and (4).*

Mostyn J readily found that the birthing care plan, which had been developed with Amira's input, was in her best interests, as it would work to protect her own health and safety and that of her unborn child. Mostyn J authorised restraint in the implementation of that care plan.

Comment

It is worth emphasising that all of the more controversial statements in what we hope we can call a characteristically contrarian judgment were obiter dicta; Mostyn J did not appear to struggle to accept either that Amira had, by the time of the hearing, lost capacity to make decisions regarding her obstetric care, or that the graduated plan of interventions which she had contributed to was in her best interests.

While being cognisant that these comments were not part of the ratio of Mostyn J's decision, we would not agree with his observation at paragraph 30 that ss.5 and 6 MCA address only emergencies. We would note the findings of the Supreme Court in N v ACCG [2017] UKSC 22 at [38], which offers no such limitation to the powers of s.5 MCA:

> *Section 5 of the 2005 Act gives a general authority, to act in relation to the care or*

> *treatment of P, to those caring for him who reasonably believe both that P lacks capacity in relation to the matter and that it will be in P's best interests for the act to be done. This will usually suffice, unless the decision is so serious that the court itself has said it must be taken to court.*

We would also note that the power to make anticipatory declarations under s.15 MCA has been repeatedly considered and found to exist; a comprehensive summary of the case law was recently conducted by Lieven J in *The Shrewsbury and Telford Hospital NHS Trust v T and Midlands Partnership NHS Foundation Trust* [2023] EWCOP 20.

Finally, Mostyn J's obiter observation that s.4B can be relied upon absent a court application having been made has a certain pragmatic appeal, but may come as a surprise to all of those making and determining so-called 'Community DoL' applications. In that context, s.4B doing all the 'heavy lifting' legally in terms of providing protection to those depriving individuals of their liberty in the community pending consideration of the application by the court.[7]

Further, we would suggest that Mostyn J's interpretation has two fundamental problems.

The first, is, as Mostyn J himself makes clear in footnote 1 to his judgment, his approach depends on rewording s.4B(2) from "there is a question about whether D is authorised to deprive P of his liberty under section 4A" to mean "there **will be** a question to be decided by the court whether D **should be** authorised." His reason for adopting this interpretation is:

> *because s. 4A(3) and (4) provide that D may deprive P of his liberty if, by doing so, D is giving effect to a decision made by an order under section 16(2)(a) in relation to a matter concerning P's personal welfare. If such an order has already been made there could never be a "question" whether D "is authorised" to deprive P of his liberty under section 4A. The authorisation in the order will be plain on its face and there could be no question about it. Therefore s. 4B(2) must be seen as stipulating a requirement that D intends, after the emergency is over, to obtain an order authorising the deprivation of liberty of P. The other, more literal interpretation, makes no sense to me.*

However, this overlooks the fact that s.4A does not just apply to situations where a court order is made under s.16(2)(a). It also applies to situations where the deprivation of liberty is to be authorised under Schedule A1. An example of a situation where there is genuine doubt about whether a situation can be authorised by a DoLS authorisation is where there is a dispute about whether the person is eligible for DoLS, or whether the MHA 1983 has to be used. In such a situation, an application is required so that the court can decide which regime is in play (as per the JS case, the appeal against which is to be heard by Theis J on 20-21 July). Between the application being made and determined, the person is in the Schrodinger's cat position of being both within the scope of DoLS (and hence s.4A) and outside its scope. The unglossed wording of s.4B(2) therefore makes entire sense within this context.

The second problem is that it drives a coach and horses through the approach to deprivation of liberty currently provided for in the MCA 2005. As also discussed in *Norfolk and Suffolk NHS Foundation Trust v HJ* [2023] EWFC 92 (see

[7] And, nb, pending **any** judicial consideration, so there is no question of a court making an order under s.48.

further below in this Report), where the line is crossed from restraint – restriction upon – liberty to deprivation of liberty, formal authority is required. On Mostyn J's approach, a person could be deprived of their liberty with no formal authority, on the basis that there is an understanding that an application will be made in due course. But what happens where – as is all too likely to be the case – the emergency passes, and no application is in fact made. Does this invalidate the lawfulness of the steps taken if the person taking them at the time (who may not be the person in charge of deciding to make the application) genuinely, but mistakenly considers that an application is to be made?

Put briefly, s.4B is not contingent on a reasonable belief that an application is to be made, but on the basis that a decision **is** being sought from the court, which we suggest makes clear that active steps are being taken – not just proposed – to obtain such a decision.

Ironically, the approach advocated for by Mostyn J is, in some ways, mirrored in the proposed amendments to s.4B that were contained in the Mental Capacity (Amendment) Act 2019. These would have provided for authority to deprive a person of their liberty in an emergency without further formal authority, on clearly defined grounds. Unfortunately, they are another victim of the decision not to implement the 2019 Act.

What should happen where it appears impossible to engage the person? A high-stakes question for the Court of Protection

Nottingham University Hospitals NHS Trust & Anor v RL & Ors [2023] EWCOP 22 (Sir Jonathan Cohen)

Mental capacity – assessing capacity

In a decision handed down in February 2023, but only published in June 2023, Sir Jonathan Cohen grappled with a dilemma that occurs relatively often in practice, but has been curiously under-considered by the courts: namely what 'communication' means for purposes of s.3(1)(d) MCA 2005. Along the way, he had also to consider how to proceed where everyone involved appeared to face insuperable challenges in engaging him.

The case concerned a man, RL, in his 30s, serving a sentence of life imprisonment for murder. His mental health having given rise to concern, he went back and forth between prison and hospital until February 2023, at which point he was selectively mute, refusing food (whether 'conventionally' or by way of nasogastric feeding), and anti-psychotic medication. He was severely malnourished, and in the view of one of his treating doctors, "*if we do not give sustained feed to RL now, we will precipitate a life-threatening scenario which could occur at any time.*" It was the view of the treating team that it would be deeply undesirable to delay and that the risk grew exponentially the longer he was not fed or did not receive the appropriate medication.

The treating Trust brought an urgent application for authorisation of a nasogastric feeding tube for the treatment for malnutrition and also for his mental health condition and, in addition, as became apparent during the hearing, the treatment of his thyroid condition. The Official Solicitor, having considered the matter carefully, acting on behalf of the man, accepted the urgency of the situation and did not seek an adjournment, as is often the case, in order to obtain further information or third-party expert opinion.

The first question was as to RL's capacity to make the relevant decisions. The case was advanced on the basis that, whilst RL could understand and retain the relevant information, he could not weigh it or communicate his decision. The evidence before the court included

that of his treating consultant psychiatrist, who considered that he was "*suffering from depression, and described him as virtually stuporous and mute. When she last saw him, he did not even flicker his eyes when she put papers in front of him and was not willing to communicate his wishes in any way at all. She described him as presenting as 'quite shutdown'*" (paragraph 10). RL was described by his mother as being a completely changed person from the son that she knew and that he had very much deteriorated over the course of recent times. The evidence was that he was not engaging with the family either, contrary to the way that he used to. When the Official Solicitor's representative went to see him, Sir Jonathan Cohen explained that "*he literally was not able to do so because RL would not come out from under the bedclothes; he remained completely invisible and would not engage in any way whatsoever*" (paragraph 11).

Sir Jonathan Cohen concluded (at paragraph 12):

> *The evidence which I accept is that, on the balance of probabilities, he is indeed unable to weigh up the information as part of the process of making a decision or to communicate his decision in the words of the statute "whether by talking, using sign language or any other means." He simply has made it impossible for anyone to know what his wishes are because he will not express them himself. He does not give any indication of understanding the link between receiving food and treatment and life and death.*

Before moving to best interests, Sir Jonathan Cohen noted that, the morning of the hearing, the treating team had inserted a nasogastric tube. As he noted, "*I think it is fairer to describe what happened this morning as an absence of any resistance by RL rather than a sudden piece of insight into his condition. He did not in any way try to interrupt the process; he was awake and conscious, but he said and did nothing*."

Sir Jonathan Cohen therefore made a declaration as to RL's lack of capacity to make the relevant decisions under s.15 MCA 2005, noting that it was more appropriate for him to use this rather than the 'interim' provisions of s.48, as he had the evidence before him to enable him to make the declaration and that, if RL's capacity returned, he would fall outside the statutory framework of the MCA.

As to best interests, Sir Jonathan Cohen identified that it was very difficult to assess RL's views. He had been recorded as having said in late January whilst in A&E that he was trying to kill himself, but Sir Jonathan Cohen did not find that this constituted a "*clear and settled wish to end life.*" He would not communicate with the Official Solicitor's representative, but Sir Jonathan Cohen noted that his mother had been very clear that her son's current presentation was "*out of character. She believes – and she knows him better than anyone else in this case – that he would want treatment if he was well*" (paragraph 18).

Sir Jonathan Cohen therefore found that there was a very strong balance in favour of the administration of medication, including by way of restraint. However, he indicated that the matter should come back within a week because "*within five to seven days there should be at least some indication as to whether or not the feeding issue is beginning to be resolved, even though the time for knowing whether the medication for his psychosis is assisting will be much longer. Since the court order includes the power to use restraint in order to address the issues of nutrition and hydration, it is appropriate that the matter should come back sooner rather than later*" (paragraph 19) (at the time of writing this, no further judgment is available in relation to RL's case).

Comment

We address in our guidance note on assessing and recording capacity the need to distinguish between a situation where a person is unwilling to take part in a capacity assessment, and the one where they are unable to take part. It is interesting to contrast this case with *Re QJ* [2020] EWCOP 3 where Hayden J considered that – on the facts of that case – there was a "good deal of evidence" that the person's reluctance to answer questions meant that they were unable to do so. Here, by contrast, it appeared to be clear to those involved that, to the extent that RL was being selectively mute, it was not a matter over which he could be said to have any conscious control.

As regards the consequences, this case fits squarely within the research that we referred to in our guidance note which suggests that, although the 'communication' limb of s.3 was intended to cover only a very narrow category of cases (such as locked in syndrome), it has been broadened to cover the situation where the person is unable to express a stable – or, here – any preference. As we put it in at paragraph 45 of our guidance note, "*in such a situation, the assessor does not have access to the person's real choice*."

In this regard, it is perhaps of note that Sir Jonathan Cohen appears at paragraph 12 to have proceeded on the basis that not only could RL not use and weigh the relevant information, he appeared also not to be able to understand that information either. Indeed, logically, if the end result is that everyone is having to proceed on the basis that the decision-making is taking place within an entirely impenetrable black box, it is difficult to see how any conclusions could be drawn (either way) as to the person's ability to retain the information either.

Disentangling decisions – and do they even need to be taken?

Wiltshire County Council v RB & Ors [2023] EWCOP 26 (Peel J)

Mental capacity – assessing capacity – residence

Summary

RB was a 29 year old woman diagnosed with Autism Spectrum Disorder. Since 2015 she had been selectively mute, and chose to communicate in writing or by pointing to words on an alphabet board. She had rheumatoid arthritis and was found in 2021 to have capacity to decline medical treatment for that condition, as a result of which her mobility was severely impaired. Since entering sixth form she had had several admissions under the MHA 1983. She has been in a number of placements which have been unsuccessful. In June 2020, she was found to have capacity to decide where to live after leaving a community placement. In August 2020, she was detained in a psychiatric hospital for over 2 years. On 3 January 2023, she was discharged to a bungalow with a 24/7 package of 2:1 care. She was clearly deeply unhappy there, partly as a result of being transported against her will and subject to physical restraint. Over two days, she undertook several acts of deliberate self-harm including attempts to strangle herself. At first instance, the court received evidence from the expert consultant psychiatrist that "….. a return would be likely to cause her real physical, emotional and psychological injury that has the potential to be lifelong". On 5 January 2023, the woman herself emailed the Court of Protection seeking the court's assistance. She also contacted the emergency services as did her carers. She was admitted to a general hospital on 7 January 2023. She was medically fit for discharge but had consistently said that she did not want to return to the bungalow, nor did she agree to

return there.

At first instance, HHJ Cronin found that RB lacked capacity to decide to consent to be discharged from the hospital to live at the bungalow. Acting by her litigation friend, the Official Solicitor, RB appealed. The appeal was not opposed by the Local Authority or the ICB. Save in one respect, it was opposed by the Health Trust responsible for the area where RB was currently hospitalised.

As Peel J noted at paragraph 5:

> *It is common ground that the hospital ward is not an appropriate environment for RB, and her presence allocates resources away from other requirements. The Hospital Trust is in the uncomfortable position of effectively housing RB until these proceedings resolve her future. It does strike me that the Trust's position in the litigation is somewhat peripheral. Its interest at a practical level is to secure the departure of RB from the hospital. The outcome of capacity and best interests assessments is only of relevance to the Trust in terms of potential delay. In saying this, I am not in any way downplaying the Trusts' commitment to the wellbeing of RB.*

Peel J noted that the decision was a difficult one, but zeroed in on the fact that there appeared to be some confusion as to precisely what capacity issue required adjudication. The declaration made by HHJ Cronin directly linked discharge from hospital to a return to the bungalow. But, as he identified, the specific decision included two components: (1) discharge from hospital; and (2) return to the bungalow. Peel J considered that:

> *22. By eliding discharge and accommodation at the bungalow, it seems me that the judge may have unwittingly fallen into an "outcome approach" which is inconsistent with autonomy and the subjective patient's individuality, and does not form part of the framework of the Act; para 13 of R v Cooper [2009] 1 WLR 1786.*
>
> *23. This is demonstrated vividly by RB herself who, in* [a letter to the court]*, clearly thought that she was being presented with one option. She was being presented with a decision which to her mind was whether to return to the bungalow or not; essentially a fait accompli. Dr Camden-Smith* [the independent expert] *refers to this in her report: "[RB] is aware that the hospital wishes to discharge her, and that currently the only option available to her is the bungalow". That was a stark option with no nuances and, what is more, one that is, on the evidence of the expert, likely to expose her to grave physical, psychological and emotional harm.*
>
> *24. Dr Camden-Smith's report at para 35 says: "I told [RB] in the email that she cannot stay in hospital and that she will end up being discharged to the bungalow if she cannot make a decision". Given that the judge, understandably, paid particular attention to the evidence of Dr Camden-Smith, my sense is that as a result she was led away from a focus on discharge to a focus on living arrangements. That is reinforced by the tenor of her judgment in which she said: "The decision the court is ultimately asked to make, if RB cannot, is a decision about: first, where RB should live on her discharge from hospital".*

Peel J considered that:

> 26. […] there *were, or should have been, two separate issues, and two separate capacity decisions, to consider, namely:*
>
> *i) Did RB have capacity to consent to hospital discharge? That*

> *evaluation depended upon, inter alia, the information recorded in the order of 21 February 2023. Inevitably, that includes a possible return to the bungalow (it would be unrealistic to separate this out) but that was not the only possible option, nor the only factor to be taken into account. Others included the Local Authority continuing searches for alternative placements, or RB simply refusing to leave hospital and accepting the potential consequence of a forced departure which might include living in a hotel or living rough (as she has done before). The latter might be deemed an unwise decision, but by s1(4) of the MCA 2005 that is not of itself indicative of lack of capacity. Moreover, as Dr Camden-Smith said, it is not irrational to refuse to leave hospital if the only alternative put to her is somewhere she adamantly refuses to go to because of previous traumatic experiences.*
> *ii) Does she have capacity to consent to going to the bungalow? That, it seems to me, would also need to be considered in the light of other relevant information such as alternative placements (as identified by Dr Camden-Smith, concrete options are required) and a full understanding of what caused her so much distress at the bungalow in the first place.*

Whilst expressing sympathy for the difficult decision faced by the judge, Peel J concluded that she was wrong to elide the declaration in the way that she had done.

In terms of the actual assessment of RB's capacity, Peel J identified that:

> *37. It is not for RB to establish capacity or justify her autonomous wishes; she is presumed to be capacitous. To interpret a refusal to contemplate returning to the bungalow as indicative of lack of capacity, or causative of lack of capacity, as the expert seems to do, should be weighed against an alternative explanation that she was simply expressing a capacitous wish not to go there again after her prior experiences. In my judgment, the judge did not adequately weigh up these competing factors in circumstances where by any measure a strongly held wish not to return to the bungalow, with clearly stated reasons, was understandable. This ground of appeal is allowed.*

In other words, the specific decision upon which the judge determined lack of capacity included two components: (i) discharge from hospital and (ii) return to the bungalow. That is how it appeared in the final version of the order, albeit not in the first version drafted by the judge.

Peel J also agreed that the judge had not undertaken any substantive analysis of the question of RB's capacity to decide upon care, which seemed not to have been referred to in the judgment but added upon a request for clarification.

Whilst allowing the appeal, Peel J emphasised that:

> Although I have concluded that in the end the judge fell into error, I am not convinced that the case was presented to her as clearly as it might have been, identifying the issues accurately and clearly. No order before the hearing set out with clarity the issues to be decided and as a result the elision of discharge and best interests was allowed to develop unchecked.

In remitting the case for rehearing, Peel J suggested that the capacity issues to be

considered were, in this order:

> *i) Does RB have litigation capacity?*
> *ii) Does RB have capacity to consent to hospital discharge?*
> *In considering this the court should direct itself to the relevant factors identified in the order of 21 February 2023 and should in particular consider the position if the bungalow is a residence option or, in the alternative, is not a residence option.*
> *iii) Does RB have capacity to decide where she should live?*
> *iv) Does RB have capacity to make decisions about personal care?*

Peel J identified, finally, that he could and should:

> *45.* […] *make a general comment about the bungalow. I appreciate the complexities of this case which is challenging to all involved. I appreciate also the immense pressure on resources. Nevertheless, from what I have seen and heard, for RB to return to the bungalow risks causing her profound harm. What happened during her time there is shocking. The expert's view about the potential impact on her physically, emotionally and psychologically is compelling. Transportation would almost certainly take place against her will, and require physical restraint. It seems to me that alternative options simply have to be sourced. The expert says that RB should be given a viable alternative that is not the bungalow, and I agree. If the bungalow is removed from the equation, it is possible (indeed, I suspect, likely), that capacity and best interests issues may well resolve themselves.*

Comment

Peel J's dissection of the actual decisions in play is important for illuminating the consequences of imprecision – but his concluding observation about the potential for the issues to resolve themselves if alternatives are found is equally important. More broadly, the decision is also helpful for shedding light on an area which causes inordinate difficulty in practice: i.e. discharge decisions in the situation where a person has impaired decision-making capacity. Part of the complexity, as alluded to by Peel J, is that there are likely to be multiple organisations involved. Alex has previously sought to undertake the exercise of disentangling who, precisely, is responsible for what, and – in consequence – what capacity questions actually arise, in a presentation available here. He is somewhat reassured to see that Peel J's analysis matched his own, even if Alex might not talk about 'consenting' to hospital discharge, as opposed to 'deciding to leave hospital,' to match the language that would be used in relation to a person whose decision-making capacity is not in question.

Executive capacity – clinical and legal realities

Warrington Borough Council v Y & Ors [2023] EWCOP 27 (Hayden J)

Mental capacity – assessing capacity – residence

Summary

This application concerned Y, who was in her early twenties. Y had been diagnosed with autistic spectrum disorder as a child. Her education records reveal difficulties with learning but she remained in mainstream education and was provided with support. In consequence of a road traffic accident, she had serious injuries, including brain injuries. She was cared under care arrangements commissioned by her deputies and managed by a case manager. A question of no doubt vital importance to Y, namely as to her capacity to decide to take cross-sex hormones, was resolved without the need for judicial determination, as was the

question of whether she had capacity to access the internet. Hayden J had to resolve the question of Y had capacity to take decisions in relation to her care and residence. Opinion on this was divided between Dr Janet Grace, Consultant Neuropsychiatrist, and Dr David Todd, Consultant Neuropsychologist. Whilst there were areas of common ground, helpfully teased out in an experts' meeting, Dr Todd was "very clear" that Y lacked capacity to make decisions as to where she resided and the care and support she required. Dr Grace "forcefully" articulated the opposite opinion.

In essence, Dr Todd considered that Y presented with Dysexecutive Syndrome, consequent on traumatic brain injury, and highlighted the operation of "the frontal lobe paradox," that those with frontal lobe damage can perform well in interview and test settings, despite marked impairments in everyday life. By contrast, Dr Grace considered that, whilst Y was "*impulsive, difficult to contain and risk taking*," this was largely confined to occasions in which she was "*clearly hyper-aroused*." Dr Grace considered that that these patterns of behaviour were present pre-injury and believed that they are not a consequence of the brain injury but due to a combination of anxiety and autistic spectrum disorder (ASD) traits. Dr Grace's evidence was that "*in common with the rest of the population, she is at risk of making decisions that are potentially harmful when she is anxious or angry*."

Much of the judgment of Hayden J consisted of an analysis of the views of the two experts, in circumstances where he considered it was important that "*this is not a case where the two experts have been sucked into an ideological battle in which both have retreated to a defence of their amour propre. There is a genuine difference of opinion in which both have engaged in an intellectually honest dialectic*" (paragraph 35). Of wider relevance, perhaps were Hayden J's observation at paragraph 45 that:

> *Executive dysfunction and frontal lobe paradox is, as Ms Butler-Cole correctly submits, not to be regarded as synonymous with the functional test for mental capacity. The former derives from clinical practice, the latter is the test prescribed by MCA. Neither is 'insight' to be viewed as equating to or synonymous with capacity. To elide those two would be to derogate from personal autonomy, every adult from time-to-time lacks insight into an issue or indeed into themselves.*

On the facts of the case, Hayden J considered that Dr Todd had not fallen into these "rudimentary errors:"

> *It must be emphasised that severe traumatic brain injury has been identified neuroradiologically in this case and that this is not challenged. Dr Todd considers that Y has cognitive, emotional and behavioural manifestations which are not confined to periods of heightened arousal but are pervasive and reductive of capacity for problem solving. These, he considers are frequently associated with frontal lobe damage. Again, whilst recognising the variability of these behaviours, I do not understand this central premise to be in dispute. The consequence, Dr Todd contends, is to impair the ability to think consequentially and ultimately, to be able satisfactorily to understand, retain or weigh information in order to make a decision about care needs and accommodation. To my mind, that establishes both the functional and diagnostic test. Moreover, for the reasons I have already explained, I consider that the accounts given by F very much reinforce Dr Todd's views and do not sit as comfortably with those expressed by Dr Grace. It is Dr Todd's opinion which unifies most of (though by no means all) the features of what is undoubtedly a complex evidential matrix.*

Ultimately, therefore, Hayden J considered that Dr Todd's opinion was to be preferred, although he made clear that he was "*particularly alert to* [Dr Grace's] *entirely proper warning that a dissociation between knowing or understanding and a failure to follow through or convert to action, is not, axiomatically, pathological*."

Returning to a familiar theme, Hayden J concluded that:

> *47. The presumption of capacity is the central tenet of the MCA. It is a powerful safeguard of civil liberty. It requires to be rebutted on cogent evidence, nothing else will ever do. The principle was well embodied in the case law that preceded the MCA. It is both a guard against the power of the state and a gateway to State support where needed. It is woven into the professional DNA of practitioners and Judges in this important and evolving sphere of the law. I feel confident that every Judge, evaluating a question of capacity, approaches the test with a resolve to find that an individual has capacity and arrives at a contrary conclusion only when the evidence demands it.*

In this spirit, Hayden J continued:

> *Having concluded that Y lacks capacity to make decisions relating to her care and accommodation, it is important always to remember that the MCA constructs an ongoing obligation to promote capacity, in effect, to build a pathway to capacity where there is a prospect of it. There is evidence that Y is making progress cognitively and more broadly. That evidence, at present, has a degree of fragility which causes me to draw back from any more confident assertion. What it indicates, however, is the importance of the obligation to provide a scaffolding of support for Y in order that she is availed of the very best opportunity to reassert her autonomy in these two very important spheres of decision taking. It may well be that in the months to come, the landscape might change and require my decision to be revisited. I suspect, though I may be entirely wrong, that some of Dr Grace's reservations may also reflect my own sense from the evidence that Y's situation remains an evolving one.*

Comment

The considered and thoughtful disagreement between Drs Grace and Todd set out in the judgment is one which repays careful scrutiny by those working in this area. Hayden J's clear reminder that the clinical phenomenon of executive dysfunction needs to be addressed by reference to the specific criteria of the MCA 2005 in relation to the facts of any individual case is of wider importance. For those who want to get a further – interdisciplinary – insight into the issues, we recommend this webinar from the National Mental Capacity Forum.

Restraint, physical health and the detained patient: the rights in play

Norfolk and Suffolk NHS Foundation Trust v HJ [2023] EWFC 92 (High Court (Family Division) (David Lock KC (Sitting as a Deputy High Court Judge)

Article 5 – deprivation of liberty – best interests – medical treatment

Summary

This case concerned the question of whether specific authorisation is required to administer physical health treatment under conditions of restraint to a person detained under the Mental Health Act 1983 who lacks the capacity to consent to the treatment. This is a question that had been considered in some detail by Baker J (as he then was) in *NHS Trust v Dr A* [2013] EWHC 2442 (COP), including the legal quirk that it was

necessary to have recourse to the inherent jurisdiction to authorise such additional deprivation of liberty as might arise even in the case of a person lacking the relevant decision-making capacity.[8]

The facts of Dr A's case – concerning a detained patient on hunger strike – were very stark. The facts of HJ's case might be said to be much more 'routine' (although the outcome of no less importance to HJ herself). In summary, HJ had a range of physical and cognitive impairments, and required enemas to treat her for constipation. The process of providing HJ with an enema was described in some detail in the judgment by a Nurse O thus:

> *She explained that when staff consider that HJ is suffering signs of distress and an enema may be needed, she is guided or physically escorted from the "pod area" towards her bed and placed in the prone position and rolled onto her left side. Staff will then go on either side of the bed and hold her arms for reassurance. Once HJ is on the bed, nursing staff explain to her that they need to administer an enema. At this time HJ will typically either attempt to pull at staff clothing or grip onto staff hands or body parts. The administration of the enema itself requires 4 people to assist with the physical restraint required; one person on each side to restrain arms, one to administer the enema and a fourth person to hold both legs and prevent HJ from kicking staff. A fifth person is also required to open doors entering her room, support her head if needed and monitor her physical state during the restraint. HJ will continue to be loud and verbally aggressive towards staff throughout this process.*

12. Nurse O further explained that:

(i) The typical duration of physical restraint when administering the enema with HJ on the bed is approximately "3-5 minutes in length";

(ii) It may take between "30 seconds to 5 minutes" for HJ to be physically escorted from the pod area to her bedroom. This escort may require some form of physical restraint (such as holding her forearms), although hand holding can be used more often than not;

(iii) HJ has had other forms of treatment provided via the same restraint procedure including: (i) administration of depot medication once per week (although this has not been required since March 2023); (ii) administration of rapid tranquilisation by intra-muscular injection on a PRN basis; (iii) taking blood samples; (iv) the administration of skin ointment (although she could not recall when this was last needed); and (v) transfers to an acute hospital for medical treatment;

(iv) The provision of enemas under restraint is reported to take "slightly more time" than other forms of treatment;

(v) HJ can remain agitated and/or distressed for up to an hour after the administration of an enema, although sometimes this can also resolve within a few minutes;

(vi) If HJ is not provided with an enema and has no bowel movement, it can become very painful for her in the short-term in addition to the serious longer-term risk of bowel perforation;

[8] Incidentally, another casualty of the decision not to implement the Mental Capacity (Amendment) Act 2019 is that s.16A MCA will not be being repealed, the provision which caused the problem in *Dr A*.

(vii) *Two other service users within the ward also require physical restraint to deliver treatment, although not to the same extent, frequency or durations as HJ;*

(viii) *A record is kept in HJ's medical notes whenever physical restraint is used;*

(ix) *HJ's ongoing care and treatment is discussed and reviewed during MDT meetings on a weekly basis, although there is no formal review of the restraint plan; and*

(x) *Staff would be prepared to undertake a more structured review of HJ's restraint plan on a periodic basis, including consideration about whether this method of delivery remains necessary and proportionate and whether any less restrictive measures could be used.*

HJ's constipation was a physical disorder not caused by her mental disorder, such that treatment – including potential restraint – could not be administered under Part 4 MHA 1983. The Trust caring for her therefore applied for a determination (presumably under the inherent jurisdiction) that it was lawful to deprive her of her liberty whilst administering the enemas; the Official Solicitor acting on her behalf agreed both that such authority was required, and that granting it was in her best interests. David Lock KC, sitting as a Deputy High Court judge, took a different view – namely that no formal authority was required.

David Lock KC started with s.5 MCA 2005, outlining how it provides a codified defence of necessity. In passing, it is clear from his analysis, applying that of Lady Black in *NHS Trust v Y* [2018] UKSC 46, that s.5 is not limited to emergency situations as suggested, obiter, by Mostyn J in *Somerset NHS Foundation Trust v Amira* [2023] EWCOP 25. David Lock KC then turned to s.6, outlining how its "broad effect" is that, where such treatment is reasonably believed to be in P's best interests, restraint short of a deprivation of liberty can lawfully be imposed on P without any further authorisation where it is reasonably believed by those providing the care that it is necessary to prevent harm and the restraint used is proportionate to the likelihood and seriousness of that harm.

On the facts of HJ's case, David Lock KC agreed that, given that only "proportionate restraint" was used to administer the enemas, the Trust clinicians could, in principle, bring themselves within the terms of s.6 MCA 2005, such that, "*if matters had stopped at that point, there would have been no need for the Trust to come to court because the legal approvals needed under these procedures of the MCA do not require court oversight*" (paragraph 22).

The Trust, however, had been concerned that the process of administering enemas to HJ was depriving her of her liberty (it is not entirely clear from the judgment precisely what gave rise to the Trust's concern that the line was crossed from restriction upon liberty to deprivation of liberty). It was that concern – initially shared by the Official Solicitor – that David Lock KC questioned, and which led ultimately to the parties agreeing that, in fact, **no** deprivation of liberty was taking place, an agreement endorsed by the court. At paragraph 32 he set out his conclusion, reached after an analysis of the relevant domestic and Strasbourg case-law as to the principles to apply when deciding whether medical treatment provided to someone in lawful detention amounts to a further deprivation of their liberty, requiring specific authorisation:

> *a) the starting point should be that it will only be in exceptional cases (see Bollan/Munjaz) where something that happens to a person who has already been lawfully deprived of their liberty will amount to a further*

> *deprivation of that person's residual liberty;*
>
> *(b) Article 5 will only arise in an exceptional case because the usual position is that "Article 5(1)(e) is not in principle concerned with suitable treatment or conditions" (Ashingdane); and*
>
> *(c) the acid test for the engagement of article 5 in any case involving an alleged deprivation of residual liberty is whether there is an unacceptable element of arbitrariness in the actions which are taken by a state body and which are said to deprive a person of their residual liberty (see Idira).*

Applying those principles, therefore:

> *32.* […] *it must follow that, save in exceptional circumstances, any proper and lawful exercise of clinical judgment by clinicians in administering medical treatment to a detained person will not amount to a deprivation of the person's residual liberty because there is no element of arbitrariness in the actions of the clinical staff. If restraint is imposed in order to enable treatment to be administered for a physical health condition for a person who lacks capacity to consent under the MCA, the tests for the lawfulness of that restraint are set out in section 6 MCA. If those conditions are satisfied, the usual consequence will be that there will be no independent breach of the patient's rights under article 5 ECHR. Part of the reason that, in my judgment, there will be no breach of article 5 rights in such circumstances is that the Trust owes a common law duty of care to HJ. That duty means that, whilst she is detained in hospital, Trust staff are required to provide her with appropriate medical treatment to meet her physical and psychological needs. The Trust discharge that duty by administering medical treatment to her, including enemas as described above, and there is nothing arbitrary about their application in HJ's case. On the contrary, as set out above, this is a carefully thought-out treatment plan which is designed to meet her medical needs in a lawful and proportionate manner. I do not consider that acts taken by clinical staff to discharge that duty are capable of amounting to the type of exceptional circumstances which could lead to a further deprivation of HJ's residual liberty. In my judgment, HJ cannot be deprived of her liberty as a result of actions of Trust staff that, to discharge their duty of care to HJ, they are required to take. I therefore consider that the revised position adopted by the Trust was correct and that the Official Solicitor was also correct to make the concession that HJ was not being deprived of her liberty when she was being administered enemas.*

Importantly, David Lock KC also went on to consider HJ's Article 8 ECHR rights, engaged by decisions made to apply enemas and the accompanying decisions to use restraint to enable the treatment to be administered. There was no dispute, as he noted, that Article 8 ECHR contains procedural as well as substantive obligations. In general terms, and echoing (although not expressly referring to, the decision of the ECtHR in AM-V v Finland [2017] ECHR 273), he found that:

> *35. The process leading up to the administration of enemas is required by section 4 MCA to fully take into account HJ's views, albeit they are not decisive. Overall, the sections 4 and 6 MCA decision making process is a process mandated by statute and, if followed, in my judgment satisfies the requirements of fairness and properly respects a patient's article 8 rights.*

He also noted that, as restraint which was applied to HJ was to take place within a mental health unit, there were the additional procedural obligations imposed by the Mental Health Units (Use of Force) Act 2018, and that the Trust:

> *36. [...] has explained how it is complying with the terms of the 2018 Act. It has appointed a responsible person or suitable seniority, adopted a policy regarding the use of force on patients by staff who work in its mental health units and is providing appropriate training. None of the steps taken by the Trust to implement the terms of the 2018 Act have been criticised by the Official Solicitor and it appears to me that the evidence provided about the way restraint is applied to HJ is consistent with the Trust policy and the recording of the use of restraint follows (if not exceeds) the requirements of the 2018 Act. I also note that the requirements of the 2018 Act supplement the duty on the Trust to have regard to the Statutory Code of Practice published under the MHA.*

David Lock KC continued:

> *37. In J Council v GU & Ors Mostyn J considered that the procedural requirements under article 8 required an additional degree of oversight because restraint was taking place outside of mental health detention and was thus occurring in a setting where there were "no equivalent detailed procedures and safeguards stipulated anywhere for persons detained pursuant to orders made under the Mental Capacity Act 2005": see judgment at paragraph 14. This case is different because (a) it takes place within the legal framework applying to patients who are detained under the MHA and (b) the procedural requirements of the 2018 Act are required to be followed and, on the evidence, are being followed. In those circumstances, I do not accept that the existing legal obligations on the Trust need to be supplemented in order to ensure compliance with HJ's article 8 rights. On the contrary, it seems to me that the requirements on the Trust to continue to comply with the best interests decision making processes under section 4 MCA, the need to ensure that any level of restraint is justified under section 6 MCA and the additional procedural requirements imposed on the Trust by a combination of the MHA framework and the 2018 Act provide an entirely adequate procedural framework to protect HJ's article 8 rights. I therefore do not accept that it is either necessary or appropriate to supplement these obligations with provisions within a court order.*

Nonetheless, and presumably because the matter was, in fact, before the court, David Lock KC indicated that he was prepared to make a declaration under s.15 MCA 2005 that the Trust was acting lawfully in administering enemas to HJ in accordance with the protocols described in the evidence in this case. However, he made clear that no declaration was needed under the inherent jurisdiction because he was satisfied that the MCA 2005 provided a sufficient framework for governing the lawfulness of the actions of the Trust and clinical staff employed by the Trust.

Comment

Substantively, it is important to see a Trust discharging its obligations to secure against the risks of constipation, a problem which is too often ignored, not just in cases such as HJ's but also – and perhaps especially – in the context of those learning disabilities. One would hope that the consideration given to the steps required would have been equally careful had HJ not been detained in the community.

Procedurally, the case raises two interesting questions. The first is as to whether, had HJ not been subject to the MHA 1983 (or a DoLS authorisation), it would have been legitimate simply to rely upon ss.5-6 MCA 2005. On one view, it is perhaps a non-question, because any care plan which contained that level of planned restriction in relation to medical interventions would almost inevitably contain sufficient restrictions upon the person's physical liberty more generally that they would need to be detained under either the MHA 1983 or under the MCA 2005. However, paragraph 22 of David Lock KC's judgment could be read as suggesting that restrictions of those being used to secure HJ's treatment could be imposed without requiring formal authorisation. With respect, Alex would suggest that, for a person who is not detained, ss.5-6 would only give the thinnest of legal ice under the feet of professionals drawing up and implementing a care plan of the kind in play for HJ given not just the nature of the restrictions but, in particular, their frequency – no matter how benignly intended.

The second question is as to whether the answer given by David Lock KC to the question of whether HJ was subject to a deprivation of her residual liberty is entirely convincing viewed through the prism of the ECHR. His essential answer rested upon the fact that the clinicians were doing that which they were required to do so to discharge their common law duty of care to her, such that the consequences of their action could not give rise to a deprivation of her residual liberty. The European Court of Human Rights in the *Bournewood* case held that reliance upon the common law doctrine necessity was not an answer to the charge that HL had been arbitrarily deprived of his liberty for purposes of Article 5 ECHR (see paragraphs 118-119). David Lock's analysis also comes close to the approach of the Courts of Appeal in the *Cheshire West* cases in conflating why steps are being taken to confine the person with what the consequences of those steps are: an approach strongly deprecated by the majority of the Supreme Court. That having been said, it is perhaps appropriate to note that the ECtHR in the *Munjaz* case did seem to elide the two in precisely that way in holding that Col. Munjaz was not deprived of his residual liberty by being subject to sustained periods of segregation, noting that the periods were "*foremost a matter of clinical judgment*," and "*could only continue for as long as those responsible for [his] care judged it necessary*" (paragraph 71).

Whether or not the answer to the Article 5 question was entirely convincing (and, indeed, whether or not the Strasbourg case-law is entirely coherent), it is important that all concerned recognised that matters did not stop at Article 5, but that Article 8 was just as important. Indeed, in *Munjaz*, the ECtHR emphasised that "*the importance of the notion of personal autonomy to Article 8 and the need for a practical and effective interpretation of private life demand that, when a person's personal autonomy is already restricted, greater scrutiny be given to measures which remove the little personal autonomy that is left*" (paragraph 80, emphasis added). In this regard, it is of no little interest to note the emphasis placed upon the Mental Health Units (Use of Force) Act 2018 (incidentally, the first time that it has featured in a judgment).

The Mental Health Units (Use of Force) Law – commonly known as Seni's Law – was introduced to respond to what might be thought to be a very different problem, that of force being used as a response to behaviours identified as challenging. But the breadth of the 2018 Act's

definition of force[9] means that – rightly – the provisions designed to secure greater accountability and transparency should apply to situations such as that of HJ, at least when they are detained in a mental health unit. Some might well ask why equivalent provisions should not apply in relation to those subject to deprivations of liberty in other settings which are, to all intents and purposes, identical.

'Deprived of her liberty': My experience of the court procedure for my mum

One of the many useful blogs on the website of the Open Justice Court of Protection Project, which has recently turned 3 (Happy Birthday!) is a blog published by 'Anna,' which makes both important and salutary reading for anyone working in the deprivation of liberty zone.

[9] Although note that its definition is not the same as that of 'restraint' for purposes of the MCA 2005. Restraint for purposes of the MCA 2005 arises where a person "(a)uses, or threatens to use, force to secure the doing of an act which P resists, or (b)restricts P's liberty of movement, whether or not P resists" (s.6((4)). Force for purposes of the 2018 Act involves "(a) the use of physical, mechanical or chemical restraint on a patient, or (b) the isolation of a patient."

PROPERTY AND AFFAIRS

Short note: common LPA problems before the CoP

In *Re Public Guardian's Severance Applications* [2023] EWCOP 24, the Office of the Public Guardian brought an application involving nine consolidated cases presenting interpretative questions relating to statute and regulations which have had recurred with sufficient frequency to cause the Public Guardian to seek clarification.[10] In his judgment, Hayden J made clear that was the wording of the MCA 2005 which must prevail, not the wording used on the forms prescribed in Regulations – but emphasised that it was self-evidently a recipe for confusion where the forms posed a different question to that posed by the Act.

Hayden J noted that the question of whether it was lawful to give primary power to one attorney ahead of other attorneys when appointed on a joint and several basis had been comprehensively resolved in *Re DA* [2019] Fam 27. Hayden J endorsed the practice of the Public Guardian of applying for severance where there is an instruction for a primary/original attorney with others unable to act (save where the primary attorney ceases to do so).

Hayden J made clear that it was not possible to read s.10(4) Mental Capacity Act 2005 as rendering it lawful to have joint and several appointments with instructions for attorneys to deal with separately defined areas of the donor's affairs or include restrictions to this effect. He considered that s.10(4) was strikingly short, succinct, and clearly intended, unambiguously, to be exhaustive. A 'purposive' interpretation would require, in effect, a significant rewriting of the statutory provision and offend each of the conventional principles of statutory construction. Further, given the practical challenges involved in dividing personal and business responsibility for the donor's estate, the need for separate LPAs would, in fact, provide a clearer and more effective route for the donor, requiring, of necessity, a more intense focus on the specific duties and obligations involved in each and a concentration on their ultimate feasibility. Hayden J was not persuaded that a wider interpretation would be either purposive or beneficial.

Hayden J confirmed that severance applications should continue to be made in relation to instruments that sought to instruct *multiple (original or replacement) attorneys to act on a majority basis*. He held that the 'majority rule' provision was inconsistent with the statutory provision. The provisions of s.10(4) MCA 2005 were drafted so tightly that they left very little, if any, scope for a purposive approach to the contrary. He noted that he was, however, sympathetic to the frustration effervescing in the judgment in *Re Public Guardian's Severance Applications* [2017] EWCOP 10 as to the cumbersome and legally unattractive position that resulted.

Hayden J made clear that whether the word 'should' or similar words used in an LPA instrument should be understood as constituting a binding instruction or a non-binding preference on the part of the donor was a highly fact specific question and its significance and force will be dependent on context. However, he confirmed that its use would not automatically give rise to severance. It was the wording on the forms that generates the ambiguity.

Hayden J found that there was an inherent ambiguity in s.10(8)(b) MCA 2005. He

[10] Neil having been involved in the case, he has not contributed to this summary.

considered that an interpretation which permitted the appointment of a secondary replacement attorney was to be preferred, and noted that he considered that Senior Judge Lush's decision to the contrary in *Re Boff* (2013) MHLO 88 had focused rather too heavily on the pre-legislative material. The alternative question of whether a replacement attorney could be reappointed to act solely was therefore otiose. Had it been necessary to resolve it, however, Hayden J made clear that he would have concluded that such a reappointment could be made, for the same reasons as in relation to the potential for the appointment of a second replacement attorney.

Hayden J recognised that, insofar as aspects of the court's analysis might raise the prospect of the need for legislative amendment, the practical and political reality was such that it would not be possible in the near future. However, the clarifications required to the LPA forms did not provide quite the same difficulties. He made clear that he considered that the amendments that they required were limited in scope and ought easily to be manageable. In many respects, he observed, they would serve to complete the constructive work that had already been done.

Powers of Attorney Bill update

The Powers of Attorney Bill received its second reading in the House of Lords on 16 June. Having been introduced as a Private Member's Bill by the Conservative MP, Stephen Metcalfe, its passage through the Lords is being led by a Labour Peer, Viscount Stansgate. Of particular interest, not least in light of the observations of Poole J in *The Public Guardian v RI* [2022] EWCOP 22 about the role of certificate provider, was the following exchange between Lords Ponsonby and Bellamy. Lord Ponsonby identified that:

> *The Law Society has raised some additional safeguarding concerns that I want to bring to the attention of the Minister. First, has he considered amending the Mental Capacity Act 2005 to make it clear that the certificate provider has a responsibility to confirm that the donor has the mental capacity to make an LPA?*
>
> *Secondly, can the Minister confirm whether future guidance on the role of the certificate provider will include questions for them to ask the donor that will test whether they can rely on the presumption of capacity? Thirdly, what steps is he taking to ensure that a certificate completed by a certificate provider for an LPA application shows that the certificate provider has been satisfied that the donor understands the information relevant to the decision to execute the LPA, and that the provider can retain the information that was used to weigh up the decision to put the LPA in place?*

In response, Lord Bellamy, the Parliamentary Under-Secretary of State for Justice, said:

> *On the points raised by the Law Society about the certificate provider and whether we have sufficient checks in that respect, the department is considering those and in due course will make proposals about the best way of achieving that. There could well be changes to the certificate itself, the forms used and the supporting guidance. I am not sure that legislation will be necessary, but we could tighten up the existing procedures, or at least review carefully whether they are sufficient, and test any potential changes with stakeholders and users to ensure that they achieve the core aims we need to achieve.*

Guidance for parents (and others) who look after young people who may lack capacity to

manage their own property and affairs

On 9 June 2023, the MOJ published a toolkit entitled "Making financial decisions for young people who lack capacity: A toolkit for parents and carers"

It is aimed at lay people (principally parents) who have a child who may lack capacity to manage their property and affairs and who is approaching 18.

It guides such people through a series of steps and questions including the MCA principles, the meaning of lacking capacity, the importance of supporting autonomous decision making and the involvement of P and busts a few "myths" about the entitlement to run an adult's finances (mainly around the idea that a parent may automatically have the right to deal with a child's financial affairs on that child's adulthood).

Though aimed at the lay person, it is a helpful reminder to all of the principles involved.

Short note: professional deputies and their firms who is the client?

In *Brassington v Knights Professional Services Ltd (t/a Knights) (Re Court of Protection - Deputyship)* [2023] EWHC 1568 (Ch), HHJ Hodge KC (sitting as a Judge of the High Court) had to consider the question of whether a former employee of a solicitors' firm acting as a professional deputy could be personally liable for costs which had been recorded on her deputyship files whilst she was employed by that firm but which could not properly be billed to, or recovered from, the protected persons in relation to whom she had been appointed deputy.

The crux of a detailed judgment answering the question with a resounding 'no' is to be found at paragraph 78, at which HHJ Hodge KC identifies that:

> *in my judgment, by subscribing to her standard deputyship letter* [an entirely standard form of letter expected where deputy is obtaining legal services], *Mrs Brassington was, in each case, contracting with Knights solely in her capacity as deputy, and as agent, for and on behalf of P. That seems to me to be the clear meaning and effect of the language of the standard-form letter, construed in the statutory context against which both parties subscribed to it. Both parties understood that P, rather than Mrs Brassington, was Knights' true client, as evidenced by the way the client was identified and referenced in Knights' statements of account and, by inference, its files and other records. That conclusion accords with both the common sense, and the commercial reality, of the retainer, with Knights owing duties in contract, and not only in tort, to P, rather than to Mrs Brassington, who was the person charged with carrying out the work in relation to the deputyship, which was the relevant engagement. After all, the work Knights was being engaged to carried out was for the benefit of P, rather than Mrs Brassington personally. That conclusion also accords with the provisions of s. 19 (6) of the MCA, which treat the deputy as P's agent, and the explanation of its effect at para 8.55 of the Code of Practice. I agree with Mr Kelly that this explanation is only a short, and necessarily, incomplete, rather than a comprehensive statement of the law concerning the personal liability of an agent; and that the terms of any contract signed by the deputy, its nature, and the surrounding circumstances, all have to be scrutinised carefully to determine whether the deputy is thereby assuming any personal liability.*

As HHJ Hodge KC observed, he had raised the question of how the standard deputyship letter:

> *might be capable of rendering her (and*

her family co-deputies) liable to Knights for unpaid WIP, representing sums by way of remuneration and expenses that have been disallowed by the SCCO, if (as both parties accept) P is not liable for such sums. I find it difficult to understand how the same words can bear different meanings, and produce different effects, for Mrs Brassington and for P. Counsel have supplied me with no satisfactory answer to this conundrum.

83. Subject to any further argument that might be presented to the court on this aspect of the case, it seems to me that the position can only be reached whereby P is not liable under Mrs Brassington's standard deputyship letter for any remuneration and expenses that have been disallowed on assessment by the SCCO if the terms of that letter are subject to an overarching implied term to that effect. Such a term could only be implied on the grounds either of business efficacy, or of obviousness, on the basis that, without it, the deputy's engagement of Knights would lack all practical or commercial coherence. Even then, there is the obvious problem that a term cannot properly be implied which would contradict an express term of the contract. Such a term would have to be justified by reference to the peculiar position of a COP-appointed deputy, and the constraints imposed by the MCA and ancillary COP and SCCO practice and guidance. The difficulty I entertain about all of this, however, is that identical, or similar, considerations would seem to me to militate in favour of the implication of such a term into any contract of retainer whereby solicitors are engaged to act in connection with a COP deputyship, whether the counter-party is P, a professional deputy, or a family co-deputy, since the constraints operate in precisely the same manner in all such situations. Fortunately, these are matters that call for no final determination as part of this judgment.

In consequence:

84. [...] no lien can be asserted by Knights against Mrs Brassington [in respect of the shortfall in costs]*, both because she was never Knights' client, and she was never personally liable for any of their costs and expenses. In principle, Knights could have asserted a lien as against any P, had they been liable to Knights for payment of any outstanding fees, disbursements and expenses. However, Mr Kelly accepts that P is not liable for any remuneration and expenses that have been disallowed on assessment by the SCCO; and it is this which constitutes the unbilled WIP.*

Perhaps the most surprising thing about this judgment is the fact that the application had had to be brought in the first place, as it is remarkably difficult to think of any principled basis upon which a solicitor acting as deputy could properly be said to have incurred costs personally in a situation such as that of Mrs Brassington.

Short note: attending on deputies in personal injury claims

In *Hadley v Przybylo* [2023] EWHC 1392 (KB), Master McCloud has confirmed that, in the context of a personal injury claim, having a fee earner attending rehabilitation case management meetings is not progressive of litigation and does not fall within the notion of 'costs' for purposes of costs budgeting. Likewise a fee earner attending on deputies so as to seek input into the ongoing drafting of the case in the form of the Schedule, when deputies do not properly play a part in such work, is not progressive. Claimants must therefore consider whether such costs (if they are to be sought) can properly be claimable as damages. Recognising the individual and wider significance of the

decision, Master McCloud granted permission for a 'leapfrog' appeal to the Court of Appeal.

The judgment is also noteworthy both for its plain language summary (something we wish all judges could attempt), for its opening line, being another of Master McCloud's pithy observations: "[o]*n rare occasions, like the transit of Venus or a triple Jovian eclipse but far less predictably, costs budgeting ceases to be a cause of judicial ennui, and raises instead something of interest legally*."

PRACTICE AND PROCEDURE

Short note: habitual residence under the spotlight

The decision in *Aberdeenshire Council v SF & Ors* [2023] EWCOP 28 serves both as a helpful reminder that Scotland is a foreign jurisdiction insofar as capacity matters are concerned, and also an example of a careful application on the facts of the approach to determining the habitual residence of a person with impaired decision-making capacity. As the opening paragraph makes clear, the case is also likely to raise some interesting questions about the extent to which Scottish Guardianship orders comply with Article 5 ECHR:

> *SF is a 44 year old woman from Scotland who has been treated in a psychiatric unit and then cared for in supported living for a total of seven and a half years in England. She has a lifelong diagnosis of moderate intellectual disability, autism spectrum disorder, associated periods of severe anxiety, and a diagnosis of difficult to treat schizoaffective disorder (bipolar type). It is not in dispute that she lacks capacity to conduct this litigation and to make decisions about residence and care. She is the subject of a Scottish Guardianship Order* ['SGO,' made in favour of her parents] *which the Applicant Council applies to be recognised and enforced in England. The Third Respondent Council, in whose area SF is currently cared for, was concerned that the SF was being deprived of her liberty in her current placement without lawful authority and made an application to bring the matter before the Court of Protection. In March 2023 Aberdeenshire Council made its application for recognition and enforcement and HHJ Scully ordered that they should become the Applicant and Sunderland City Council should become the Third Respondent.*

As Poole J identified:

> *12. The issue before me is a preliminary issue in the application by Aberdeenshire Council for recognition and enforcement of the 2021 SGO. Given my determination that in June 2021, upon making the renewed SGO, the Sheriff must have been satisfied that SF was habitually resident in Scotland and that therefore the court had jurisdiction to make the SGO, it follows, applying Baker J's approach* [in *The Health Service Executive of Ireland v PA & Ors* [2015] EWCOP 38] *and the recognition and enforcement provisions of MCA 2005 Schedule 3, paragraphs 19 to 24, that there is no power to challenge the finding made in Scotland in June 2021 that SF was habitually resident in that country. There is no challenge to the measure itself. It might be contended that the determination of habitual residence for the purposes of jurisdiction to exercise the powers under the MCA2005 is not part of the "process to recognise and enforce a provision in this country" [Baker J, above] but the determination of habitual residence for the purposes of the application by Aberdeenshire Council, is for the purpose of that process and the court has ordered that Aberdeenshire Council be made the Applicant in these proceedings. That is therefore the application in which the determination of habitual residence is being made. In any event, it would be unfortunate for the court to be bound by the finding of habitual residence at a particular point in time for one purpose, but to come to a different finding about habitual residence at that same time for another purpose. As it is, I am bound by the finding of habitual residence made by the Scottish court in June 2021.*
>
> *13. I am not bound to find that*

> *SF remains habitually resident in Scotland. Indeed, there have been some changes in her position since June 2021, in particular she has been discharged from detention in hospital under MHA 1983 s3 into supported living. Accordingly, I shall review the authorities on the correct approach to determining habitual residence for adults who lack capacity, consider the particular evidence in this case, and state my conclusions.*

Poole J proceeded to do exactly that, and ultimately concluded that, whilst the issue of habitual residence was finely balanced, the evidence showed that SF remained habitually resident in Scotland. He concluded at paragraph 23 with an important reminder that:

> *Although the principles to be applied are common to determinations of the habitual residence of a child who is the subject of an application under the 1980 or 1996 Hague Conventions, and an incapacitous person who is the subject of an application under the 2000 Hague Convention or the MCA2005, this case highlights the significant differences in the evidence and factors that the court may have to consider when applying those principles.*

Court of Protection payments for local authorities

As of 1 July 2023, the Court of Protection is no longer accepting cheques and card payments from Local Authority applicants. Instead, payments will have to be made via Payment by Accounts portal. More information can be found here.

Short note: contempt and the Court of Appeal

In *MacPherson v Sunderland City Council* [2023] EWCA Civ 574, the Court of Appeal heard Mrs Macpherson's appeal against an order of Poole J in the Court of Protection dated 20 January 2023 committing her to 28 days' imprisonment, suspended for 12 months, for five contempts of court.

Not least as Mrs Macpherson was acting in person, the Court of Appeal set out a number of broad principles of law, the two key principles relating to contempt being:

> *15. As some of the Appellant's submissions appear to be directed to showing that she should not be found guilty of contempt of court even though the breaches were admitted, the case of R v Tredget [2022] EWCA Crim 108; [2022] 4 WLR 62 provides some assistance by way of analogy. In that case the Court of Appeal Criminal Division reviewed the basis on which an appellant might appeal against conviction after a plea of guilty. Three main categories were identified. These were: (1) the guilty plea was vitiated either because the plea was equivocal or because impermissible pressure had been exerted on the appellant; (2) there was an abuse of process because there had been entrapment, for example; and (3) where it could be shown that the appellant had not as a matter of fact committed the offence. The court made it clear that the categories were not closed.*
>
> *16. In Her Majesty's Attorney General v Timothy Crosland [2021] UKSC 15; [2021] 4 WLR 103 [44] the court set out the proper approach to sentencing for contempt of court. The court should adopt an approach similar to that in criminal cases and assess the seriousness of the conduct and the harm caused, intended or likely to be caused. The court should consider whether a fine would be a sufficient penalty. If the contempt were so serious that only a custodial sentence would suffice, the court should impose the*

> *shortest period of imprisonment which reflects the seriousness of the contempt. Weight should be given to mitigation, including any genuine remorse and previous good character. There should be a reduction for an early admission of contempt. Once the appropriate term has been decided, consideration should be given to suspending the term of imprisonment.*

Peter Jackson LJ's short concurring judgment explains pithily why, on the facts of the case, Mrs Macpherson's appeal failed:

> *34. The way in which the judge has conducted these sad proceedings cannot be faulted. The orders which the Appellant admitted breaching were clearly necessary in FP's best interests. The Appellant's disagreement with those orders has been carefully considered by the Court of Protection on several occasions in decisions upheld by this court when refusing permission to appeal. The Appellant maintains her entrenched opinions which have repeatedly been found to be gravely misguided. In the circumstances, a sentence of 28 days' imprisonment suspended for one year was, in my view, entirely appropriate. No valid ground of appeal from this order has in the end been placed before us. Accordingly, the appeal is dismissed.*

Court of Protection statistics

The most recent set of statistics (covering January to March 2023) show the following;

- There were 1,554 applications relating to deprivation of liberty made in the most recent quarter, which is a decrease of 7% on the number made in the same quarter in 2022. However, there was an increase by 58% in the orders made for deprivation of liberty over the same period from 656 to 1,035.
- Of the 1,554 applications, 145 were s.16 applications, 537 were s.21A applications, and 872 COPDOL11 ('Re X' or 'community DoL' cases). We note that this means that 65% of the applications would not have attracted non-means-tested legal aid for P (if P were joined as a party, which may not necessarily be the case, especially in 'Re X' cases).
- There were 8,948 applications made under the MCA more generally between January to March 2023, up by 3%. Of those 34% related to applications for appointment of a property and affairs deputy. During the same period there were 12,803 orders made, up by 14%.
- In January to March 2023, there were 269,537 LPAs registered, the highest in its series and up 33% compared to the equivalent quarter in 2022

Transparency orders, reporting restriction orders and different courts

Hannah Taylor of Bevan Brittan and Alex have worked up a table seeking to set out the (complicated) map of statutory provisions applying in different courts considering the welfare of child and adults. It is a work in progress, and Alex welcomes feedback.

THE WIDER CONTEXT

The LGSCO and deprivation of liberty

The Local Government and Social Care Ombudsman ('LGSCO') decision in Surrey County Council (22 014 808) (23 March 2023) considered significant delays in the processing of DOLS applications. The LGSCO noted that it had become aware of these delays in the process of investigating another complaint, and 'consider[ed] that others may be affected by these significant delays.'

The LGSCO also considered figures provided by NHS Digital regarding the Council's handling of DOLS requests in 2021-2022. The decision stated:

> *18. Information about Councils' handling of DoLS requests is contained in NHS Digital figures for England. These figures show that Surrey County Council had 5700 outstanding DoLS requests on 31 March 2022. This is the highest backlog in England.*
>
> *19. The Council's backlog increased by 600 during 2021/22.*
>
> *20. The NHS Digital figures show the mean duration to complete a DoLS assessment in England is 154 days. However, the mean duration for the Council to complete a DoLS assessment is 345 days.*
>
> *21. The Council completed only 7.6% of the standard requests it received within 21 days. In England the average number of standard requests completed within 21 days is 20.4%.*
>
> *22. During 2021/22 the Council assessed and made decisions on 3700 requests. Of these decisions the Council:*
>
> - *granted 840 requests*
> - *did not grant 1320 requests because the person had died.*
> - *did not grant 1400 a further requests because of a change in the person's circumstances, such as a change in care home. A new DoLS request would need to be submitted.*

The decision stated that it understood that many local authorities were "*struggling with the number of DoLS requests they receive and the lack of resources to address this. The Council appears to be following ADASS advice on prioritising cases. However, the statutory timescales as set out in paragraph 10 still apply, and planned new legislation has not been introduced that may change these requirements*" (paragraph 23). The LGSCO considered that the Council was "*failing to issue DoLs authorisations within the statutory timescales and in many cases the delay is so significant that the person has moved to another care or nursing home, or has died without the Council's DoLS authorization*" (paragraph 24). The LGSCO found that "*there may be many people who, because of the Council's delays in assessing DoLS requests, have had restrictions placed on them that were not the least restrictive options, had they been properly and promptly assessed.*"

The Council agreed to provide an action plan within three months on how it would address these delays and reduce the backlog.

Wirral Metropolitan Borough Council (22 010 680) was a complaint was brought by Ms B, on behalf of her mother, Mrs C, who complained that the Council had failed to take a proper best interests decision or facilitate a move from a residential care home back to the family home before Mrs C's death in April 2021. Ms B further complained that Mrs C's deprivation of liberty in the care home had not been authorised, and the

Council had not explained the law to her.

Mrs C had been diagnosed with Alzheimer's disease. She was admitted to a care home in December 2019 at a time when her husband had been admitted to nursing care, and both the social workers and Ms B felt that Mrs C was not safe to live on her own. The decision describes this move as an 'emergency short-term admission to care', and states that Mrs C was found to lack capacity to make decisions as to her care. An application was made for a DOLS authorisation, which was considered a 'medium priority.'

Ms B had consistently stated her view that Mr and Mrs C should return home with a package of care. A 'trial' return home for Mrs C was conducted in January 2020, with Ms B caring for her. This trial ended early due to adaptations being made to the home (the installation of a wet room). Ms B was planning to leave employment to care for her parents if her partner was able to secure employment.

Mrs C's husband died in February 2020. Preliminary discussions regarding funding a direct payment for Mrs C did not progress (it appears likely due to the first wave of the pandemic), and the Council arranged for Mrs C to live in a care home on a long-term basis. Ms B continued to wish for Mrs C to return home, but a meeting to discuss this was not convened until December 2020. The social worker then stopped the meeting when Ms B brought a friend to support her.

The Council then carried out what appeared to be the fourth capacity assessment undertaken in a year, which indicated that Mrs C was opposed to returning home. Mrs C's deprivation of liberty was not authorised until February 2021.

Ms B had proposed making an application to the Court of Protection to determine Mrs C's residence. In the winter of 2021, the Council "*advised Ms B that she would need to become Ms B's Deputy before Mrs C could move to the family home. The Council record says it would then take a best interest decision and "wrap around care and support should be planned for a safe return home for [Mrs C] if [Ms B's] powers are granted [..] by COP [Court of Protection]".*"

Some progress was made in March 2021, with a new social worker being appointed, who carried out a home visit and recommended an OT assessment. Mrs C sadly became ill in March 2021 and died in April 2021.

The LGSCO considered that the Council had committed fault for several reasons:

- The Council failed to authorise Mrs C's deprivation of liberty for 15 months. This was a significant delay beyond the 21-day limit.
- Council documentation had wrongly recorded that a standard authorisation was in place in April 2020.
- "*[T]he Council could have done more to explain to Ms B what the Deprivation of Liberty safeguards are and their use; the relevance of the Mental Capacity Act; what is meant by 'best interest' decision making and the role of the Court of Protection. These are not familiar concepts to those who do not work within social care. And even in that environment, confusion sometimes arises.*"
- The Council gave inaccurate advice that Mrs C's potential move home could not occur unless Ms B were her deputy, and "*failed to distinguish between what was legally permissible and its own views towards the move. If it considered such a move was not in Mrs C's best interests,*

then it could have referred the matter to the Court of Protection, possibly to run alongside Ms B's application to become Mrs C's deputy. But it was not the case that one had to depend on the other."

- The LGSCO had concerns that the Council's view of the situation may have "*unreasonably influenced the mental capacity assessment in December 2020. The record for this is conspicuously less thorough than for other similar assessments. This assessment found Mrs C wanted to remain in the care home. But that went against the grain of all other mental capacity assessments which found Mrs C did not have capacity to decide where she should live or where her care needs should be met."*
- The LGSCO found that injustice arose from the faults above, causing avoidable distress to Ms B. She was to be paid £500 as a symbolic payment to reflect the unnecessary time and trouble caused by the failings above.

The Council also agreed to take steps to introduce a procedure so it can identify when it has failed to meet the 21-day limit to consider a request for a DOLS authorisation; remind social work staff "*of the importance of giving clear information to relatives on the Deprivation of Liberty safeguards; Mental Capacity Act assessments; the role of the Court of Protection and best interest decision making*" and review written materials given to families.

However, the LGSCO was "*not persuaded the overall trajectory of this case would have been different if* [the faults] *had not occurred*" because he was "*not persuaded that at any point Ms B was in a position to receive Mrs C back at the family home, with a package of care in place (to include the support needed from a PA). I accept this was Ms B's aspiration and she undertook efforts to make that aspiration a reality. But it is clear from the record the COVID-19 pandemic caused a significant interruption in Ms B's plans. So, it was not until December 2020 when she began to push the Council to support a move for Mrs C back to the family home. The time period to put in place arrangements for Mrs C's return, before she died, was therefore short – a little over three months. For it to have happened, the Council would have needed to satisfy itself the family home was suitably adapted for Mrs C; that there was 24-hour care on hand to meet her needs and that such a move was in her best interests. As Ms B herself noted these arrangements were not ones that could be rushed.' While more could have been done to progress matters and issues of fault arose, the LGSCO did 'not consider these factors delayed the progress of Ms B's request to any significant degree. I also find there is much evidence from both before and after December 2020 that the Council never closed its mind to the idea of Mrs C returning home. But as I have said above, I think there was simply too much to be done that could have enabled the move to happen before April 2021. A view that must also take account of Mrs C's poor health in March 2021 which would have delayed a move.' The LGSCO did consider that greater speed in authorising Mrs C's deprivation of liberty 'may have helped focus the Council's mind sooner on the steps that would be needed if Mrs C were to return home. But it would not have changed the chronology of those events in Ms B's control which were fundamental in making any move happen. Nor would it have stopped the disrupting influence of the pandemic."*

The LGSCO did not find fault on the part of the care provider in restricting visits during the pandemic, though considered that it was disappointing '*that no more record keeping has been provided to show how the Care Provider sought to balance these competing pressures at the time. This is especially in the light of it*

recording Mrs C's distress at window visits.

Comment

Delays in authorising deprivations of liberty have been a repeated theme in LGSCO decisions (see, e.g., its findings in relation to severe and systemic delays in Staffordshire, including failing to consider many applications at all, delays in assessments in Kent which separated an elderly couple and a recent finding against the London Borough of Sutton). In these judgments, the delays in authorisations were striking, and both reveal systemic backlogs which appear to be endemic. We note the NHS England findings which make clear that the average processing time across the country is more than seven times the 21-day limit cited by LGSCO. It appears likely that many more local authorities will find themselves subject to decisions of this nature for so long as the severe backlogs persist.

OPG guidance about vaccination

The OPG has issued helpful guidance for health and welfare attorneys and deputies about their role in vaccination (both for COVID and more generally), including guidance about how to make a best interests decision in the event that the person lacks capacity to consent to the vaccination. It highlights the circumstances under which a disagreement about best interests will trigger an application to court, serving as an important reminder that those working with attorneys and deputies do need to keep being professionally curious about whether the steps that the attorney / deputy are in the best interests of P.

Article 2 and deprivation of liberty

R (Maguire) v His Majesty's Senior Coroner for Blackpool & Fylde and another [2023] UKSC 20 (Supreme Court (Sales, Reed, Lloyd-Jones, Rose, Stephens SCJJ)

Best interests – medical treatment – practice and procedure (Court of Protection) – other

Summary[11]

Jackie Maguire lacked capacity to make relevant decisions and was subject to a standard DoLS authorisation in a care home. Weeks before her death, she began to experience symptoms of a sore throat, diarrhoea, vomiting, and a raised temperature. On 21 February 2017 her symptoms worsened, and she suffered a fit. Care home staff called an ambulance but she refused to go to hospital. Paramedics obtained out-of-hours advice from a GP who advised that, while it was desirable for her to attend hospital, her condition was not so serious that they should override her wishes and force her to go. The following morning she collapsed again. Paramedics used light physical restraint and took her to hospital in her best interests where, shortly after admission, she suffered a fatal cardiac arrest. A post-mortem revealed a perforated stomach ulcer resulting in peritonitis.

The central issue was whether Article 2 ECHR required an "expanded" or standard conclusion for the purposes of s.5(2) Coroners and Justice Act 2009. The standard version would be confined to how, when and where she died whereas an expanded conclusion involves a commentary about the circumstances in which Jackie came by her death. This is required where the enhanced procedural obligation applies.

The Supreme Court noted that there are three

[11] Note, Alex, Tor and Nicola having been involved in the case, none of them have contributed to this summary. Jackie Maguire is referred to by her first name here – and in the Supreme Court judgment – at the request of her family. We would otherwise have called her "Ms Maguire."

types of positive procedural obligations:

1. Basic: to check whether there might be any question of a potential breach of a person's right to life under Article 2, State authorities should take some steps to establish whether the cause of death is from natural causes.
2. Enhanced: in particular contexts, a State may be required to take further steps to investigate possible breaches of the Article 2 substantive obligations to ensure appropriate accountability and redress and, as appropriate, to punish persons responsible for the death.
3. Redress: in certain other cases where there is no relevant compelling reason giving rise to an enhanced procedural obligation, but there is still a possibility that the substantive obligations in Article 2 have been breached, there is an obligation to provide means by which a person complaining of such possible breaches can make that complaint, have it investigated or obtain redress.

Article 2 provides two types of positive substantive obligations which, on the facts of this particular case, resulted in the following conclusions (the numbers in square brackets being references to numbers in the judgment).

1. The systems duty: to have appropriate legal regimes and administrative systems in place to provide general protection for the lives of citizens and persons in its territory. In a healthcare context, only rarely will this be breached: [145]; the same is true in a care home context: [147]. In this case, the systems in place at the care home were capable of being operated in a way which would ensure that a proper standard of care was provided to residents, even though there may have been individual lapses in putting them into effect: [146]; [156]; [165]. Whilst criticism could be made of people's individual performances, there was no failure of the systems duty: [153]; [155]; [184].

2. The operational duty: to take operational steps to protect a specific person or persons when on notice that they are subject to a risk to life of a particularly clear and pressing kind.

   (a) *Care homes*: When an individual is placed in a care home, a nursing home or a hospital, the State does not assume responsibility for all aspects of their physical health; it is not the guarantor of adequate healthcare in all respects: [190]. The focus must be on the specific risks to Jackie's health of which the authorities knew or ought to have known: [192]. The operational duty applies in a graduated way depending on their perception of the risk to Jackie: [199]. The care home's responsibility was to look after Jackie on behalf of the State in substitution for her family. Their task was to ensure that she could access the healthcare which is available to the population generally in the same way that a family could secure access for a vulnerable member [199] and this is what the care home staff sought to do: [200]. There was therefore no arguable breach of the operational duty by the care home: [204].

   (b) *Healthcare providers:* When assessing whether the operational duty arose, it is necessary to take into account a range of relevant factors, including the desirability of fostering Jackie's sense of personal autonomy and a sense of trust between her and her carers, by respecting her wishes where possible: [57]-[60]; [205].

> None of the healthcare professionals involved was on notice that Jackie's life was in danger on 21 February 2017 and the paramedics gave proper consideration to the question of whether she ought to be removed forcibly to hospital. They made an assessment which was reasonable in the circumstances, that the risk to her was not so great as to make that appropriate: [208]. As a result, there was no arguable breach of the operational duty by any of the healthcare providers: [209].

Comment

The judgment provides a useful summary of the various procedural and substantive duties under Article 2. In relation to the systems duty, it illustrates the importance of the CQC's regulatory role which, shortly after Jackie's death, had inspected the care home and was satisfied with the systems in place and standard of care. As to the operational duty, the judgment recognises that this is not limited to prisons and hospital settings and therefore could be triggered in care homes. But, crucially, actual or constructive knowledge of the nature and degree of the risk to the particular person's life is key which, on these facts, did not trigger the duty.

Visiting in care homes, hospitals and hospices – consultation on proposed new legislation in England

The Department of Health and Social Care is consulting (with a closing date of 16 August 2023) so as to obtain "*views on introducing secondary legislation to protect visiting as a fundamental standard across CQC-registered settings so that no one is denied reasonable access to visitors while they are resident in a care home, or a patient in hospital or a hospice. This includes accompanying people to hospital appointments (outpatients or diagnostic visits).*"

The consultation document can be found here, and the consultation response form here. For queries, email visiting@dhsc.gov.uk.

In terms of formulating responses, it may be of assistance to some to note that the Joint Committee on Human Rights made the following recommendation in its report published in July 2022 on protecting human rights in care settings (full disclosure, Alex was the specialist adviser to the Committee for this inquiry):

> 81. ***We still do not believe that there are sufficient measures in place to ensure adequate respect for the right to private and family life (Article 8 ECHR) in relation to care users and visiting arrangements in care settings.***
>
> 82. We remain concerned that in England, non-statutory guidance that intends to restrict visiting does not adequately meet the criteria of "in accordance with the law" that is required for any interferences with human rights. Moreover, given the variable application of the guidance, it also seems to be failing to ensure adequate positive protection for the right to family and private life. Even if every care setting now complied with the guidance seeking to facilitate visiting, stronger assurances would be needed to adequately protect the rights of care users and their loved ones against future improper interference.
>
> 83. *The Government must introduce legislation to secure to care users the right to nominate one or more individuals to visit and to provide support or care in all circumstances, subject to the same infection prevention and control rules as care staff.*
>
> 84. *The Government must legislate to give the CQC the power to require care*

> *settings to inform them of any changes to their visiting status, and to report live data on levels of visiting and restrictions. The CQC must make compliance with visiting restrictions a key consideration when undertaking its regulatory and monitoring roles*.

Updated guidance from the Law Society

The Law Society has produced updated guidance for solicitors working with clients who may lack capacity to give instructions. [12] It helpfully sets out the relevant details in the context of making a will or lifetime gift and conducting civil proceedings, with guidance on what to do if capacity is questionable. Separate updated guidance has also been provided for those advising clients who may be at risk of financial abuse, with practical steps to take, many of which will assist other professionals, such as social workers, who face similar dilemmas.

Safe Care At Home Review

During the passage of the Domestic Abuse Act 2021, concerning evidence was presented by Peers and the deaf and disability sector on abuse against people receiving care in their own homes. In response, the government decided to review the existing protections and support for adults with care and support needs who are at risk of, or experiencing, abuse in their own homes by people providing their care. The Safe Care at Home Review was jointly led by the Home Office and Department of Health and Social Care, and was published on 12 June 2023. It applies only to England, as health and social care is a devolved matter.

The 86 page review is a detailed and thorough analysis, highlighting in particular that:

- *our understanding of the prevalence and nature of abuse in care relationships is limited. Research in this area can often focus on specific subsets of groups, such as those with disabilities or older people. This evidence may not be generally applicable to all adults receiving care in their own homes. For example, while NHS digital data on safeguarding adults collect data from local authorities on the scale of safeguarding activities, this data cannot be applied as a prevalence measure as not all cases of abuse will be reported.*

- *Based on the evidence collected, the review identified three key themes as areas where improvements should be made, underpinned by eight key findings. The review proposes a set of actions for government to take forward in response to these findings – and, perhaps importantly – each set of findings is accompanied by specific actions to which DHSC and Home Office have committed themselves.*

- *One finding of note is that "Frontline professionals often lack the necessary tools and resources to fully protect and support people with care and support needs who are, or are at risk of being, abused in their own home by the person providing their care," and one action of note is that "DHSC will review any new and relevant evidence on powers of entry for social workers since this issue was last considered by government during the passage of the Domestic Abuse Act 2021. This should include Safeguarding Adult Reviews in England and the use of equivalent powers in Scotland and Wales."*

Specifically in relation to matters mental

[12] Full disclosure, Alex was involved in both sets of guidance discussed here.

capacity related, the Review noted (footnotes omitted):

> *108. Understanding the implementation of the Mental Capacity Act 2005 and its interaction with the Care Act 2014, was especially highlighted by social work and policing practitioners as an area where significant improvements are needed. For example, stakeholders reflected that in some cases, section 42 enquiries under the Care Act 2014 may not be investigated fully if there is any question about the victim's mental capacity. Existing guidance and resources available to support the police include 'Achieving Best Evidence' which is designed to ensure that victims are heard no matter their needs. Despite this, practitioners noted that the police would sometimes halt investigations when there was a question of someone lacking capacity. This was because police officers felt that they would not be able to gather enough evidence to pursue these sorts of cases in court.*
>
> *109. DHSC have supported SCIE, as a sector-led improvement partner, in the development of online training materials regarding the Mental Capacity Act 2005, to increase understanding of the application of the Act among social care professionals. However, some stakeholders emphasised that training on the Act alone will not address all issues with its implementation. Knowledge and understanding of executive functioning, referring to the ability of an individual to understand the relevant information and give effect to their decision, has developed since the inception of the Act. The University of Bristol noted in their SAR analysis on self-neglect, that practitioners lack confidence in carrying out capacity assessments or determining when they would need to do them. Someone may 'seem' able to make a decision on a specific issue at a given time and place, such as accepting they 'agreed' to gift someone providing care with their assets, but may not be able to understand the consequences of this decision in the longer term. Safeguarding leads reported that continual updating of training on mental capacity aimed at frontline professionals is required, but that it is challenging to get it right despite their best efforts.*
>
> *110. Practitioners including police and social workers expressed concerns about abuse of people with care and support needs who 'do have capacity' to make all relevant decisions but are targeted by people ostensibly providing care. Stakeholders shared the example of individuals with disabilities being 'groomed' to provide sexual favours or financial payments. Policing and social work stakeholders highlighted that the combination of limited resources and the complexities of these cases make them difficult to respond to.*

Despite the depth of the Report, it is important to note that it does not cover the situation where the abuse (whether physical, emotional, financial or otherwise) is not committed by a person in a 'care' relationship. The problem of 'grooming' identified immediately above occurs frequently outside such relationships – and in situations which do not fall within those caught by the Domestic Abuse Act. At the risk of sounding like a stuck record, Alex would note that, were the Law Commission to be able to undertake a 'Vulnerable Adults' project as he has sought for some time, it would be able to look at all aspects of the law here, rather than having to salami-slice things according to relationship.

A striking asymmetry – adolescents choosing and being responsible

In Re ZA [2023] EWCA Crim 596, the Court of Appeal set out a number of important 'learning

points' in relation to the sentencing of children and young people. We flag it because of one paragraph:

> *52. It has been recognised for some time that the brains of young people are still developing up to the age of 25, particularly in the areas of the frontal cortex and hippocampus. These areas are the seat of emotional control, restraint, awareness of risk and the ability to appreciate the consequences of one's own and others' actions; in short, the processes of thought engaged in by, and the hallmark of, mature and responsible adults. It is also known that adverse childhood experiences, educational difficulties and mental health issues negatively affect the development of those adult thought processes. Accordingly very particular considerations apply to sentencing children and young people who commit offences. It is categorically wrong to set about the sentencing of children and young people as if they are "mini-adults". An entirely different approach is required.*

We do not disagree, but venture to note that the observations sit at a striking tangent to the analysis of capacity for purpose of the MCA 2005. On one view, it could almost be said on the basis of this passage that the condition of being under 25 might, itself, be an impairment or disturbance in the functioning in the mind or brain…

Quite what capacity – and / or competence – is supposed to look like in relation to those under 18 was a theme of the Independent Mental Health Act review, and was picked up by the Joint Committee which scrutinised the draft Bill (see the report at paragraphs 221-222). We do hope that it is possible for the Law Commission in its recently announced project to review the law relating to social care for disabled children finally to grasp this nettle.

Research corner

Alex has done an 'in conversation with' Dr Kevin Ariyo about the research that he led (as part of the as part of the Mental Health & Justice Project) into interpersonal influence and decision-making capacity, focusing on the way in which this issue has played out in the courts, and asking what the research might tell us about how we can think better about this area. The article Alex and Kevin discuss was led on by Kevin with Dr Nuala Kane, Dr Gareth Owen and Alex, and was published in June 2023 in the Medical Law Review: Interpersonal influences on decision-making capacity: a content analysis of court judgments. The survey of professionals Kevin mentions towards the start of the discussion can be found here.

Many may find nuggets of useful information in Baddeley, A, Brewin, CR, Davies, GM, Kopelmann, MD & MacQueen, HL 2023, 'Legal aspects of memory: A report issued by the Psychology and Law Sections of the British Academy', *Journal of the British Academy*, vol. 11, pp. 95-97 with annex. The chapters cover (1) a review of memory; (2) memory through the lifespan; (3) witness testimony; (4) eyewitness identification; (5) conditions that may impair memory (6) suspects' testimony; and (7) the memory expert in court (the last including 'mental capacity and fitness to plead).

EU proposals for improvements in cross-border protection of adults

On 31 May 2023, the European Commission set out two proposals to seek to secure better cross-border cooperation in relation to adults who are not in a position to protect their own interests. A

proposed Regulation would introduce a streamlined set of rules that would apply within the EU. The rules, modelled on those contained in the 2000 Hague Convention on the International Protection of Adults, would govern, which court has jurisdiction, which law is applicable, under what conditions a foreign measure or foreign powers of representation should be given effect and how authorities can cooperate. The proposed regulation, going further than the 2000 Convention, also proposes a set of practical tools, such as:

- facilitating digital communication;
- introducing a European Certificate of Representation, which will make it easier for representatives to prove their powers in another Member State;
- establishing interconnected registers that will provide information on the existence of protection in another Member State;
- and promoting closer cooperation among authorities.

It should be noted that the proposed Regulation – as with the 2000 Convention – will not expressly cover advance decisions / advance choice documents save and to the extent that these contain directions to a specified representative. It is unclear whether this is an oversight or deliberate; either way, it is unfortunate given the increasing recognition of such tools as powerful methods to secure respect for the will and preferences of adults facing a potential loss of decision-making capacity.

Alongside the proposed Regulation, a proposed Council Decision provides for a uniform legal framework for protecting adults involving non-EU countries, by obliging all Member States to become or remain parties to the 2000 Convention.

The proposal for a Regulation will still need to be discussed and adopted by the European Parliament and the Council. It would apply 18 months after its adoption and Member States would then have 4 years to make their communication channels electronic, and 5 years to create a register and interconnect it with registers of other Member States.

The proposal for a Council Decision is to be adopted by the Council after consultation with the European Parliament. Member States that are not yet party to the 2000 Convention will have 2 years to comply with the Council Decision and join the Convention.

Whilst the proposed Regulation will not directly affect the UK, given Brexit, the fact that there is a likelihood that within the medium term the majority of countries with whom there is regular cross-border 'traffic' in relation to adults requiring protection will be signatories to the 2000 Convention will only increase the pressure on the UK to ratify the Convention in respect of England, Wales & Northern Ireland in addition to Scotland.

Deprivation of liberty applications relating to children: what is actually happening?

[In an extremely helpful, but depressing, report published on 22 June 2023, the Nuffield Family Justice Observatory analysed applications received during the first two months of the national deprivation of liberty court pilot (July and August 2022), focusing on the legal orders subsequently made, with cases tracked up to 31 December 2022.[13] For the avoidance of the

[13] The NFJO is also regularly collecting, analysing and publishing data from the court, and estimates that approximately 1,300 applications will have been made over a 12-month period.

doubt that we see manifest everywhere, the national DoL court has nothing to do with the Deprivation of Liberty Safeguards regime provided for in the Mental Capacity Act 2005. The 'DoLS' regime applies solely to adults over the age of 18 in care homes and hospitals. The National DoL court is nothing other than an (important) administrative mechanism for the listing of cases before the High Court exercising its inherent jurisdiction to authorise the deprivation of liberty of those under 18.

It is not sensibly possible to improve on the summary of the report prepared by the NFJO themselves, as follows]:

Nuffield FJO's study is the first national overview of the outcome of DoL applications. It analysed whether orders applied for are granted and how long for, the nature of the restrictions authorised, where children are placed, and children's and parent/carers' participation in proceedings. The study focused on 113 children – a subsection of a larger sample of 208 children included in previous Nuffield FJO research on the needs of children subject to DoL applications.

In 104 of the 113 cases (92 per cent), applications for DoL orders were granted. [In the other cases, the full report notes that "the case was withdrawn at or before the first hearing. Mainly, this was because the deprivation of liberty was no longer thought necessary but in some cases the local authority was directed to apply to the court of protection due to the child's age, or a secure accommodation order was made to place the child in a secure children's home."] While these orders are intended to be a temporary measure, most children (68.3 per cent) were still subject to an order on 31 December 2022.

The restrictions authorised by the court involved severe constraints that remained in place for significant periods of time. Each child was subject to an average of six different types of restriction on their liberty, including, in almost all cases (99 per cent), constant supervision, usually by multiple adults. The use of restraint was permitted in over two-thirds (69.4 per cent) of the 104 cases. Over a six-month period, only a minority of children (seven, 9.2 per cent) experienced a relaxation to deprivations of their liberty.

While it didn't appear that the restrictions applied for were routinely questioned or scrutinised, in some cases, the court ordered the local authority to file an 'exit plan', with clear information about how and when the restrictions would be reduced, to share with the child. In a small number of cases, the court refused to authorise some of the restrictions – usually related to the use of restraint or limits placed on the child's access to the community.

In over half of the cases (53.8 per cent), children were placed in at least one unregistered2setting, ranging from semi-independent accommodation, Care Quality Commission-registered accommodation, hospital wards, and temporary rented accommodation, including hotels or caravans. A significant majority of children (over 70 per cent) where the deprivation of liberty was sought primarily to manage risks related to criminal exploitation, emotional difficulties, behaviours that were a risk to others, and self-harm were placed in at least one unregistered setting, indicating a lack of suitable regulated provision for children experiencing such risks. Children subject to a DoL order primarily due to a learning and/or physical disability were the least likely to be placed in unregistered accommodation.

The placements were also far away from where

children were living – on average 56.3 miles away from their home. Six children were placed in Scotland (at an average of 254.4 miles from the child's home area).

Information about children's access to education and therapeutic services was limited in the orders, and concerns about this were often raised by the court, children's guardians and parents or carers. In several cases, the court directed the local authority to provide a more detailed care plan.

The research also highlights that children have limited opportunities to formally participate and have their voices heard in DoL proceedings. Article 12 of the UN Convention on the Rights of the Child (UNCRC) states that children have the right to express their views in all matters affecting them, and to have their views considered and taken seriously. Yet just 10 out of 104 children attended at least one hearing in their case. Five spoke to the judge directly before the hearing and six wrote to the judge to share their views. Furthermore, in 15 per cent of cases, a children's Cafcass guardian had not been appointed for the child at the first hearing. This was usually due to applications being made at very short notice or delays in making children party to proceedings. Five children were separately represented (where the child separates from the guardian and instructs their own solicitor).

Furthermore, despite DoL orders having a severe impact on family life, most parents or carers did not have legal representation; parents and/or carers were legally represented (for at least one hearing) in just 12 cases (11.5 per cent). This is likely to be because parents are not automatically entitled to legal aid for legal representation in DoL cases, unlike in care proceedings.

[One of the authors of the report, Alice Roe, spoke at the seminar that we held in Chambers in March 2023, at which a range of speakers addressed many of the issues relating to deprivation of liberty of children and young people. A recording of the seminar can be found here.]

IRELAND

We are delighted to have two Irish correspondents join us to provide us with news from on the ground as the new Irish capacity regime takes effect. The first is Emma Slattery BL, a barrister who has been in practice since 2013, specialising in capacity law. Emma is the author of the forthcoming Bloomsbury work 'Assisted Decision-Making Handbook.' The second contributor is Henry Minogue BL, who was called to the Bar in 2016 with interests in family law, human rights law and commercial law.

Their first news from across the Irish Sea follows.

Overview of the ADMA Acts & Commencement

On 26th April 2023, the Assisted Decision-Making (Capacity) Act 2015 and the Assisted Decision-Making (Capacity) (Amendment) Act 2022 ('ADMCA' [14]) were commenced. The ADMCA repealed the Marriage of Lunatics Act 1811 and the Lunacy Regulation (Ireland) Act 1871 which applied a status approach to capacity. There are an estimated 2,200 wards of court in Ireland who will transition out of wardship over the coming three years. The ADMCA has put in place a three-tier system of support for those who either lack capacity in relation to some or all of their personal welfare,

[14] The Decision Support Service has collated links to the primary and secondary legislation here.

property and affairs, or both, or whose capacity is or may shortly be in question. At the lowest tier, a relevant person with capacity can appoint a decision-making assistant to assist them in making certain decisions. At the mid-tier, a relevant person with capacity can appoint a co-decision-maker to make certain decisions jointly with them. At the top-tier, the Court can appoint a Decision-Making Representative to make decisions as agent for the relevant person or determine that the person lacks capacity, unless they have a co-decision-maker to make decisions jointly with them. From a practical and procedural perspective, the ADMCA grants the Circuit Court (the second lowest court in a 5-tier court system) almost exclusive jurisdiction to hear and determine matters arising under the ADMCA, with the exceptions of living organ donation, withdrawal of life sustaining treatment, applications under the Convention on the International Protection of Adults, and appeals from the Circuit Court.

The ADMCA requires that capacity be assessed functionally based on the relevant person's "*ability to understand, at the time that a decision is to be made, the nature and consequences of the decision to be made by him or her in the context of the available choices at that time*". A person will be considered to lack capacity to make a decision if that person is unable to use, retain, and weigh the relevant information, and communicate the decision.

The ADMCA has introduced guiding principles which provide for a presumption of capacity, and which require the provision of assistance prior to deeming a person to lack capacity. The principles further provide that unwise decisions alone do not indicate incapacity and that any intervention should be based on individual circumstances and with due respect to the person's rights and dignity. The person's will, preferences, and beliefs must be considered, and the person him or herself must be involved as much as possible. Finally, the potential for recovery and urgency should be considered when intervening in respect of a person lacking capacity.

The ADMCA also supersedes the system for creating Enduring Powers of Attorney with a more robust system, along with increased safeguards, and provides for the creation of Advanced Healthcare Directives, with the option of appointing a Designated Healthcare Representative.

2. The Decision Support Service

Part 9 of the ADMCA provides for the creation of the Decision Support Service ('the DSS'), to which Áine Flynn was appointed Director in October 2017. The Director's role involves promoting public awareness of the ADMCA and the matters relating thereto, boosting public confidence in its processes, and providing relevant information to those affected and their support network. The Director is also responsible for supervising the compliance of various decision-makers with the Act.

Section 95B permits the Director to specify that any document be in electronic form or be submitted in electronic form. The DSS has thus adopted a 'digital first' model. The 'digital first' model of the DSS has caused some disquiet[15] amongst the legal community, particularly with regard to EPAs[16]. The main issue raised relates to the online process requiring the solicitors' use of their client's MyGovID (which requires a Public Services Card[17]), with no access to a solicitor's portal. Concerns were raised that a solicitor may

[15] Statement from the Dublin Solicitors Bar Association in May 2023
[16] Irish Times article dated 18th June 2023
[17] The Public Services Card has been the subject of two unfavourable investigations by the Irish Data Protection Commissioner, a summary of which can be found here.

be requested to provide the legal practitioner's statement in circumstances where they had not observed the full process of the creation of the EPA[18]. However, through engagement with the Law Society's Mental Health and Capacity Taskforce, a paper-based system and guidance has been provided to practitioners.[19]

3. Rules of Court and Practice Directions

The ADMCA is a far-reaching Act with many 'moving and interlinked' parts. As such, it comes as no surprise that the legislation and subsequent Rules and Regulations were completed in a staggered fashion.

The Circuit Court will be the workhorse of the ADMCA, and thus the Rules published on 28th April 2023 are necessarily detailed and involved. In general, applications are made by way of originating notice of motion and grounding affidavit. This procedure benefits from being assigned a hearing date from the point of filing, thus there is no delay or waiting for one party to set the matter down for hearing.

The Circuit Court has commenced hearing applications, with many initial applications arising in circumstances where a declaration of capacity is required to enable an application be made under the Nursing Home Support Scheme.[20] The technical and detailed process is proving difficult for both lay applicants and legal practitioners to navigate, with Sage Advocacy appearing in the Dublin Circuit Court to offer support to litigants. However, one notable feature is that the relevant person the subject of the application was not represented in any of the applications before the Court on the 23rd June 2023.

The Rules of the Superior Courts were published on the 30th May 2023. In the intervening period, the President of the High Court bridged the gap with Practice Direction HC 120 and 121.

Pursuant to Part 6 of the ADMCA, all 2,200 current adult wards must be discharged from wardship within three years of commencement (i.e., 26th April 2023). It is understood that the uptake has been slow and that only around 27 applications for discharge have been issued.

The ADMCA was originally intended to come into force alongside a statutory regime regulating deprivation of liberty. Work is underway to prepare the heads of bill of "Protection of Liberty Safeguards Bill"[21], the purpose of which is to provide legislative clarity on the issue of deprivation of liberty safeguards.[22] The High Court's jurisdiction with regard to deprivation of liberty orders was considered recently in the decision *In the matter of KK* [2023] IEHC 306, which will be discussed in greater detail in the next issue.

Part 10 of the ADMCA requires the review of detention orders made by the wardship court prior to commencement. Practice Direction HC 121, which came into effect on the 11th day of May 2023, outlines the process.

One notable feature of the Rules is that the participation of the relevant person is a common theme. This can be observed in the sections concerning 'Service of Application', 'Remote participation in hearings' and within the affidavit of service. The Rules provide that the relevant person must be served personally with the application, the summons server must explain the nature and implications of the application, explain that the person is encouraged to

[18] Law Society Practice Note dated 22nd May 2023
[19] Law Society Statement dated 22nd June 2023
[20] Further information about the Nursing Home Support Scheme
[21] Government Legislation Programme Spring Session 2023
[22] For further context see *The Deprivation of Liberty Safeguard Proposals: Report on the Public Consultation*)

participate in the hearing, during which his or her participation will be facilitated, and the Court must be made aware of any special arrangements required to facilitate the relevant person's participation in the hearing. Additionally, the relevant person will be facilitated in attending the hearing remotely.

Another central theme is the expeditious use of court time and the minimisation of costs. This appears in the amending sections of the rules concerning; hearing of applications under Part 6, Reviews under ss. 107 and 108, and proceedings for the care, treatment or detention of persons who lack capacity. It is important in respect of costs to have regard to a recent decision from the Court of Appeal, *Re TH* [2023] IECA 35, which gave practitioners firm guidance with respect to the handling or management of cases relating to matters of wardship, and particularly where the issues of costs and its potential impact upon the estate of the ward are to be considered.

Regulations

Since April, several statutory instruments have been made to implement various sections of the main act. These regulations include S.I. No. 202/2023 which outlines the applicable fees and instances where these fees may be waived; S.I. No. 203 of 2023 which specifies the payment of expenses and remuneration to decision-making representatives; S.I. No. 204 of 2023 which details the types of healthcare professionals recognised by the Act and the requirements for their respective registries; S.I. No. 205 of 2023 which focuses on the formalities of decision-making agreements; and S.I. No. 206 of 2023 which concerns the inspection of registers and receipt of documents for services provided by various professionals under the main Act.

There is also a provision in the Act authorising the Director to make specifications, with the consent of the Minister. However, as of writing, these specifications have yet to be published.

SCOTLAND

2,612 at AWI Masterclass

The Mental Welfare Commission for Scotland, and NHS Education for Scotland, working jointly identified an unexpectedly large need for training in the basic requirements of the Adults with Incapacity (Scotland) Act 2000, in the context of the current human rights landscape. They organised a "Masterclass" on 23rd February 2023, which I conducted. A video recording of the event, with associated papers, is now available via the Turas Once for Scotland: Adults with Incapacity page. If you need to register for a Turas account, you can do so here.

To the surprise of all concerned, the event attracted a registered attendance of 2,612, of whom the great majority were directly involved in "frontline" provision of social care (approximately two thirds of the total) or healthcare (approximately one third of the total). The total attendance is understood to be unprecedented. The size of the attendance, and the nature of the 54 questions entered in the chatbox during the event, appear together to have demonstrated two things. The first is the huge, and apparently unmet, demand, mostly by frontline practitioners, for basic information about the 2000 Act and its application. The second is the very limited, and at times not entirely accurate, knowledge which such staff already have. Those factors, and positive responses received to the Masterclass, have prompted Mental Welfare Commission and NHS Education for Scotland to arrange a follow-up event ("Masterclass 2") which has been scheduled for Thursday 24th August 2023. The "flyer" for that event is available here.

Adrian D Ward

ELI project on advance choices

We have previously reported that following upon issue of the final report of a Law Society of Scotland project on advance choices, and medical decision-making in intensive care situations, there has been considerable international interest in the topic of advance choices, and European Law Institute established a project to draft model laws for use across Europe on advance choices, with relevant supporting materials. The project commenced on 1st January 2023 and is scheduled to run for 30 months, including publication and initial dissemination of a final report. ELI's normal procedure is to hold a "kick-off webinar". For the advance choices project, the kick-off webinar took place online on 15th May 2023. A video recording of the event is now available and can be accessed here.

Adrian D Ward

Scottish Government Response to the Scottish Mental Health Law Review (1)

The Scottish Government published its response to the Scottish Mental Health Law Review (Scott Review) recommendations on 28th June 2023. This broadly supports the Scott Review recommendations, endorsing their human rights-based approach, and commits to a wide-ranging mental health and capacity reform programme with the high-level priorities of:

- Adults with Incapacity law reform
- Supported Decision-Making
- Mental Health law reform
- Human Rights Enablement
- Enhancing carers' rights and role
- Reducing coercion across the system

- Strengthening accountability, and scrutiny in the mental health system

It also provides some general initial timescales for delivery under these seven priorities grouped under 2023-26, 2026-29 and 2029+.

As the response states this is a high-level response to the Scott Review recommendations the reform programme will take place alongside other reforms such as the proposed creation of a National Care Service, incorporation of international human rights treaties into devolved law in Scotland and Learning Disability, Autism and Neurodiversity legislation, and also the Scottish Government's Mental Health and Wellbeing Strategy (which does not appear to have a timespan) which was published on 29th June. The precise detail and how closely the reform programme follows and gives effect to the Scott Review recommendations will thus become clearer over time. It is, however, imperative that reform momentum is not lost.

Jill Stavert

Scottish Government Response to the Scottish Mental Health Law Review (2)

Alex would also observe that the summary of the 'listening exercises' conducted by the Scottish Government and recorded in the response provides an interesting snapshot of areas of consensus / disagreement in this area, of interest both in Scotland, but also more broadly:

> *To shape this high-level response to the SMHLR, we met with a range of stakeholders, including those representing lived and learned experience of the system. These meetings were designed to hear views on the final report, its recommendations and identify priorities for change. We also attended wider stakeholder meetings and network events to hear people's views about the SMHLR final report.*
>
> *In general, we heard strong support for the ambition and overall direction of travel set out by the SMHLR and a desire to see progress towards this, together with meaningful lived experience involvement. Stakeholders noted a particular need for AWI and guardianship reform. This was almost universally identified as the priority for legislative reform, and for embedding of human rights-based approaches. There was also recognition of the need to strengthen accountability across the system with concerns about the perceived fragmentation of the current approach to regulation and scrutiny of services. There was also agreement on the importance of supporting carers' role and rights, including the potential for families, friends and wider support networks to enhance our approach to early intervention and prevention and to whilst balancing with the rights of the individual and their autonomy. In addition to these points, a broader range of views were also expressed on some of the more specific technical and policy reforms proposed in the final report.*
>
> *A number of people with experience of caring for or supporting people with dementia and other similar conditions and human rights organisations, highlighted concerns about the way that the Adults with Incapacity Act currently operates. The absence of a Deprivation of Liberty framework within Scots law was highlighted as a particular concern, with many stakeholders wanting action to progress recommendations in these areas as a priority.*
>
> *People with a learning disability, autistic people and many organisations who advocate for or on behalf of them, raised concerns that the SMHLR recommendations would mean that people with a learning disability or*

autistic people could still be subject to detention and non-consensual care and treatment under reformed mental health law. This is because the Review recommends their continued inclusion within the group of people who the Mental Health Act would apply to. There was strong support amongst these groups for the removal of learning disability and autism from any definition that replaces 'mental disorder' as part of any future reform to ensure that they are no longer within the scope of the Mental Health Act.

We recognise these concerns and note that the SMHLR has taken a different approach on this issue from that of the Rome Review which preceded it. As a result, there was a strong desire for the recommendations of the Rome Review to be considered alongside the SMHLR recommendations and for Scottish Government to work with people with lived as well as learned experience of the system.

In contrast, others supported the SMHLR recommendations to change the purpose and scope of the law and they supported the proposed new approach to human rights. They felt this would create a more effective human rights basis for our legislation, in line with the UNCRPD. It was also unclear what the implications of alternative options would be or what legislative framework people with a learning disability or autistic people who require care and support would prefer or find most effective for upholding their rights in the future.

Some of those with lived experience felt that the SMHLR did not go far enough in recommending the end to all forms of non-consensual or compulsory care and treatment. They felt that this was not in line with human rights standards. In contrast, others with lived experience felt that there are times where non-consensual care and treatment can be necessary and that the recommendations would help to strengthen safeguards, whilst retaining provisions to provide non-consensual care and treatment where this was deemed to be necessary or beneficial for the safety of themselves or others.

There were also questions about the level of investment required to fully deliver on the ambition set out in the Review, at a time when resources are constrained.

Concerns were additionally raised about the implications of the recommendations for the diverse workforces who deliver our mental health and social care support and services. It was recognised that many of the proposed changes would place additional pressure or demands on their capacity or require further training, support, and skills development to deliver effectively. People were particularly concerned about how this would be achieved in practice and what the resource implications would be.

We also heard concerns about introducing significant further change at a time when there is already wider transformation underway across our health and social care systems. It was felt that some of the proposals and a focus on further reform at this time could increase pressure on service delivery. Stakeholders were also keen to understand how the Review recommendations would fit within developments across the wider health and social care landscape, some of which have been noted earlier, and sought assurance that appropriate links will be made across government to ensure coherent and well-managed change.

Equally, stakeholders recognised that a long-term programme of reform will be needed, and that legislative reform will necessarily take time. There was support for a staged approach, working in partnership. There were also concerns about the potential for unnecessary delay in some areas and calls to make progress in the shorter term on areas of reform that have broad stakeholder support and do not require substantial change to the law.

We will build on this early engagement and continue to work with stakeholders to scope and agree a way forward. What is clear is that there are areas where change and reform is more pressing, coupled with a strong consensus to see early progress made. While other areas need further work and detailed consideration before reaching a decision about whether, or how, to proceed.

Alex Ruck Keene

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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.

Alex is leading a masterclass on approaching complex capacity assessment with Dr Gareth Owen in London on 1 November 2023 as part of the Maudsley Learning programme of events. For more details, and to book (with an early bird price available until 31 July 2023), 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 September. 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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