

Welcome to the April 2024 Mental Capacity Report. Highlights this month include:

- (1) In the Health, Welfare and Deprivation of Liberty Report: a very difficult dilemma arising out of covert medication, and key deprivation of liberty developments;
- (2) In the Property and Affairs Report: fixed costs for deputies, deputies and conflicts of interest, and the Child Trust Fund saga continues;
- (3) In the Practice and Procedure Report: three amended Practice Directions, when (and why) should the judge visit P and fact-finding in the Court of Protection;
- (4) In the Mental Health Matters Report: the Government (rather surprisingly) responds to the Joint Committee on the draft Mental Health Bill, and important reports from the PHSO and CQC;
- (5) In the Wider Context Report: a snapshot into litigation capacity and Jersey sheds light on the concrete realities of assisted dying / suicide;
- (6) In the Scotland Report: the Assisted Dying for Terminally Ill Adults (Scotland) Bill.

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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This 5-year long case concerned a 25-year-old woman ('A') who was being covertly medicated in a care home whose mother sought her return to which all other parties were opposed. The previous judgments were reported at [\[2019\] EWCOP 68](#); [\[2020\] EWCOP 76](#); [\[2022\] EWCOP 44](#). By way of reminder, in a previous closed hearing, it was decided to be in her best interests to be administered hormone replacement treatment ('HRT') covertly. Two years later Poole J decided her mother should be informed and for contact between them to be reintroduced. In September 2022 it was decided that a plan should be prepared to transition to open medication.

A was told that she has gone through puberty and she steadfastly refused to take the medication voluntarily. The issues at this hearing were whether it was in her best interests to return to her mother's, in respect of which the issue of covert medication was inextricably linked. Poole J noted that:

24. ... the assessment of best interest involves consideration of very different concepts such as medical risks and benefits, human rights, wishes and feelings, autonomy, and relationships. Those disparate matters have to be taken into account but a balance sheet exercise may not be particularly helpful.

Covert HRT had produced a significant medical benefit for A by ensuring she went through puberty, protected her against the loss of bone density and the very significantly increased risk of cardi-vascular disease. However, Poole J was troubled by the fact that the plan for covert medication had no end date in sight; she was not severely cognitively impaired; its purpose – to induce puberty – had happened; and if HRT ceased, she would likely experience menopausal symptoms.

Poole J was concerned about the impact on A's health and welfare if she made the discovery and that, if her mother lost hope of her return home, she may tell her. Poole J doubted it was sustainable for years ahead. The mother's proposal to covertly medicate her at home until she persuaded her daughter to take HRT voluntarily was unrealistic as her actions did not match her words. There was a high risk she would find out if she moved to her mother's. However, the provision of covert medication required her to be deprived of her liberty, to live away from home, and for her contact with her mother to be regulated.

Dr X, who acted both as A's treating clinician and as the expert reporting to the court, gave evidence to the effect that A should be covertly medicated for the rest of her life and it was unlikely she would do so voluntarily. Nothing attempted so far to move to open medication had been successful and no transition plan had been prepared. To do so would require (a) honesty about her having been covertly medicated and (b) the input of her mother to whom she was more likely to listen.

Poole J carefully analysed the benefits and burdens of returning to her mother's against her continued stay. On balance, and contrary to the position advanced by the local authority, the Trust and the Official Solicitor, his Lordship decided it was in her best interests (i) to return home to her mother's care; (ii) for covert medication to cease; (iii) for her to be informed that she has been covertly administered HRT and that it has been of benefit to her health and stopping it would be harmful to her health; (iv) to allow her mother to try to persuade her to take HRT voluntarily; and (v) for support to be provided to her in the community whilst she is living at home. Poole J held:

84. The assessment of best interests in this case is complex. Whatever decision

is made, or if no decision is made, there will be both positive and negative consequences for A. I acknowledge the risk that my determination of A's best interests will result in her returning home to an unhealthy relationship and will expose her to the harmful consequences of ceasing HRT. However, those risks are outweighed by the benefits of ending the deprivation of A's liberty and the serious interference with her Art 8 rights, and of avoiding the risk of an unmanaged disclosure to her of the covert administration of HRT. The Court is enjoined to seek to achieve purposes "in a way that is less restrictive of the person's rights and freedom of action" (MCA 2005 s1(6)). Here, severe restrictions have been imposed in order to achieve the benefit of medical treatment. Now, the continuing and remaining benefits of treatment are not sufficient to justify the continued restrictions.

Accordingly, he directed, a plan should be prepared for her return home and for the release of information to be carried out in stages (paragraph 85).

Comment

The covert medication stakes were particularly high in this case and could not be siloed from residence. Rather than adopting a balance sheet exercise, the court's analysis very much focused on the issues of necessity and proportionality. Given the risks and benefits of the two options, was her continued detention and separation from her mother's care still necessary and proportionate to the health benefits of HRT? With the primary goal of the treatment having been realised - with A having gone through puberty - the balance had shifted and honesty was now the best policy.

Poole J's observations about the dual role of Dr X are also of note. Dr X himself had said in

evidence before Poole J that this was not a satisfactory combination of roles, and Poole J agreed that this should be avoided (paragraph 7). That is not the same as saying that clinicians cannot give evidence based upon their expertise. As Hayden J noted in *London Borough of Southwark v NP & Ors* [2019] EWCOP 48

*vi. In Court of Protection proceedings, the Court will frequently be asked to take evidence from treating clinicians. Invariably, (again especially at Tier 3) these will be individuals of experience and expertise who in other cases might easily find themselves instructed independently as experts. Treating clinicians have precisely the same obligations and duties upon them, when preparing reports and giving evidence as those independently instructed. Further, it is the obligation of the lawyers to ensure that these witnesses are furnished with all relevant material which is likely to have an impact on their views, conclusions and recommendations. (see: *Re C Interim Judgment: Expert Evidence*) [2018] EWFC B9). This should not merely be regarded as good litigation practice but as indivisible from the effective protection of P's welfare and autonomy.*

Exercising legal capacity and termination: a creative approach by the Court of Protection

Rotherham and Doncaster and South Humber NHS Foundation Trust v NR & Anor [2024] EWCOP 17 (Hayden J)

Best interests – medical treatment

Summary¹

This very difficult case concerned a pregnant woman, detained under the Mental Health Act 1983, who was ambivalent about carrying her baby to term. She had an extensive history of drug and alcohol abuse. This was her fifth pregnancy. She had two daughters, H and L (now in their teens), both of whom were removed from her care. H was 10 years of age when removed and L, 9 years. The children's social care records reveal that NR experienced difficulties with her mental health during the pregnancy with H. When NR was approximately four months pregnant with H, she attended the hospital on what was described as "multiple occasions", reporting self-harm. Following the birth of her second daughter, she was identified as suffering from post-natal depression. NR was, in this period, living with the father of the children, BG, who was a violent man who subjected her to repeated domestic violence. At the time, the judgment records, she was unable to understand or confront the effect of this violence on either her or the children. BG has had no contact with the children for several years. NR had experienced a miscarriage in the past and a termination of pregnancy prior to the birth of her daughters when she was 15 years of age.

As regards her capacity, the evidence of her responsible clinician, Dr A,² and its implications was recorded at paragraph 12 thus:

On 23rd February 2024, Dr A met with NR in her room, which I note was at her request, supported by a staff nurse with whom she felt comfortable. The discussion revolved around "termination of pregnancy" in its broadest and non-specific sense. NR understood what the word involved but she declined to hear anything as to what the procedure

would entail at this stage for her. When I say declined to hear anything, I should emphasise that she was completely adamant that she did not want to know anything about what would actually be involved. She has, by and large, stuck to this view throughout these enquiries. This poses rather a challenge in assessing her capacity. As I have set out above, an understanding of what the termination procedures is a significant facet of evaluating P's understanding. Of course, it is not axiomatic that a refusal to think about something infers an inability to do so. However, Dr A told me that it is the agitation caused by her mental health condition that prevents her from engaging in a consideration of what is involved in the termination. He told me that she was, in effect, "unable" and "incapable of" participating. It is this that renders her incapacitous. No party disputes this conclusion and I have accepted the analysis as rebutting the presumption of capacity erected by the MCA 2005.

The much more difficult question was at best interests, given the consistently inconsistent statements that NR was making as regards her pregnancy. Having reviewed the evidence at some length, Hayden J identified at paragraph 37 that:

NR finds herself on the horns of the most invidious dilemma. She clearly, and most probably correctly, apprehends that if she carries the baby full term, it will be removed from her at, or shortly after birth. This may even be her wish, though she plainly anticipates the possibility of being ambushed her own emotions. Many of the notes set out above reflect NR, at very least contemplating these possibilities. Equally, she plainly contemplates a

¹ Katie having been involved in the case, she has not contributed to the note.

² Note, no independent expert appears to have been instructed in this case to report upon capacity.

termination, even though that may not sit easily with her prevailing beliefs. Ultimately, I do not, as I have said, find that the evidence in this case supports a determined view either to terminate or to continue with the pregnancy. The evidence, in my judgement, reflects a woman who is paralysed by conflict, which is pervasive. I accept Dr A's opinion that her unwillingness to confront the practical realities of the termination is also a facet of her mental ill health. However, NR certainly confronts the ethical and emotional aspects of both the termination and a continued pregnancy. Even if they are to be regarded as distorted by her condition, they are real for her and require to be afforded both weight and respect. I emphasise that I am entirely satisfied that it would be wrong and unsafe to draw a concluding view as to what NR's wishes and feelings truly are.

Hayden J therefore had to look more widely to determine where NR's best interests lay, and read into the judgment the detailed plan for the termination procedure should it go ahead. He then zeroed in on the discussions that the Official Solicitor's representative, Ms Crow, had had with her, and in particular this passage from one of her attendance notes:

I explained to [NR] that my role is to make sure that the Judge knows what she would like to happen and so I wanted to be sure I had that right. I summarised that she had said that she didn't want to have the baby and that she would like a "caesarean" to terminate the pregnancy, and that she would like this to be done under a general anaesthetic. [NR] said that was right. She said that she was getting hot and so she moved seats and removed her fleece top; she had another jumper on underneath. [NR] said "you can't really tell [I am pregnant], can you?". I confirmed that if I didn't know then I

wouldn't necessarily be able to tell. [NR] said "I don't really like people to see it [her bump]. I think it is a boy, I saw the scan and thought that. It is not like I don't want it, but I just don't think I would be able to cope". I told [NR] that I thought she was being very brave and she said "I don't want it, it will make me more ill and my family don't want me to have it. I need to make the right decision for me for once".

Hayden J considered that NR's conclusion that she needed to make the right decision for her "captures where her best interests lie, i.e. that this decision should be NR's" (paragraph 47). He also agreed that this case was similar to that of *Avon and Wiltshire Mental Health Partnership v WA & Anor* [2020] EWCOP 37 where, although he had similarly found the person to lack capacity on the central issue, he had nonetheless left the decisions to him, because he had considered that the priority was to recognise and enable him to assert his own autonomy. He considered that this was precisely what he wished to achieve with NR:

50. What is required is that the Court, having considered best interests, makes a declaration as to lawfulness. The care plan which has been dynamic and has evolved during this hearing now emphasises the importance of helping NR to reach a decision by giving her clear and tangible options but emphasising that the decisions are hers. The amended plan sets out its overall aim in the introductory paragraphs in these terms:

"Prior to the commencement of this plan (preferably in the days before), staff at [the Yorkshire hospital] will take [NR] through the stages involved in the plan, explaining to her what is involved at each stage, that it is [NR]'s choice whether to go

through each and every stage and that she can stop the process at any stage until the termination has reached an irrevocable stage..."

51. *The centrality of NR's autonomy is emphasised throughout the plan, and I am entirely satisfied, is recognised by all involved:*

[NR] will not be compelled to undertake the termination or to undertake any of the stages in the plan. The staff shall use their clinical judgment (including verbal encouragement and discussion) to support [NR] to make her choice whether to go through each stage in the plan. No coercion or force will be used".

52. *The initial application for a declaration was that I should state that it is lawful and in NR's best interests to have a termination. I expressly decline to make that declaration. I do, however, approve the proposed care plan and confirm the lawfulness of it. Thus, I make a declaration that the care plan, setting out the arrangements for a termination of NR's pregnancy is lawful. I go no further. So far, the options presented to NR have been uncoupled from the practical realities. There is now a finely structured plan where a decision, one way or the other, is unavoidable. It is important that NR knows that I am respecting her rights as an autonomous adult woman to make this decision for herself, with the help of those she chooses to be advised by. I should also like Ms Crow to explain to NR that whatever decision she takes, will have my fulsome support. As I discussed during the course of the hearing, a copy*

of this judgment is to be made available to all the key professionals involved in the plan in order that they know the reasoning behind the conclusions I have reached and what the objective of the plan is.

Comment

On the face of it, it might seem somewhat odd for the court at the same time to conclude that the person lacks capacity to make the decision in question, but that it is in their best interests for them to decide what should happen (or perhaps, to be more precise, for their choice to be respected as determinative³). It might also seem somewhat odd for the court to decline, expressly, to make any best interests decision, given that a key part of its statutory *raison d'être* is to make such decisions on behalf of individuals unable to do so. It might, finally, be thought somewhat odd on the facts of the case that NR was, in fact, unable to make a decision about whether to undergo a termination given the passage of the attendance note of the meeting with Ms Crow that Hayden J placed such weight upon.

However, taking a step back, it might equally be said that this case represented a truly CRPD compliant approach to supporting the exercise of legal capacity by NR and, ironically, but importantly, did so by focusing not on NR herself, but rather on those who would need to act upon her wishes and, in effect, telling them that they would be legally determinative.

Short note: "Two Ps" – a worked example

Not enough judgments of District Judges are published. This is in part because very many decisions that they make are set out in oral

³ Given that the MCA 2005 refers expressly to a person's mental capacity to make the decision in question, by definition a view expressed where it has been held that

they do not have that capacity cannot, legally, be a 'decision' in the sense of an act with an automatically determinative legal effect.

judgments, rather than in reserved judgments (i.e. those handed down after the hearing, and written up after the hearing by the judge). It is also in part because of the extraordinary pressures of time on such District Judges. However, the end result is that the body of case-law does not capture many of the realities of the decisions that are taken up and down England & Wales by the judges who hear the vast majority of cases before the Court of Protection.⁴ It is therefore all the more interesting to see the judgment of District Judge Simpson in *Re MA & AA (Re Section 21A of the Mental Capacity Act 2005)* [2023] EWCOP 65, which recently appeared on Bailii. As a decision of a District Judge, it can have no precedent value, but is a very thorough 'worked example' of the 'two P' scenario addressed in *HH v Hywel Dda University Health Board & Ors* [2023] EWCOP 18, where Francis J set out how the Court should proceed. After confirming that proceedings should be consolidated, and that the same judge should hear both sets of proceedings, Francis J had held (at paragraph 43) that:

I accept that this may lead the judge, and if that is me, it may lead me, to making a finding that each of them has different needs and different best interests, and so their best interests may conflict. Surely the appropriate thing then that we need to do is to balance these interests, to consider the conflict and to make a proper determination in a holistic manner having regard to the needs of each of them and the best interests of each of them.

The two – conjoined – decisions are sufficiently complex that they cannot easily be reduced to a summary but they do show the workings out of a very difficult situation where it was not possible

⁴ For more on this, see this [article](#). The Open Justice Court of Protection website contains many blogs of hearings before such judges which give invaluable

(on the face of the evidence) to meet the care needs of the two spouses with dementia in the same place, one spouse no longer seemed to recognise the other, and video calls between the two seemed to cause nothing but pain to the spouse whose dementia was less advanced.

Lieven J puts the (Cheshire West) cat amongst the pigeons

Peterborough City Council v Mother (Re SM) [2024] EWHC 493 (Fam) (Family Division (Lieven J))

Article 5 – deprivation of liberty – children and young persons

Summary

Lieven J is proving herself the spiritual successor to Mostyn J as regards challenging *Cheshire West*. Readers with long-ish memories will recall that Mostyn J took on the Supreme Court decision in full-frontal fashion in *Rochdale MBC v KW* [2014] EWCOP 45, concerning a woman who was 'barely ambulant,' and was thought soon not to have the motor skills to walk even with her frame. At that point, Mostyn J observed (at paragraph 22):

If she becomes house-bound or bed-ridden it must follow that her deprivation of liberty just dissolves. It is often said that one stress-tests a proposition with some more extreme facts. Imagine a man in hospital in a coma. Imagine that such a man has no relations demanding to take him away. Literally, he is not "free to leave". Literally, he is under continuous supervision. Is he in a situation of deprivation of liberty? Surely not. So if Katherine cannot realistically leave in the sense described above then

insights into these cases, but there is a difference between a report of such a hearing and the public record of a judgment.

it must follow that the second part of the acid test is not satisfied.

And then, at paragraph 25:

She is not in any realistic way being constrained from exercising the freedom to leave, in the required sense, for the essential reason that she does not have the physical or mental ability to exercise that freedom.

He observed that the definition of deprivation of liberty in *Cheshire West* should be reconsidered by the Supreme Court, and sought unsuccessfully to bring about a leapfrog appeal. An appeal against his decision was allowed by consent; Mostyn J then sought to reconsider the question, and, on a further appeal, was firmly told off (to use a legal term) by the Court of Appeal, who made it clear that in endorsing the consent order they were necessarily deciding that KW was deprived of her liberty and that his legal analysis was of no legal effect (see [here](#) at paragraphs 18 and 31 respectively).

Now, 10 years later, and just in advance of the 10 year anniversary of *Cheshire West*, Lieven J has taken another run at a situation involving a person with profound cognitive and physical impairments. SM was a 12 year old girl with profound and enduring disabilities, who was non-mobile and non-verbal, and whose situation was described at paragraph 4 of the judgment thus:

In practical terms SM cannot leave her bed of her own volition, and according to her Mother does not like sitting up. Her only body control is to be able to push her hands away and to wriggle and roll from side to side. She is moved by her carers from the bed to the floor, which according to her Mother she enjoys. She cannot communicate in any form and does not understand language. It is difficult to assess her cognitive functioning, but her Mother described

her responding like a child of a few months. She does respond to stimuli, and for those who know her well it is possible to tell whether she is responding positively or negatively. All her care needs are met by carers.

Having been made subject to a final care order, SM lived with foster carers who provided her with a high quality of care. The local authority applied for an order authorising the deprivation of liberty to which they said she was subject in consequence of the following restrictions:

a. SM is supervised 1:1 in the home at all times either by a physically present person or by remote live only video feed;

b. SM is moved by her carers as appears reasonable or necessary to meet her welfare needs;

c. SM's feeding and administration of medicine is managed by her carers through her gastrojejeunal button as appears reasonable or necessary to meet her welfare needs;

d. SM is dressed and undressed, washed and her needs arising from her incontinence are managed as appears reasonable or necessary to meet her welfare needs;

e. SM's bed has bars on the side to prevent her moving while in bed so as to fall and injure herself;

f. SM is supported outside of the home at all times, with up to 2:1 supervision to ensure her safety and ability to mobilise as appears reasonable or necessary to meet her welfare needs;

g. External doors to the property are kept locked for the purpose of ensuring the integrity and security of SM's home.

The case was referred to Lieven J by a circuit judge concerned as to whether was an appropriate case for such an order. SM's Guardian opposed the making of the order on the basis that it was not necessary.

Lieven J started her analysis at paragraph 8 by observing that:

Quite apart from the overarching issue as to whether SM should be subject to a DoLs order at all, there are a number of aspects of the above restrictions which do not amount to a deprivation of liberty. In my view (a), (b), (c), (d) and (e) are on any analysis part of her care provision, and not actions which deprive her of her liberty. This would be the case whether or not SM was severely disabled. It is important that the "mission creep" that seems to have set into the DoLs applications to the High Court. There are many aspects of care which may intrude on an individual's privacy and autonomy, and which may interfere, albeit with justification, into the scope of Article 8. But they are not interferences with the right to liberty enshrined in Article [5].⁵

She also noted at paragraph 10 that such orders had:

*become a depressingly common matter in the Family Division of the Family Court. Over the period of 12 months something in the region of 1700 such orders have been made. The exponential growth in these orders has been referred to in numerous cases in the High Court, Court of Appeal and Supreme Court, see *Re T (A Child)* [2021] UKSC 2136. The enormous expansion of this area of law can be traced to two factors. Firstly, the caselaw, in particular the judgment of the Supreme Court in *Cheshire West v P* [2014] AC 896; and secondly the*

*severe shortage of places in secure accommodation units, see *Re T*. The present case does not concern the problem of the shortage of places. It is a product of the decision in *Cheshire West* and the approach that has been taken to potential prospective breaches of Article 5 European Convention on Human Rights ("ECHR").*

Lieven J then turned to *Cheshire West* itself, observing that

*24. The ratio of *Cheshire West* [i.e. what the Supreme Court decided as a matter of law] is therefore that for there to be a deprivation of liberty the individual must be under constant supervision and control, and not be free to leave. The test that Lord Kerr sets out at [78] that the child should be compared to someone of the same age is not a separate test adopted by the majority of the Supreme Court. The dissenting judgments (Lord Carnwath and Lord Hodge, and Lord Clarke in a separate judgment) largely focused on the need to consider the "concrete situation" and the fact that the individuals had no wish to leave and were living in a "domestic setting", see [98].*

25. It is not straightforward, certainly in the more complex cases, to apply Lord Kerr's approach in a meaningful manner. Firstly, assuming that one should compare SM with someone of "her age and station" is a difficult exercise with a child. There is no paradigm 12 year old who can be assumed to have a particular level of maturity, and therefore subject to a particular level of restraint and control. Secondly, and more fundamentally, it is a wholly unreal exercise to compare SM with another 12 year old. To the degree that such comparisons are useful, she functions

⁵ The judgment says Article 8, but from context clearly means Article 5.

cognitively in a way comparable to a baby of a few months in age and therefore, on the facts, that would be a much more useful comparator. Lord Kerr was simply not addressing the type of facts, and thus the legal issue, that therefore arises in this case.

Lieven J considered that the local authority's application took the principles set out in *Cheshire West*:

31. [...] to a logical but extreme conclusion that, in my view, defies common sense and is not required by the terms of the Supreme Court decision. It is important to note that Cheshire West was concerned with the three individuals' inability to consent to the deprivation of their liberty, and their apparent compliance with the restraints placed upon them. They were all physically capable of leaving the property, and would have been stopped if they had tried to do so. That is not the facts of the present case.

At paragraph 33, Lieven J identified that she considered that it was "axiomatic that [the three individuals] were not free to leave because of some action (or inaction) of the State," and that the Supreme Court's decision did not "deal with the situation of a child such as SM who is incapable of 'leaving' because of a combination of her physical and mental disabilities, not by reason of any restraints placed upon her." She identified that both Counsel in the case had not found any case either in the UK courts or in Strasbourg where a court had not found any case, whether in Strasbourg or the UK Courts, where a court had found a deprivation of liberty in circumstances similar or analogous to those of SM.

Lieven J considered that there were a number of different ways of explaining why SM was not deprived of her liberty, but that they:

35. [...] all come down to focusing on the reason why she cannot leave where she is living. That reason is her profound disabilities, not any action of the State, whether by restraining her or by failing to meet the State's positive obligations to enable her to leave.

Lieven J considered that:

36 Fundamental to a breach of Article 5 is a deprivation of liberty attributable to the State, whether by negative or positive action. Often this will involve putting in place restrictions, such as locked doors or windows; or physically restraining the individual. However, the action to prevent someone leaving could be purely verbal or indeed psychological, which often will involve "close supervision and control". In Cheshire West the facts suggest that there was little physical restraint, but the nature of the supervision was such that the individuals knew they were not allowed to leave and would be prevented if they tried to do so. So simply telling someone that they are not allowed to leave, may be sufficient to amount to a deprivation of liberty.

In response to the emphasis placed by the local authority on the extent to which SM was under supervision and control, Lieven J noted that this was to confuse two things:

37. SM is undoubtedly under close supervision and control, but that is not in order to prevent her leaving. The close supervision is to meet her care needs. It does not need to be, and is not, for the purpose of preventing her leaving, because she is wholly incapable of leaving, both because of physical inability but also because she is unable to form any desire or intent to leave. It is simply not a concept of which she has any consciousness.

Lieven J then emphasised that:

38. On a conceptual level it is difficult to see how one can be deprived of something that one is incapable of doing. Equally, how can one be deprived of a right that one is incapable of exercising, not through the actions of the State or any third party, but by reason of ones own insuperable inabilities.

39. In Cheshire West the Supreme Court, particularly in the speeches of Lady Hale and Lord Kerr, were concerned to protect and facilitate the rights of disabled people. There will be many instances where a disabled person cannot do something through their own volition, by reason of their disability, but could do it with appropriate support. An obvious example is a disabled person who cannot move without a wheelchair, and therefore cannot leave the property without assistance. It is easy to see that that person may be deprived of their liberty because they are not free to leave, even though they need third party help in order to leave. In that situation the State may be under an obligation to assist the person in leaving, and failing to do so might amount to a breach of Article 5. Equally, there will be people with mental disabilities, who may not assert their right to liberty, but are restrained by being told that they are not allowed to leave. Those are the type of situations which were in contemplation in Cheshire West.

Lieven considered that this was a wholly different situation to that of SM, because she was both physically incapable of exercising her right to liberty, and mentally incapable of asserting it. Returning to Lord Kerr's focus on the comparison with a child of the same age and station, she identified that it was not quite clear what he meant by this, but that neither Lady Hale

nor Lord Neuberger adopted the argument that the comparison must simply be a child of the same age and station, such that "*the binding ratio of the case is the test of close supervision and not being free to leave, rather than necessarily comparing SM with a non-disabled 12 year old.*" That having been said, "*in many, indeed most cases, such a comparison will be very useful, and the approach has been applied in many subsequent cases as an appropriate exercise, never so far I am aware on facts similar to SM's*" (paragraph 40). Lieven J was clear that:

41. As I have said, the approach of comparing SM with a non-disabled 12 year old, as an "objective" analysis, is a wholly unreal exercise, and one that leads to a nonsensical result. Ms Scarborough submitted that not finding SM was deprived of her liberty would involve discriminating against her as a disabled person. To some degree this was the concern of the majority in Cheshire West. The Court emphasised the universal quality of the rights granted by the ECHR, see [36]. This was not however a legal argument of unlawful discrimination under Article 14, as opposed to a general concern to protect the rights and interests of disabled people.

Aware, perhaps, that her approach could be seen as potentially discriminating against those who are physically and mentally incapable of exercising their right to liberty, Lieven J tackled Article 14 ECHR head on, noting that "[i]n order for there to be a breach of Article 14 it is necessary for there to be different treatment between people in a relevantly similar situation for the purposes of the decision or matter in question" (paragraph 42) and that

The able bodied 12 year old is plainly not an appropriate comparator because there is a material difference between them and SM as regards the matter in

question, here the constant control and supervision. There may be good reason to apply a strict approach to Article 5 in respect of disabled people given the fundamental importance of protecting liberty. However, a discrimination argument does not, certainly on the facts of SM's case, progress the analysis.

Before refusing the application for a DoL order, Lieven J concluded by observing that:

The need to ensure the universal applicability of Convention rights is central to the analysis in Cheshire West, and how the term "deprivation of liberty" is defined. However, that does not mean that where the facts show overwhelmingly that the State is not depriving someone of their liberty the universal quality of the right force the Court to a conclusion that defies the facts and commonsense.

Comment

It is undoubtedly true that it is depressing how many applications are being made for authorisation of deprivation of liberty in relation to children, it is important to note, as did Lieven J, that many of these applications are being made because of the crisis in service provision. That crisis does not just relate to the provision of secure accommodation. As the work of the [Nuffield Family Justice Observatory](#) shows, it is also relates to the crisis in both social and health care provision for children with complex needs, with situations escalating in consequence.

SM's case, however, is very different to the cases covered by the Observatory's report, and indeed, we anticipate, to the vast majority of those cases involving children being put forward for

⁶ Although the reality is that cases such as SM's case are likely to be so far down the priority / triage list for local authorities working with children with complex

authorisation, and it is easy to see why the case was referred to Lieven J to determine whether an order authorising deprivation of liberty was required in her case. Her conclusion that one was not required is likely to have considerable resonance with many people – and not, we hasten to add, just because of the potential for reducing the number of deprivation of liberty applications which might need to be made.⁶ It is also entirely easy to see that Strasbourg might find SM not to be deprived of her liberty, even if perhaps less easy to work out the principled basis upon which it might do so, given that the only case in which it has previously considered the position of children (*Nielsen*) is one whose logic is somewhat difficult to disentangle.

Because of the way in which she approached the question before her, Lieven J's judgment perhaps represents the most serious (albeit first instance) challenge to *Cheshire West* in the 10 years since it was handed down, more serious, even than the challenges launched by Mostyn J in *Rochdale* case noted above, and also *Bournemouth Borough Council v PS* [2015] EWCOP 39, because engages with the judgment in a more sustained and detailed fashion. Whilst it relates to a child, and on its face can only apply to a child given its focus on the 'comparator' approach of Lord Kerr, an approach that does not apply to those over 18, its underpinning logic is not so limited as Lieven J's analysis was founded upon a conceptual approach towards the meaning of liberty which is not limited to children.

That conceptual approach to what it means to be deprived of one's liberty chimes with the extra-judicial observations of District Judge (and Professor) Anselm Eldergill in an article published in 2019 called "[Are all incapacitated](#)

needs that it is on one view quite surprising that the council in this case in fact even considered making an application.

people confined in a hospital, care home or their own home deprived of liberty?" It might also be thought to be consistent with the underpinning rationale of the Court of Appeal in the *Ferreira* case which, as expressed by Lady Arden in *Re D* [2017] UKSC 42 (now as a Supreme Court judge, having sat previously on the Court of Appeal panel hearing *Ferreira*) that there may be circumstances where the person may lose their liberty but fall outside the scope of *Cheshire West* because "the loss of liberty is due to the need to provide care for them on an urgent basis because of their serious medical condition, is necessary and unavoidable, and results from circumstances beyond the state's control" (paragraph 120).⁷

We understand that the decision will not be appealed, so the appellate courts are not going to be able to pronounce upon her observations or her conclusion. This is particularly unfortunate, because the judgment does give rise to some significant questions that it would be very helpful to have addressed at an appellate level.

The first is in relation to the application of the decision of the Supreme Court in *Re D* [2019] UKSC 42, not referred to by Lieven J, but in which the Supreme Court expressly considered the position of those under 18 (at least, those aged 16 and 17). In that decision, Lady Hale (for the

majority) identified that the crux of the matter was whether the restrictions fell within normal parental control for a child of the relevant age (see paragraph 39), and by reference to Lord Kerr's discussion in *Cheshire West* analysed by Lieven J considered that: "[i]t follows that a mentally disabled child who is subject to a level of control beyond that which is normal for a child of his age has been confined within the meaning of article 5" (paragraph 42). For Article 14 ECHR purposes, Lady Hale was therefore giving a clear comparator: a child of the same age, with the question being whether the restrictions went beyond those which would be considered societally acceptable for a child of that age.⁸ Lady Black agreed with, and did not add to, the analysis of Lady Hale (see paragraph 90), as did Lady Arden (see paragraph 116). For Article 14 purposes, therefore, it might be said that not treating the disabled child as deprived of their liberty would be to allow unjustified differential treatment in the form of socially unacceptable restrictions being placed upon them that would not be accepted in respect of a non-disabled child of the same age.

One response to the question of the relevance of *Re D* might be that, whilst Lady Hale in *Re D* observed that her conclusions would also apply to a child below the age of 16, the other judges (both in the majority and minority) specifically did not address their position.

⁷ However, it is important to note that the Court of Appeal in *Ferreira* found that they were not bound by *Cheshire West* because that case concerned living arrangements, whereas *Ferreira* concerned immediately necessary life-saving physical health treatment: see paragraph 91. SM's case undoubtedly concerns living arrangements.

⁸ See also in this regard Sir James Munby's 'rule of thumb' at paragraph 43 of *Re A-F (Children)* [2018] EWHC 138 (Fam) that "(i) a child aged 10, even if under pretty constant supervision, is unlikely to be "confined" for the purpose of *Storck* component (a); (ii) a child aged 11, if under constant supervision, may, in contrast be so

"confined", though the court should be astute to avoid coming too readily to such a conclusion; and (iii) once a child who is under constant supervision has reached the age of 12, the court will more readily come to that conclusion," although "all must depend upon the circumstances of the particular case and upon the identification by the judge in the particular case of the attributes of the relevant comparator as described by Lord Kerr." As noted above, the 'wiggle room' in terms of the attributes of the comparator has been significantly reduced by *Re D*, handed down subsequently.

However, when SM turns 16, and given that it is unlikely on the face of the judgment that her position will materially have changed, she will be firmly into *Re D* territory. Further, Lieven J did not purport to limit her observations about the scope of deprivation of liberty to those under 16. The question of the application of *Re D* to cases of children below the age of 16 (or, at a minimum, the question of why it should not apply) is therefore a live one. This is perhaps particularly important for the fact that *Re D* makes clear that each element of the Article 5 “trinity” needs to be considered separately, i.e. confinement, consent and state imputability. Whilst Lieven J expressly addressed the question of confinement, she appeared in effect, also, to link it to SM’s cognitive abilities: a matter which would, for those in the *Re D* zone, be relevant to consent, not confinement. Does this mean that there is a different approach required altogether for younger children?

The second is as to the applicability of the Court of Appeal’s decision in *KW*, which it might be thought to have been a little surprising that the researches of the Counsel appearing before Lieven J did not identify, given that – as noted above – the case expressly considered the position of a person said not to be “*in any realistic way being constrained from exercising the freedom to leave, in the required sense, for the essential reason that she does not have the physical or mental ability to exercise that freedom.*” Whilst *KW* was an adult, and *SM* a child, the framing is identical.

A third question is as to Lieven J’s observations at paragraph 37 in relation to the supervision and control to which *SM* was subject. It is entirely understandable that she focused on the issue of whether such supervision and control was directed to preventing *SM* leaving. Indeed, this was precisely what the Official Solicitor argued in *Cheshire West*, only to be met with the response

from Lady Hale at paragraph 49 that she would not go so far as to agree that “[t]he supervision and control is relevant only insofar as it demonstrates that the person is not free to leave. A person might be under constant supervision and control but still be free to leave should he express the desire so to do. Conversely, it is possible to imagine situations in which a person is not free to leave but is not under such continuous supervision and control as to lead to the conclusion that he was deprived of his liberty. Indeed, that could be the explanation for the doubts expressed in *Haidn v Germany.*” So the fact that supervision and control was in *SM*’s case was not directed specifically at stopping her leaving would not, applying *Cheshire West*, itself, be determinative.

A fourth question is how the decision sits with that in *HL v United Kingdom*, in which a central feature of the case before the domestic courts was the assertion that *HL* (who was autistic and non-verbal) never tried to leave, the judgments giving the strong sense that *HL* did not appear to have the capacity to understand that he could try to. The ECtHR had little truck with the fact that false imprisonment at English common law only arises where the person seeks to leave and is prevented, noting that such a distinction was not of central importance under the ECHR, and that (paragraph 91) “*the key factor in the present case to be that the health care professionals treating and managing the applicant exercised complete and effective control over his care and movements [and that] the concrete situation was that the applicant was under continuous supervision and control and was not free to leave. Any suggestion to the contrary was, in the Court’s view, fairly described by Lord Steyn as ‘stretching credulity to breaking point’ and as a ‘fairy tale.’*” In the passage from *Cheshire West* cited in the paragraph above, and consistent with *HL*, it can be seen that Lady Hale proceeded on the basis of asking what would happen if the person did

express a desire to leave, not on whether they had done so.

Alex is on record as considering that the Supreme Court did take a wrong turn in *Cheshire West*, but that, as discussed [here](#), the wrong turn was (in effect) not listening closely enough to P, MIG and MEG to discern whether the arrangements were – to use CRPD language – in line with their will and preferences or otherwise. That wrong turn arose because they assumed, on the basis of the agreed position of the parties before them, that MCA 2005 incapacity to consent to the arrangements meant that they could not give valid consent for purposes of Article 5 ECHR. However, the reversal of that wrong turn would require the Supreme Court to reconsider the matter.

Our concerns in relation to any attempt to narrow the scope of *Cheshire West* – as understandable as they are, and especially in *SM*'s case – by reference to the objective test, is how to avoid falling into the trap of discriminating against those who are physically incapacitated. Lieven J was undoubtedly alive to this in *SM*, and her reference (at paragraph 35) to the State's positive obligations that might be in play to support a person to leave is clearly very important – it is clear that she considered that, in effect, there as was (and could be⁹) no evidence that *SM* would wish to leave, and that her conclusions would have been different had she had such evidence. However, it is all too easy to see the judgment being applied to situations where little or no work is done to identify what the person wants. To this end, it is perhaps important to reiterate that, whilst its underlying logic may be thought to apply to those over 16 /

over 18, it is a decision which relates to a child of 12.

For all these reasons, it will be very unfortunate if there is no appeal, such that the questions will remain to be resolved – but hopefully before *SM* reaches the age of 16 so that those responsible for her at that point know what they should be doing in her case.

Law Society guidance on deprivation of liberty

The Law Society has [updated its practical guidance](#) on identifying a deprivation of liberty.¹⁰

Since the publication of the original guidance in 2015, there have been important developments in the law relating to deprivation of liberty, including clarification of the position of:

- those under 18
- those in receipt of life-sustaining medical treatment

For several years, it had been anticipated that these developments would be reflected in an updated version of the statutory Code of Practice.

However, with the announcement of an indefinite delay to the implementation of the Liberty Protection Safeguards (LPS) in April 2023, there is no immediate prospect of an updated code to accompany the LPS.

This guidance draws together the assistance that can be found in the case law and from the practical experience of the authors who, in different contexts, advise upon and act in cases involving questions of deprivation of liberty.

⁹ Although we note that, although she was described as being unable to communicate, it was also identified that it was possible to identify that she responded positively or negatively to stimuli. Likewise, it is clear from all that

is known about HL that he hated being in Bournemouth Hospital.

¹⁰ Alex edited it, and Neil was one of the authors.

It includes an overview of the legal framework, including the special considerations relating to those under 18.

The guidance applies that framework to different settings:

- hospitals
- psychiatric care
- care homes
- supported living/shared lives/extra care
- at home
- palliative care and hospices

For each setting, a list of potentially 'liberty-restricting' factors are given that may indicate that a deprivation of liberty is occurring.

Scenarios are also given, which illustrate:

- a deprivation of liberty
- a potential deprivation of liberty depending on the circumstances
- a situation unlikely to amount to a deprivation of liberty

Each chapter concludes with a list of questions that professionals can ask themselves whenever they are confronted with a situation which may amount to a deprivation of liberty.

You can download the whole guidance, or as individual chapters covering specific care settings.

You can also download quick reference guides for each setting.

Alex has done a walkthrough of the key points [here](#).

[DoLS prioritisation tool and rights guide](#)

West Midlands ADASS has published an updated [DoLS prioritisation tool](#), a [Rights Guide](#) for people subject to DoLS authorisations, and an [Easy Read Rights Guide](#). All of these have been endorsed by ADASS nationally.

Deprivation of liberty and care providers – how thick is your legal ice?

In a recent [report](#), entitled *A Hidden Crisis*, Age UK has highlighted the extent of the problems with DoLS, setting out the results of qualitative research carried out with care home staff, representatives of local authority DoLS teams, and families of those affected by DoLS. Age UK sets out clearly the (depressingly familiar) problems, and notes that:

The problems with DoLS are arguably part of a wider story of policy neglect and underfunding impacting social care. The current social care staffing crisis means that care homes often do not have sufficient staffing levels to deliver care in a way that properly reflects the human rights principles set out by the DoLS and the Mental Capacity Act. Care home managers do not always have the resources to provide person-centred care and this means that care practices can be more restrictive than they ought to be, and that the minimal restrictions specified in DoLS authorisations are not always adhered to or reviewed. For example, people may be locked up for long periods in their room in a care home, or not supported to go outside or to leave the setting at all due to a lack of staff to accompany them. There are also concerns that in some instances restless residents are simply sedated to keep them quiet.

Age UK further identify that its research found

a marked lack of concern from some professionals and others caught up in the system about the absence of proper

DoLS processes being followed on the basis that what really mattered was that the individuals in question were safe.

Age UK notes that:

This is understandable, given our beleaguered system of social care and health services, but the Charity believes it is important to challenge this narrative, as infringing liberty can be a 'slippery slope' and freedom is such a fundamental right in our society.

We do not for one minute disagree, but it is important to highlight that those delivering care are on the horns of a true dilemma. The CQC has already noted in its most recent [State of Care report](#) that:

Meanwhile, people who are waiting to be assessed may be restricted without the appropriate authorisation in place. This could mean that people are being deprived of their liberty for longer than they should have been, or where less restrictive options could have been identified if they had been assessed. When assessments are delayed, staff face the challenge of keeping people safe while protecting their rights. This is particularly difficult if an urgent DoLS authorisation expires before the person has been assessed for a standard authorisation. Providers are not always clear on how to navigate the difficult legal situation of caring for people who are waiting for an assessment. This situation also affects people's ability to challenge the deprivation of liberty, as public funding for legal support depends on an authorisation being in place.

(emphasis added)

As the Age UK report notes:

Once an urgent authorisation has expired, any deprivation of liberty without a standard authorisation is

unlawful. In these circumstances, care home staff are faced with a difficult choice. If they place restrictions on someone who may need them, they are at risk unlawfully depriving the person of their liberty, but if they follow the law and do not deprive someone of their liberty while they wait for a DoLS authorisation to be approved, they then face the challenge of keeping someone who may be at high risk of harm safe.

A case study then follows, of 'Helen's Grandad,' which we reproduce in full below:

"I was saying 'let's do it [the DoLS application] today'. But it took ages. It took six weeks and he was running around all over the place. They said there was backlog and there were more urgent ones they had to deal with. I was pleading with staff ... saying "stop him", they were saying "Helen, we can't – we're not allowed to". It was frustrating." Helen's Grandad, Peter, has had Alzheimer's for a long time and has been living in care for two years. He was regularly leaving the care home and being found roaming the streets as he thought he was going to work. As the care home was close to a dual carriageway, Helen and her family felt a constant sense of dread that something serious would happen. Each time he left the care home, Helen had to come into the care home to speak to the staff.*

As her Grandad's power of attorney, Helen was approached by the care home about implementing a DoLS. It was framed as a way which would enable staff to prevent him from leaving the home, and she was relieved that there might be a solution. They contacted the local authority and a BIA was assigned who organised a multi-agency meeting with the care home, Peter's GP, the family and the local authority. This was followed by a BIA assessment.

Following these assessments and meetings, Helen and her family heard almost nothing from the local authority about the application for over 6 weeks. They were informed there was a backlog, but in this time – as there was no emergency DoLS in place – her Grandad was regularly leaving the home on his own and the care home staff could do nothing to force him to remain. Helen describes feeling totally helpless during this period and frustrated because she couldn't understand what was taking so long.

When Peter's DoLS eventually came through it was a relief.

(emphases added)

The case study is interesting in that, rather contrary to the picture painted in the extract from the report set out above, this shows a care provider intensely concerned about the right to liberty. The underlined passages are also concerning because they suggest the care provider may not have been assisted to think through the balancing act required as between life and liberty. Whether it is framed by reference to the European Convention on Human Rights or at common law,¹¹ we can confidently state that, in the context of those reasonably believed to lack capacity to take the relevant decisions, the courts will almost invariably prioritise life over liberty, at least when it comes to determining the consequences for the care provider which has deprived the person of their liberty unlawfully

¹¹ If 'Peter' is a self-funder, or his care is funded by NHS Continuing Health Care, complicated questions might arise about the application of the Human Rights Act to the care provider (as flagged here in this [report](#) from the Joint Committee on Human Rights on Human Rights in Care Settings).

¹² The nerds will have spotted that this comes from s.4B MCA 2005, which we need to emphasise only applies to give legal authority to deprive someone of their liberty where an application has been made to the Court of Protection to determine a question about whether D is authorised to deprive P of his liberty under

because their attempts to get the position authorised have not yet succeeded (see this presentation [here](#)).

If CQC could be tempted to come off the fence to help care providers work out what they are meant to do, it might be said that assessing the thickness of the legal ice for the care provider might be tested by reference to the extent to which they can say they reasonably believe that preventing the person leaving is necessary in order to:

(a) give life-sustaining treatment, or

(b) to carry out any act which the person doing it reasonably believes to be necessary to prevent a serious deterioration in the person's condition.¹²

If the provider (a) reasonably believes that either of these apply; and (b) they have done all that they can to help the relevant body authorise the situation,¹³ it seems to us that there is a strong case that they are the right side of a line we should not be having to draw.

Sharing information about health and care

In an unreported case determined in January 2024 by Sophia Roper KC sitting as a Tier 2 judge, permission was given by the judge to publish a [note](#) setting out the relevant information given to the capacity expert to assess P's capacity to consent to permit professionals to share information about her

s.4A. However, this does provide a useful framework to tease out the level of risk to the person. In legal terms, this would, in turn, then provide a basis upon which it could be argued that any unlawful deprivation of liberty to which the person was subject pending authorisation caused them no harm, and hence, in turn, only grounds the right to a declaration and nominal damages (i.e. £1).

¹³ And to contact the relevant body on a regular basis to enquire as to when their request for authorisation will be processed (and, if necessary, to alert them to any change in circumstances).

health and care provision with her family, which was agreed between the parties. The relevant information was identified in the note as being:

- (a) What sort of information might be shared by professionals.
- (b) The benefits of sharing this sort of information with their family including support with appointments, monitoring of care provision, support to engage with services and medication and so on.
- (c) The risks of not sharing this information with their family, including the risk of deterioration, the reported risk of death due to substance abuse, the risk of non-engagement with services. The court also identified that P would need to be able to recall and weigh up past events where their family have, and have not been provided with information, and the impact of those decisions on P.

This provides us with the opportunity to remind me people of our recently updated [guidance note](#) on relevant information for different categories of decision.

PROPERTY AND AFFAIRS

The obligations on the certificate provider

Updated fixed costs Practice Direction

As noted in the Practice and Procedure section, [Practice Direction 19B](#) has been updated with effect from 1 April 2024, to reflect cases such as ACC and also to uplift the costs fixed costs deputies can claim.

The tendency of human nature to be swayed by interest rather than duty

Irwin Mitchell Trust Corporation v PW & The Public Guardian [2024] EWCOP 16 (Senior Judge Hilder)

Deputies – property and financial affairs

Summary

The Court of Protection has given a clear statement that there is an actual conflict of interest when a Trust Corporation acting as property and affairs deputy appoints an Asset Management company with the same corporate owner. To avoid breaching rules against conflicts of interest, a deputy must seek ratification for any such conflict of interest from the Court of Protection.

This application was brought by Irwin Mitchell Trust Corporation (IMTC), a wholly owned subsidiary of Irwin Mitchell LLP, which acted as property and affairs deputy for PW. PW had significant assets following a personal injury award which had been paid partly as a lump sum and partly by ongoing annual periodical payments. IMTC had acted as PW's property and affairs deputy since 2017, and had appointed Irwin Mitchell Asset Management (IMAM) 'as investment manager for a significant part of PW's damages award' [19] in the same year. In 2020, following a successful statutory will application, IMTC was directed by the Court of

Protection 'to make an application "to seek retrospective authority" to instruct IMAM.' [10] The matter was delayed due to issues of funding representation for PW in proceedings.

14. The unchallenged evidence of IMTC...is that £600,000 of PW's funds was initially invested with IMAM. There have been two subsequent withdrawals. The total return during the period of investment is £49,255, equivalent to approximately 3% per annum. The total charges for the calendar year 2019 were 1.89%, including 0.59% in IMAM's advice fees and 0.08% in IMAM transaction costs.

Senior Judge Hilder rehearsed the propositions of fiduciary duties, noting:

- A person with a fiduciary duty should not ordinarily put himself in a position "where his interests and duty conflict"; *Bray v Ford* [1896] AC 44 at paragraph 51, but this may be departed from 'in many cases';
- "The consequence of this rule, and the underlying rationale for it, is that transactions entered into where the fiduciary's duty conflicts with their interests are capable of being set aside as of right by their principal. This is 'the self-dealing rule'" (paragraph 20);
- "Where the principal lacks capacity to make decisions about their property and affairs, only the Court of Protection may grant...ratification" (paragraph 21) of a conflict of interest.

The MCA 2005 provides at s.19(6) that "A deputy is to be treated as P's agent in relation to anything done or decided by him within the scope of his appointment and in accordance with this Part."

Senior Judge Hilder considered that "the primary question which I am now asked to determine is whether the conflict of interest rule applies to the

appointment by IMTC as deputy of IMAM as asset manager for PW's funds: ie would a reasonable man looking at the relevant facts and circumstances of this particular case think there was a real sensible possibility of conflict?" (paragraph 26).

The central argument of IMTC was that while there is *"a theoretical potential" for a conflict of interest...there is no "real sensible possibility" of conflict because it has adopted procedures which eliminate that potential"* (paragraph 32). Looking to case law from New Zealand and Hong Kong, IMTC argued that where a management company was a well-recognised specialist and other options had been considered, there was not necessarily any actual conflict of interest if a trustee selected the firm to which it had links after considering the market more generally.

Senior Judge Hilder was not persuaded by the non-binding case law and observed that *"human nature being what it is, neither pre-eminence nor success of the linked business is any guarantor of unconflicted motivation in the fiduciary. Indeed they may just encourage complacency, so that the fiduciary fails to consider the alternatives properly. The rule is founded in practical expediency and applies even though it may be breached without disadvantage to the beneficiary"* (paragraph 33(a)).

IMTC made the following submissions as to why its processes prevented a 'real sensible possibility of conflict':

- It is a highly experienced deputy and is accustomed to taking decisions regarding the appointment of investment advisers.
- It is not alone in using a linked financial adviser or investment manager.
- IMTC *"maintains a 'panel' of investment advisers for consideration on behalf of any person for whom it acts as deputy. Inclusion*

on that panel is a matter kept under review by an 'investment executive committee' of IMT...All the companies on the panel have specialist teams that deal either exclusively or largely with Court of Protection clients and it is a strict requirement that they do not have any entry charge fees nor any exit fees applicable to the portfolio" (paragraph 39(a));

- IMTC undertakes a 'beauty parade' for deputyship firms, and a family member of the protected person will be invited to participate. Each firm selected for the 'beauty parade' is given the same instructions and invited to prepare a proposal, and the assessment of the bids are by set criteria;
- IMAM will be excluded from the 'beauty parade' if the family member objects, but the shortlist will typically include IMAM if there has been no objection.
- The family member participating in the 'beauty parade' will be informed of how IMAM and IMTC are related.
- If a family member is involved, the 'beauty parade' will be an attended event.
- A best interests decision is taken which takes into account the views of P's family members and other relevant matters.
- The performance of the portfolio and investment are kept under continuous review.

This process was followed in PW's case, and her husband attended a 'beauty parade,' following which IMAM was chosen.

Expert evidence filed in the case and evidence filed by deputies did not support the position taken by IMTC, and expressed views that

appointing an internal investment manager would create a conflict of interest.

IMTC's position was opposed by both the Official Solicitor and the Public Guardian, and both considered that there was a clear conflict of interest. They expressed concern that IMAM would have specialist knowledge which would advantage it in the 'beauty parade', and felt that IMTC had wrongly attempted "to treat members of the family as if they were the person for whom it is appointed, capable of consenting to the conflict of interest" (paragraph 59). The Official Solicitor argued that:

The actual conflict of interest would only be "wholly extinguished" in the following circumstances...:

- a. *where IMTC was not responsible for the appointment, for example because it was made before IMTC had been appointed as deputy (and even so, the subsequent reviews would be problematic, giving rise to concern as to whether a subsequent appointment of IMTC would be in P's best interests);*
- b. *the appointment process was conducted in a wholly independent way unconnected to IMTC (the independent expert identifies the possibility of using an external adviser but again the reviews would be problematic);*
- c. *the Court approved the appointment.* (paragraph 40)

Senior Judge Hilder accepted the position of the Official Solicitor and Public Guardian. She considered that taking to account the views of family members was relevant to the decision but "an insubstantial safeguard against conflict" (paragraph 42(a)). The family member is already in a position of trust with IMTC, and in PW's case, PW's husband had instructed Irwin Mitchell LLP

to act in the personal injury proceedings. "The IMAM proposal is then presented with familiar graphic style and express reference to its close relationship to the Irwin Mitchell law firm. Such inclusion of a family member is hardly robust oversight" (paragraph 42(a)). The court also noted that "the frequency with which IMAM is invited to take part in the 'beauty parade' seems very likely to give IMAM an advantage in knowing how to pitch its presentation" (paragraph 42(b)). Finally, the 'objective' scoring system was "manifestly subject to subjective interpretation and then human error as well, to a degree capable of changing who actually comes out with the highest score" (paragraph 42(c)).

Senior Judge Hilder found that the appointment of IMAM had been a conflict of interest. IMTC did not deny that the appointment of IMAM made IMTC better off, and "[t]he processes which IMTC has adopted when considering the appointment of IMAM do not target the substance of the self-dealing rule: that is, they do not remove the financial gain to IMTC. Such processes could have been adopted, for example by agreeing to waive any fee to IMAM where the instruction comes from IMTC as deputy. Then there would be no financial advantage to IMTC in the instruction of IMAM, no interest to be in conflict with the interests of the person for whom IMTC acts. Of course, I recognise that the Irwin Mitchell group would be likely to reject this approach as lacking commercial sense but that merely reinforces the existence of IMTC's interest in the appointment of IMAM" (paragraph 63). She did not consider that the participation of a family member protected against the risk, and the family member could not give consent to a conflict of interest on behalf of the protected person where IMTC was property and affairs deputy: only the Court of Protection could do so.

The judgment concluded that "[t]aking into account all the evidence in respect of IMTC

processes, in my judgment there remained a very clear, not remotely fanciful, actual conflict of interest in IMTC appointing IMAM to manage PW's funds. IMTC's processes were not capable of extinguishing, and did not extinguish, that conflict" (paragraph 67).

Senior Judge Hilder went on to consider whether the appointment had been ratified, and concluded that it had not. Senior Judge Hilder considered that the judgment of Senior Judge Lush in *Re MWS* was "*unequivocal (at paragraph 23) that there is a conflict of interest in appointment of IMAM by IMTC as deputy" (paragraph 77) and did not act as ratification or provide general authority for an appointment of this nature. Senior Judge Hilder similarly found that email communications following the judgment did not provide any such authorisation, and was clearly somewhat uncomfortable about the communications, noting that "such informal communications, without input or even awareness of the other parties to proceedings, are not capable of establishing any binding authority. That they took place at all is probably best put down to a lingering cultural hangover from a time when the Court of Protection was an Office of the Supreme Court, as opposed to the independent court of record which it is now" (paragraph 79). In any event, she found, they did not amount to such authorisation.*

Senior Judge Hilder declined to consider whether the appointment ought to be ratified pending receipt of further evidence and submissions. Senior Judge Hilder accepted that "*management of damages awards is a specialist expertise, significantly different to the management of earned or inherited wealth, with a relatively small pool of firms offering such expertise and experience. However, there is a limit to the impact of these accepted points: fiduciary duties are well settled, as demonstrated by the age of the authorities cited above as fundamental*

propositions, and the pool of specialist firms is not so small that IMTC cannot maintain a standing panel more than twice the size of the numbers considered appropriate to engage in a beauty parade" (paragraph 76).

Her conclusion was pithy:

93. In my judgment the appointment by IMTC of IMAM to manage the assets of PW clearly conflicts with the rule against self-dealing. There is actual conflict of interest in that the Irwin Mitchell group gains financially. There is nothing in Re MWS or subsequent e-mail communications which can reasonably be understood as approval of appointment of IMAM if it follows a beauty parade in which a family member of a protected person participates. The processes adopted by IMTC do not and could not extinguish that conflict. In my view, that these proceedings have been necessary at all is a paradigm example of Lord Herschell's wise recognition of the tendency of human nature to be swayed by interest rather than duty.

Comment

The conclusions in this case could not be clearer or more robust in finding that a conflict of interest existed. Beyond the implications for asset management, this judgment appears likely to cause significant consideration on the use of 'in-house' services by property and affairs deputies, and likely many applications for ex post facto ratifications of conflicts of interest. It also throws into sharper light other situations where conflicts might arise – an obvious one being where the firm instructed on a personal injury claim also puts itself forward to act as deputy for the management of any monies received. That, in fact, had happened in the instant case, but the judicial Eye of Sauron did not descend upon that aspect. It may not be very long before it does.

Child Trust Funds

A [debate](#) in the House of Commons on 19 March 2024 highlighted the ongoing concerns about access to the money of former beneficiaries of such accounts, now adults, who lack capacity to make decisions to manage their affairs. For the background to this, see this [post](#) from Alex. We set out here the material parts of the concluding remarks of Mike Freer MP, the Parliamentary Under-Secretary of State for Justice:

I will not tiptoe down memory lane, as colleagues have – I am not sure that revisiting the coalition Governments of 2010 onwards is particularly helpful to today’s debate. What I want to do and what is important – and I am sorry if it is dry – is lay out the legal framework that is there is to protect vulnerable people. I understand clearly that the actions of the vast majority of parents are well intentioned, and that they act with great honour and kindness looking after their child or young adult. However, my job is also to protect vulnerable people from any form of abuse, and that weighs heavily on any reforms that we take forward. I appreciate that people will disagree vehemently with me, but I have to take into account the fact that not every parent would act with the best of intentions when accessing the funds. It is a well-established common-law principle that an adult must obtain proper legal authority to access or manage the finances or property of another adult. That includes, for the purpose of today’s debate, a matured child trust fund of a young adult. People are understandably unaware of that legal principle, and it may be surprising to parents and carers who have been heavily involved in decision making for their young person prior to their turning 18. I want to iterate the steps that we have already taken to try to improve the process, particularly as regards awareness of what steps need to be

taken as the young person reaches the age of 18.

Ed Davey

Before the Minister talks about reforms that have been made, can I bring him back to the point of principle that he outlined at the beginning of his remarks? I do not think anyone disagrees that there is an important principle, but there is equally a principle of proportionality that I mentioned in my speech. Can the Minister address that point? Where does proportionality arise in his thinking about the principles involved?

Mike Freer

I have to say to the right hon. Gentleman that I am happy to have an ongoing conversation. In fact, this is the first time we have discussed the matter face to face since I took on my portfolio. Proportionality is a valid point, but what is the level of risk that the right hon. Gentleman is willing to take? It will be different from the one that I or the Government are prepared to take. The right hon. Gentleman or anybody in this room may be prepared to say that 10, 20, 100 or 1,000 young people could have their money accessed inappropriately. That is a proportionate risk that they are willing to take. My view is that I want to minimise that risk and that proportionality is not easily measured.

I am not a lawyer. I look to my right hon. Friend the Member for Horsham and my legal friends to say that there may be a legal definition of proportionality. However, the definition of proportionality for those who are making decisions against those who are asking for change may be different. I am willing to see if we can bridge the gap, but my view is that I want to ensure that we can both improve access and that

protections remain in place so that those who may not have the best interests of the young adults in mind do not get access to funds with total liberty.

Ed Davey

I am grateful to the Minister for that answer. It was direct and to the point, and he has given way again, which is generous.

When we look at the risk, we have evidence from the industry, which has looked at the case and many firms and funders have said that they are prepared to take on the risk themselves. Even though the Government are behind it, because the risk and the amount of money are so small, the firms have taken on that risk themselves. Is that not a lesson that the Minister should dwell on? If the MOJ is not prepared to act on that, would he at least go and talk to his colleagues at the Treasury and see if they can make a statement about the way in which the financial services could take on that risk and how the Government would support that?

Mike Freer

I am always happy to discuss with any provider and certainly the provider I have spoken to. No provider has beaten a path to my door saying, "We think you have got it wrong and our risk assessment is right." Any organisation is entitled to make their own risk assessment and accept the consequences if they get it wrong. That is their decision. As for my risk assessments, perhaps I am being over-cautious. I am willing to be challenged on that and I appreciate that people have a different view, but I want to ensure that I take the least risk regarding vulnerable adults.

I will talk briefly in the time left about the work we have done with the Investing and Saving Alliance to try to improve accessibility and knowledge. Given the time, I will have to skip over the part of my speech about the legal framework of the Mental Capacity Act 2005. I think everyone in the room is probably aware of the methodology of applying for the deputyship that gives people access or the ability to act on other people's behalf. I will not go through that in any great depth.

We have heard that the court process was cumbersome, which is why we looked at how we could change that. We consulted on what kind of different system we could put in place, but there was not a consistent view from the consultation on how we should reform access to the funds.¹⁴ In fact, if we go into the consultation, many people wanted to add safeguards to a new form of access that actually made the system even more cumbersome than the one we were trying to reform. That was a difficulty, as we did not get a common view on what checks and balances needed to be in place. We talked not just to parents, but to charitable organisations, the legal and finance sectors, groups representing the elderly and so on, and we heard that it was too complex. The big message that came out was that people were not really aware of what they had to do or when they had to do it.

I think that the first ask from my right hon. Friend the Member for Horsham was whether we would extend appointeeships to cover child trust funds. We are working with the Department for Work and Pensions to extend the availability of information. I am more than willing to go back to the

¹⁴ See [here](#).

DWP and talk about whether its process is suitable for child trust funds. It is a very different process: it is about accessing regular payments rather than lump sums, so there is a different quantum at risk. It would take primary legislation to access the DWP-type processes—we double-checked that today. It is not a quick fix, but it is certainly one that I am more than happy to go back and have another look at.

I want to ensure that we are streamlining the processes. Can we take the paper out? Can we use more digital processes? We have seen that the time has reduced from 24 weeks to 12 weeks. We will continue to liaise with the President of the Court of Protection to monitor performance and see what more can be done.

A key issue is that people often do not know what they have to do until the child turns 18, and then they are locked out. We have done two things; I apologise if this sounds a little disjointed. I sat down with TISA, the major provider of child trust funds, and we agreed that as part of its normal maturity mailing, it will include advice and information about how to access and use the Court of Protection to get the relevant legal powers in place. We are taking early steps to educate people as to what they need to do before the person turns 18. That comes alongside the toolkit, which, as hon. Members have noted, provides practical guidance on how to access and navigate the legal process.

My right hon. Friend's second ask was about making people aware of how to find lost funds. We are doing more work to provide information. People can use the "Find my child trust fund" service on gov.uk. We can continue to do more to raise awareness of that.

Alex Cunningham

It is a good idea that providers are prepared to write out and provide additional information. I welcome that, but it is not going to solve the problem. Does the Minister agree that it is no good just having a one-off? It will have to be done on a regular basis, as more young people become mature and approach the age of 18.

Mike Freer

The shadow Minister pre-empts me. This is a regular communication strategy: TISA will continue to notify those who are heading towards maturity of what they need to do to access the fund once they turn 18.

I have also been working with the Department for Work and Pensions on accessing its client bank. We have agreed with the DWP that we will contact the cohort of parents and carers who receive personal independence payments and who may lack the mental capacity to access their child trust fund. We have an agreement in principle that we will do a mailing—not a one-off, but a constant mailing—so that people in this cohort, which we think is particularly relevant to child trust funds and difficulties of access, will become aware in advance of what they need to do. One of the big messages from the consultation was about the lack of understanding and knowledge of the steps until it was too late.

I appreciate that hon. Members have said, "Give them the money." I get that. As I mentioned at the start of my speech, the vast majority of parents act in the very best interests of the child. I am not a parent, so I cannot possibly understand the role of a parent having to juggle all the demands of everyday life while having a child who needs additional support. I accept that my

knowledge is limited, but the risk of just one parent not acting in their child's best interests, but accessing those funds inappropriately, weighs very heavily on me.

I accept all the points about proportionality, and I am happy to have a conversation about where the line on risk is drawn. Broadly speaking, where I am coming from is improving education, improving access and improving knowledge, but I cannot in all good conscience say that I am going to throw open the accounts and give unfettered access without some checks and safeguards to ensure that the very small minority do not have the ability to abuse a young adult. However, I will commit to following through with colleagues at the DWP to see whether there is anything we can do to copy or piggyback on their approach and make the system more accessible.

PRACTICE AND PROCEDURE

Amended Practice Directions

Amendments to three Practice Directions supplementing the Court of Protection Rules 2017 have been made. In summary the changes are:

- Practice Direction 2A is amended to make provision for circumstances in which circuit judges and recorders may act as Tier 3 Judges.
- Practice Direction 19B is substituted to reflect updates to fixed costs that may be claimed by deputies, and to make other consequential amendments to reflect recent case law.
- Practice Direction 20B is amended to clarify the circumstances in which appeals from a Tier 2 Judge may be heard by the Court of Appeal.

The amendments to the Practice Directions come into force on 1 April 2024.

All the Practice Directions can be found on the Court of Protection Handbook [here](#).

When (and why) should the judge visit P?

Wareham v Betsi Cadwaladar University Health Board & Ors [2024] EWCOP 15 (John McKendrick KC, sitting as a Tier 3 Judge)

Mental capacity – assessing capacity

This case concerned a 36 year old autistic woman, Laura Wareham, who strongly asserted her own capacity to make decisions about the conduct of the proceedings, and in respect of her (i) residence; (ii) care and support; and (iii) contact with others. The judgment of John McKendrick KC, sitting as a Tier 3 Judge of the Court of Protection, is lengthy and detailed in its

analysis of the evidence – including that (unusually) of rival expert reports, one prepared on a joint instruction basis, and one on a sole instruction basis, by Ms Wareham’s parents. For the reasons set out in the judgment, John McKendrick KC determined that Ms Wareham lacked capacity in the material domains in issue, not least because evidence of the sole expert had materially evolved under cross-examination:

She accepted she had not put all the relevant information to Laura. Her view was that this was for the treating team to do. She accepted she had overly relied on what Laura had told her and had not triangulated this with treating clinicians. She accepted her reports did not set out in writing the conversations she had had with Laura when discussing the functional tests in any detail. She also accepted that her conversations with treating clinicians had not been set out in any detail in her reports. As I have set out above, on each decision, she ultimately was not asserting that Laura had capacity (paragraph 87)

Of wider relevance are the following points.

First is the useful self-direction that the judge set himself at paragraph 76 as regards the determination of capacity (footnotes omitted:

- a. A purpose of the MCA is to promote autonomy and this applies to both the concepts of capacity and best interests.*
- b. There is a statutory presumption Laura has capacity unless it is established otherwise.*
- c. Laura is not to be treated as unable to make a decision unless all practicable steps have been taken*

- to help her to do so without success.
- d. *Laura is not to be treated as unable to make a decision merely because she makes unwise decisions.*
- e. *It is for the Health Board to prove on the balance of probabilities that it is more likely than not Laura lacks capacity in respect of each identified decision. Laura and her parents need not prove anything. [note that in relation to situations outside court, the question for purposes of s.5 MCA 2005 is whether the person carrying out the act has a reasonable belief that the individual lacks capacity, and belief is different to proof: see by analogy *Barnet Enfield And Haringey Mental Health NHS Trust & Anor v Mr K & Ors* [2023] EWCOP 35 at paragraph 57]*
- f. *Whilst two experts have opined, the decision is mine having regard to all the evidence, attaching what weight I consider appropriate.*
- g. *I am assessing Laura's capacity as against the identified decisions in February 2024.*
- h. *The assessment of Laura's capacity is decision specific which requires formulations of the matters to evaluate whether Laura is unable to make the decisions.*
- i. *I should first identify the decisions which fall to be considered.*
- j. *In respect of each decision it will generally be necessary to identify the relevant information.*
- k. *The identification of relevant information must be made "within the specific factual context of the case."*
- l. *The information relevant to the decision includes information about the "reasonably foreseeable consequences" of a decision, or of failing to make a decision.*
- m. *I should not overlook Laura's 'values and outlook' and the weight she attaches to relevant information in the decision making process, if I consider she is able to weigh and use the information.*
- n. *The previous case law identifying relevant information is a useful guide but each case turns on its own facts and previous lists should be appropriately tailored to the decision in question on the facts of the case.*
- o. *It is then necessary to consider whether Laura can make a decision in respect of the matter for the purposes of section 3 – by understanding, retaining and using and weighing the relevant information.*
- p. *It is not necessary for Laura to understand and/or use and weigh all peripheral information but only the salient information.*
- q. *If Laura is unable to make a decision in respect of the matter, it is necessary to consider whether Laura has an impairment and/or disturbance of the mind or brain.*
- r. *Thereafter I must consider whether this impairment and/or*

disturbance causes Laura to be unable to make the decision.

- s. *It is not necessary for the court to have a formal diagnosis or to formulate precisely the underlying condition(s) to consider the causative question between the inability to make a decision and the impairment/disturbance. This it is a question of fact for the court to consider against all the evidence.*

Second is the reminder (at paragraph 69) for those concerned with DoLS that:

*[t]he issue of residence is distinct from the decision in respect of the mental capacity qualifying requirement in Schedule A1 - namely whether the person has capacity "in relation to the question whether or not he should be accommodated in the relevant hospital or care home for the purpose of being given the relevant care or treatment" – see paragraph 15 of Schedule A1, MCA. In *A Primary Care Trust v LDV & Ors* [2013] EWHC 272 (Fam) Baker J (as he then was) indicated that the relevant information in answering the DoLS test includes – in essence – the core elements of the confinement to which the person is subject.*

Third is John McKendrick KC's observation in relation to the suggestion that the decision in relation to contact included Ms Wareham's attempts to contact medical specialists, the Food Standards Agency, the Office of the Public Guardian and the Equality and Human Rights Commission. At paragraph 80, he noted that the evidence did not deal with these organisations, and that:

In any event, I would need some considerable persuasion that the

Court of Protection should be making declarations that P lacks capacity to contact others to grant itself a best interests jurisdiction to make an order that it is not in P's best interests to contact regulatory agencies. That issue seems very much a matter for the agencies to manage and not the court.

Fourth and finally is the detailed discussion of the reasons that a judicial visit to see Ms Wareham in advance of the hearing. As there is so little judicial discussion of this difficult area, we set out his reasoning in full:

6. *At previous hearings, prior to the start of the hearings, I have had the pleasure of conducting remote judicial visits to Laura. Such visits have been conducted with the agreement of the parties, consistently with Laura's wish to meet the judge, and have taken place in compliance with the Practice Note on Judicial Visits found at [2022] EWCOP 5, dated 10 February 2022. The previous hearings have largely determined case management and interim best interests decisions.*

7. *I have been asked to meet with Laura in advance of this hearing. Her solicitor set out a written plan for Laura's participation in this hearing. It anticipated I would meet with Laura in advance of this contested three day capacity hearing. I indicated, in an email to the parties sent in advance of the hearing, that whilst I would welcome the parties' submissions on the issue, my preliminary view was that I would meet with Laura at the conclusion of this stage of the decision making process to explain the outcome and to permit her to engage with the person (me) who is making decisions on her behalf.*

8. I was concerned that there was no directly meaningful purpose to meeting with Laura in advance of the hearing. It would not be to elicit her wishes and feelings, in a section 4 MCA sense for obvious reasons and I am aware her view is that she has capacity to make the decisions with which this application is concerned. Nor am I carrying out an assessment, formally or informally, of Laura's capacity. Instead I am required to read and hear the written and oral evidence on these issues and then apply the law to the evidence to reach determinations.

9. Not only was there no obvious reason to meet with Laura in advance, I was concerned a judicial visit with Laura may influence my decision making one way or another, based upon my own observations which could not necessarily be fully communicated in her solicitor's written note of the meeting. The non-verbal communication and observation undertaken may have provided additional information that would be incapable of being communicated in a written note. Not only is there a risk of unconscious bias; a visit may cause an unfairness to the parties who are deprived of the context and non-verbal communication. Whilst judges are used to hearing evidence and then excluding it, my experience is that a judicial visit can leave a lasting impression.

10. In terms of the law, I note that section 4 (4) of the MCA places a duty on the court: "so far as reasonably practicable, [to] permit and encourage [Laura] to participate, or to improve her ability to participate, as

fully as possible in any act done for her and any decision affecting her." However this must be interpreted consistently with the language and purpose of the MCA. Section 4 (4) is set out within section 4 which is concerned with best interests. The heading to section 4 is 'best Interests'. I consider the qualified duty on the court to ensure Laura's participation in these proceedings is principally directed at best interests decision making. Sections 2 and 3 which deal with capacity do not provide for a similar qualified duty. Whilst I accept that the court's determination of the capacity issues is a "decision affecting [Laura]" the common sense reading of this duty is that it relates to best interests. The Practice Note on Judicial Visits does not envisage judges conducting remote visits to P in respect of contested capacity. That is not to say such visits are prohibited. They are not. However, the decision whether or not, or how, and when, a judicial visit to P should be carried out is a case management decision which should be undertaken consistently with the Court of Protection Rules and in particular in compliance with Rule 1.1 (the over-riding objective) which requires decisions to be made *inter alia* 'justly' and by 'having regard to the principles contained in the Act' which of course includes the qualified section 4 (4) MCA duty). Regard must also be had to Rule 1.2 which deals with the participation of P in the proceedings. This issue was largely dealt with by Cobb J in the normal way at the outset of the proceedings, but I have kept that matter under review.

10. I also remind myself that in the context of the Family Court^[3], there is an increasing focus on the concept that a meeting between a child and a

judge is a visit for the child to meet the judge; and not for the judge to meet the child. There is something of a read-across of this concept into this adult welfare jurisdiction. For the avoidance of doubt, I did not meet Laura (or hear from her in open court) for the purposes of my need to meet her to consider her capacity, or otherwise.

11. I have not overlooked Laura's participation in these proceedings which determine decisions affecting her. First, she is a party. Secondly, I have already met her on at least three occasions (each at her request to meet the judge). I have that background firmly in mind. Thirdly, she is represented in these proceedings by experienced solicitors and counsel. Fourthly, I have ensured there is a hybrid link so she is able to follow the hearing from her placement (and I delayed the start of the hearing for around an hour as various technical problems were worked through to ensure Laura could hear and see the proceedings). Fifthly, I determined to meet with Laura to explain my decision, although I emphasise this was for her to meet me to hear the outcome before others.

13. Lastly, I was persuaded to accede to Mr Brownhill's suggestion that Laura address the court at the conclusion of the evidence. Laura wanted this opportunity and no party opposed it. She spoke in public with members of the public watching her. She was not daunted by this although I do harbour doubts about the appropriateness of an incapacitated person choosing to address the court

from her hospital bed in respect of intimate aspects of her life. As was apparent, whilst she was mostly calm, she appeared distressed before the short adjournment on day three and I quickly rose to provide her with a break. As I communicated to the parties after the adjournment, I was giving active thought, of the court's own motion, to making the case management decision to sit in private for the purposes of protecting Laura¹⁴. I indicated I would hear submissions from the parties and from any member of the public observing before making such a decision. Thankfully, this was unnecessary and Laura presented as calm and collected.

Fifth is the question of the extent to which it can really be right that (irrespective of the undoubted excellence of the representation) Ms Wareham was represented by the Official Solicitor required, ultimately, to argue a case directly contrary to what she wished.¹⁵ The court undoubtedly benefited hugely from the expertise of Counsel (and the solicitors) instructed by the Official Solicitor, but on the face of it this might well be thought to be a paradigm case in which the truly right course of action would have been for P to be represented by a person charged with advancing her case. To the extent that the court required the assistance of experienced lawyers whose sole duty was to assist it, rather than juggle that duty with a duty to a client, the Official Solicitor could have been invited to act as Advocate to the Court.

Fact-finding and the Court of Protection

An ICB v G LF, GR and CJ [2024] EWCOP 13 (Hayden J)

NHS Foundation Trust v FD & Ors [2023] EWHC 2634 (Fam).

¹⁵ We should emphasise that it is entirely clear that this is what is required by the law as it stands. See, for a recent statement of this, Gloucestershire Health & Care

Practice and Procedure – fact finding

This is the latest episode in the long running and highly contested proceedings concerning G, a 29-year-old woman, suffering from a profound, degenerative neurological condition.¹⁶ The earlier judgments can be found at [\[2021\] EWCOP 69](#) (judgment on 13 December 2021 when G was still living in a Childrens Hospital) and [\[2022\] EWCOP 25](#) (Court of Appeal judgment regarding injunctive relief).

This judgment is the culmination of a fact-finding hearing that took place over 19 days between July and November 2023. The evidence before the court was extensive, including a 17-page Scott Schedule produced by the ICB with a 9 page counter-Scott Schedule of countervailing allegations of negligence or malpractice, prepared by LF (G's father's team). The judgment runs to 213 paragraphs. A summary of the highly detailed findings on the disputed factual allegations is beyond the scope of this report, but it is important to note that the allegations made against the family were extremely serious and included allegations that they had tampered with G's equipment including her ventilatory support.

Hayden J observed that

42. Scott Schedules have been prepared in this case because they were considered to be the appropriate framework by which to attempt to marshal a very large body of evidence, requiring scrutiny of human behaviour as well as extensive documentation. However, I consider that the reservations expressed about Scott Schedules, in the Court of Appeal, have clear resonance in this case. What I find myself evaluating is an alleged course of behaviour, manifested in different ways and contested to varying degrees. A

great deal of the behaviour in focus relates to interactions between the staff and the family but some of it concerns specified allegations of covert tampering with G's ventilation equipment. Additionally, as I have mentioned, there is a schedule, prepared on behalf of LF, setting out allegations of general negligence against the care home (CH).

43. The Court of Appeal recognised that specific pleading of individual incidents in Scott Schedules, in family cases, might too easily divert the focus from the important broader picture and serve, paradoxically, to minimise the seriousness of the allegations by severing them from a course of conduct. The alternative options, however, are elusive. One of the suggestions made involved creating "narrative statements" which it was submitted, would allow there to be consideration of the overall nature of the relationships in focus. It was advanced that such an approach would allow the court to identify the real character of the allegations before then going on to look at the "granular detail". I recognise that the structure of the allegations here is steeped in 'granular detail' and also runs the risk of occluding the significance of the totality of the alleged behaviours and their impact, on both sides. Ms Roper KC, on behalf of the Official Solicitor, suggests that the Court should approach its judgement by "narrative" findings based on an adaptation of the model discussed above. I am not sure whether my judgment reflects Ms Roper's aspiration but I have endeavoured to address the overall picture emerging from the broad evidential canvas as well as its individual parts.

¹⁶ Nicola being involved in the case, she has not contributed to this note.

Hayden J (unsurprisingly perhaps) decided that it was not 'necessary or proportionate' to address each and every alleged "breach" in the Scott Schedule, going on to say "[t]hat would serve merely to expand this already extensive judgment and further to feed into the high-octane 'lawfare' that this case has become and which I am resolved to stop" (paragraph 195) What he did do was identify and then consider the 'key incidents'. This approach allowed the court "properly to evaluate the nature and extent of any future risk and provide a foundation for a forensically objective evaluation of G's 'best interests,' predicated on a substratum of determined facts as opposed to allegations" (paragraph 195).

Ultimately the ICB proved their case in relation to the key incidents. Hayden J found (amongst other findings) that LF had engaged in a "pattern of sustained, controlling and bullying behaviour' which had caused 'a wounding psychological impact' on the staff at G's nursing home" (paragraph 207). The Court dismissed the countervailing allegations made regarding the key incidents as being entirely without substance.

The last paragraph of the judgment raises an issue that will be familiar to many of us who practice in this area:

The court itself has become a theatre of conflict. The family's enthusiasm for litigation, as I find it to be, is a different facet of their behaviour within the care home and earlier in the hospital. It is disruptive, calculated to cause distress. It has, at times, degenerated into 'lawfare' and rather than promoting G's welfare, the court process risks becoming inimical to it.

Quite what that this judgment means for the contact arrangements for G in the future is difficult to know.

Of wider interest are the paragraphs relating to the approach to Scott Schedules noted above, and paragraph 22, which addresses the matters that the court should consider when deciding whether or not to undertake a fact-finding in the Court of Protection.

For my part, I do not think that in this sphere of law, they have quite the same practical utility that they can have in the Family Court. In the Court of Protection, the range of welfare options for P is frequently very limited and unlikely to vary very much in response to a shifting factual matrix. In determining whether a fact-finding hearing should be convened, Judges must consider, rigorously, what real purpose it is likely to serve i.e., from the perspective of informing decisions relating to P's welfare. Such hearings are inevitably adversarial and invariably generate further hostility. This is inherently undesirable. Delay in reaching conclusions is inimical to P's best interests. In a very pressing and literal way, time is often not on P's side. Delay can only be justified if it is identifiably purposeful.

The factors in this case that persuaded Hayden J that a fact-finding was required were the gravity of the allegations, the nature of the family's responses and the 'clear resonance for the central welfare issues i.e., as to where G will live and whether or to what extent it will be in her best interests further to promote her relationship with her family" paragraph 22). This was because this was a family who (at paragraph 209) Hayden J considered could 'soothe and comfort' G in a way that only a parent could, and who when alone with G in the community, provided exemplary care to her. It was therefore their conduct in and around G's placement that gave rise to the very serious risk of harm to G (both physical and psychological), and risked the breakdown of her highly specialised placement.

It is inevitable in such circumstances that the court must have a firm factual foundation on which to assess best interests.

Short note: attendance at rehabilitation case management meetings

In *Hadley v Przybylo* [2024] EWCA Civ 250, the Court of Appeal has confirmed that (contrary to the views of Master McCloud) it, in principle, the attendance of fee earners at rehabilitation case management meetings and on deputies are recoverable costs in personal injury litigation. The Court of Appeal did, however, make clear that solicitors should not assume that they are entitled to attend every routine rehabilitation case management meeting, noting (at paragraph 61) that:

*There was no such default or blanket entitlement, and the Serious Injury Guide and the Rehabilitation Code do not justify a contrary approach. And whilst it is accepted that a damages claim for the costs of rehabilitation can be the subject of a reduction if the judge concludes that they were spent on poor or inadequate case management (see *Loughlin v Singh & Ors* [2013] EWHC 1641 (QB), where Kenneth Parker J reduced the damages under this head of claim by 20%), so that a solicitor needs to keep an appropriate eye on the rehabilitation plans going forward, that does not justify any sort of default or blanket entitlement either.*

Court of Protection statistics (and High Court child DoL orders)

The statistics covering October to December 2023 have been published.

In October to December 2023, there were 8,581 applications made under the MCA 2005, up by 17% on the equivalent quarter in 2022 (7,319 applications). Of those, 37% related to

applications for appointment of a property and affairs deputy. In comparison, there were 13,740 orders made under the MCA 2005, up by 13% on the same quarter in 2022. Of those, 36% related to orders by an existing deputy or registered attorney

Annually, the total number of orders made in 2023 was up 25% compared to 2022. Applications by an existing deputy or registered attorney represented the highest proportion of orders made under the MCA 2005 during 2023, totaling 37% of the 58,530 orders made throughout the year.

Since the Supreme Court clarified the definition of deprivation of liberty in 2014, there has been a significant increase in the number of applications. There were 15 applications in January to March 2013 which increased to a high of 1,744 in July to September 2020. There were 1,569 applications in October to December 2023. Of these, 103 were 'straight' s.16 MCA applications, 497 were applications under s.21A and 969 were applications under the *Re X* process (broadly comparable with the quarter before, when 927 applications were made under the *Re X* process).

Whilst deprivation of liberty orders made saw an increase by 70% from 770 last year to 1,311 in the latest quarter, higher than in previous quarters due to efforts being made by the courts to increase the number of orders made and clear backlogs.

Annually, the total number of applications in 2023 was 6,210 which is similar to the 6,265 deprivation of liberty applications in 2022 and a slight fall from the peak of 6,286 applications made in 2021. Deprivation of liberty orders in contrast almost doubled (increase of 95%) compared to the previous year, with 5,276 orders made during 2023, the highest in its series.

Separately, the statistics show that there were 289 applications made between October and December 2023. Most of these children were teenagers; 57% aged between 13 and 15 and 31% aged between 16 and 18 years.

MENTAL HEALTH MATTERS

Government response to the Joint Committee on the draft Mental Health Bill published

To the surprise of some, given the silence for over a year, the Government published on 21 March 2024 its [response](#) to the [report](#) of the Joint Committee on the draft [Mental Health Bill](#), published in January 2023. Whilst no Bill appeared in the most recent King's Speech, so no legislation will be forthcoming this Parliament, the Government does say in its response that "[w]e will seek to introduce a revised bill when Parliamentary time allows." The responses to the key recommendations are as follows.

Detention criteria: wording

The government agrees that it will be important to clarify the new detention criteria in the code of practice. It will set out in guidance its view on how the terms 'serious harm' and 'likelihood' should be interpreted in practice by decision makers.

The committee recommended that consideration of 'how soon' harm might occur should not be included in the draft bill itself. Their view was that it would be difficult for professionals to assess objectively. They were concerned that it might dissuade potentially beneficial and shorter interventions at an earlier stage that would be in keeping with the principles. The government has agreed to review the wording on 'how soon' harm may occur.

Detention criteria: Part 3 patients

The committee recommended that the changes in detention criteria should be consistent for individuals under either Part 2 or part 3 of the MHA.

The government has not agreed to this change. Their view is that leaving the detention criteria for

Part 3 patients as currently drafted will ensure that, for example, vulnerable neurodivergent offenders in the criminal justice system, who would otherwise go to prison, can continue to be diverted to hospital (where appropriate), where they are more likely to receive more therapeutic and specialist support.

Statutory test for competency for children under 16

The committee recommended that the government should consult on the introduction of a statutory test for competency, or 'child capacity', for children under 16.

The government has not accepted this recommendation. They are concerned that setting out a statutory test for competence in the MHA could potentially put under 16s in a more complicated position, particularly those assessed as having competence to consent to decisions under the MHA definition but who would be considered not to have competence using the existing test of *Gillick* of competence, or vice versa. Their view is that the best place to set out how practitioners should assess children and young people's competence and capacity under the Act is in the code of practice.

Advance Choice Documents (ACDs)

The committee recommended that there should be a statutory right for patients who have been detained under the MHA to request an advance choice document be drawn up. Their view was that this should be offered to everyone who has previously been detained, as recommended by the independent review.

The government has not accepted this recommendation. It supports placing a duty on services to carry out activity in relation to ACDs (the precise meaning of this phrase is somewhat obscure) as opposed to introducing new rights for individuals to request an ACD. They think that

this approach is likely to be more effective as, rather than the onus being on individuals to 'request' to create an ACD, it will be on services to take action. They agree that a mechanism to store ACD information digitally is the best means of ensuring that they can be shared easily and readily accessed by the relevant professionals at the point of need.

Mental Health Tribunal: role in challenging treatment decisions

The committee agreed with the Independent Review that a mental health tribunal (in a slimmed down a form) should be able to consider whether a patient is entitled to challenge their treatment plans, if requested, following a Second Opinion Appointed Doctor (SOAD) review of their care and treatment plan or a major change in treatment. They recommended that the government amend the draft bill to allow for pilots in the first instance.

The government has not accepted this recommendation. They do not think the tribunal should be able to make determinations about whether an individual clinical judgement about treatment, made in good faith, is right or wrong in a particular case.

Interface of the MHA and the MCA

The committee recommended that the government review the interaction between the two pieces of legislation. In particular, it said the government should review the use of the MCA to authorise admission to, and treatment in, mental health units.

The government said it will continue to consider the interface between the MHA and the MCA as it implements mental health reforms. It will also continue to engage with stakeholders to understand what support and guidance could help improve application of the interface. It will not be considering concerns the committee

expressed in relation to LPS as the government has decided to delay LPS beyond the lifetime of this Parliament.

Principles

The committee recommended that section 118 be replaced with a new section, requiring the Secretary of State to draw up the code of practice having regard to and including the principles set out in the independent review: choice and autonomy, least restriction, therapeutic benefit and the person as an individual.

The government has said that the new principles will be clearly set out up front in the next revision of the code of practice. Their view is that this will make it clear to practitioners that the recommended principles should inform all decisions made under the Act.

Appointing a Nominated Person: role of Approved Mental Health Professionals (AMHPs)

The government accepted the recommendation to work with AMHPs to improve the practicalities around appointing a nominated person in the legislation. They intend to amend the Bill in order to improve the final provisions.

Short-term emergency detention power

The committee recommended that the government should consult further on a short-term emergency detention power, and whether this would provide greater legal clarity to clinicians and accountability for what is happening in A&E services.

The government accepts that there may be a need to provide greater legal clarity to clinicians in A&E. It will continue to engage with stakeholders to understand how the current legal framework is being applied and what, if any, legislative changes may be required.

Use of the MCA to deprive people with learning disabilities or autistic people of their liberty in inpatient mental health units

The committee recommended that the government should urgently review the operation of the MCA, with a view to amending the deprivation of liberty safeguards so they cannot be used as an alternative route to the MHA to deprive people with learning disabilities or autistic people of their liberty in inpatient mental health units for lengthy periods of time.

The government said it does not believe that it is always inappropriate for the MCA to be used to authorise a deprivation of liberty for the treatment of mental health conditions. In certain circumstances, where a person lacks the relevant capacity but is not objecting to admission to hospital or treatment, they think it may be the most appropriate option.

The government notes the concern of the committee that Deprivation of Liberty Safeguards will continue to be available to apply to some people with a learning disability and autistic people when the Bill is implemented. They are aiming to reduce the scope of the MHA to detain people with a learning disability and autistic people without a co-existing psychiatric illness.

The government will review the impact of changes to the detention criteria with regard to people with a learning disability and autistic people, with the aim to ensure detention in hospital is only used where there is a direct therapeutic benefit to the person, and not simply a displacement from the MHA to the DoLS.

Discharge from mental health care: making it safe and patient-centred

The Parliamentary and Health Service Ombudsman (PHSO) has published a new report,

'Discharge from mental health care: making it safe and patient-centred.' The PHSO analysed more than 100 complaints investigated from 2020 to 2023 involving failings in mental health care, finding that "[c]omplaints related to discharge and transitions in care emerged as common themes across these cases." The report identifies common failings in care:

Failings in patient, family and carer involvement in discharge planning

'The most common failing we see in our casework involving discharge planning in mental health services (and in our health casework more broadly) is the involvement of patients, their families and carers in decision-making. Patients' own views are sometimes not fully considered when services are making decisions about the risk of discharge from inpatient care... We cannot underestimate the importance of communicating effectively with families and carers about the day discharge happens. If families are not expecting discharge, or are unable to prepare for it, then patients are not given the best chance of being able to stay at home with the right support. The cases we have investigated show where the duty to take a person-centred view of discharge has not been met. The planning for where an individual is being discharged to and their support system beyond the hospital, including signposting to voluntary and community sector organisations, has not been good enough. To break the readmission cycle, a joined-up view of the social factors involved in this transition is just as important as looking at the physical or mental health aspects.'

Poor record-keeping: *'One of the central parts of the previous NHS Care Programme Approach (the standard for coordinating care around the needs of mental health service users), which was in place until September 2019, was*

having a written care plan that is jointly agreed with members of the multidisciplinary team, GP, individual patient, carers and any other relevant agencies...Care plans that are missing or not managed well can have significant negative consequences for care, at that time and in the future. Poor management of care plans also affects family, carer and patient involvement in planning for discharge. When complaints about care are made, poor records can worsen the distress for complainants and their families. They can be left not knowing how decisions were made and whether a different outcome could have been possible. Without adequate records, we can also be prevented from getting answers to our questions and making sure accountability and learning can take place.'

Poor communication between clinical professionals and teams in planning transfers of care *'Discharge from mental health services or transfers of care usually involves multiple teams and professionals. This means decision-making can be incredibly complex and challenging. Effective communication between professionals who understand the aims and potential risks of discharge is vital to make assessments and planning as comprehensive as possible. Poor joint-working across clinical professionals, and between physical and mental health expert teams, results in quick readmission. This shortfall is especially severe in the case of eating disorders where cross-team, and sometimes cross-trust, management is vital.'*

The report also makes recommendations 'about how good discharge should be carried out and the wider values that guide discharge care':

1. We note the Department of Health and Social Care's (DHSC) national

statutory guidance on discharge from mental health settings. As it is implemented, DHSC and NHS England must engage with people and services to assess the impact the guidance has on them. In particular, they must make sure that Integrated Care Systems account for the different professionals that should be involved in the discharge multi-disciplinary team (MDT). To make sure transitions of care consider a patient's full condition and situation, an MDT must be involved in discharge planning and delivery. This team should include representatives of the different points in a patient care pathway. This will create a 'safety net' of care around a person when they leave an inpatient setting. The MDT members should be seen and referred to as equal partners in someone's care.

2. NHS England should extend the requirement for a follow-up check within 72 hours of discharge for people from inpatient mental health settings to include people discharged from emergency departments.

3. NHS England and integrated care boards (ICBs) should make sure that people who are being discharged from mental health settings can choose a nominated person to be involved in discussions and decision-making around transitions of care.

4. NHS England should make sure that patients and their support network are active and valued partners in planning transitions of care and are empowered to give feedback, including through complaints.

5. The Government must show its commitment to transforming and improving mental health care by introducing the Mental Health Bill to Parliament as a priority.

The Report also expressed disappointment that reforms to the Mental Health Act have been indefinitely delayed, and called on the Government to take action:

One of the major failings identified in our casework around discharge is the lack of involvement of families and carers around important decisions. Enshrining this in law would go some way to building the foundations for discharge care and planning that puts people, their carers, loved ones and safety at its heart. We are disappointed by the lack of government progress to bring the desperately needed proposed reforms into law. The long overdue Mental Health Bill is an opportunity to overhaul the way the system works when people are in a mental health crisis and make it fit for the twenty-first century. Mental health campaigners have worked tirelessly for the reform of this law. Their voices must not go unheard, and we will continue to support calls for reform.

The report is worth a closer read, not just for the other resources it points to - the Department of Health and Social Care's 'Suicide prevention in England: 5-year cross-sector strategy' in published September 2023, and Rethink Mental Illness' Getting Started: lessons from the first year of implementing the Community Mental Health Framework' - but also for its cut-out-and-keep table of which bodies are responsible for which mental health complaints – a tangled web which in and of itself seems to suggest reform is well overdue. (see paper p.12).

CQC Monitoring the Mental Health Act in 2022/20223

CQC published on 21 March the 2024 its latest [report](#) on the monitoring of the MHA 1983 in England. Key findings included that:

Workforce retention and staffing shortages remain one of the greatest challenges for the mental health sector, affecting the quality of care and the safety of both patients and staff.

Longstanding inequalities in mental health care persist. More work is needed to address the over-representation of Black people detained under the MHA and to prevent prolonged detention in hospital for people who need specialist support.

Despite additional investment, rising demand and a lack of community support means that children and young people face long waits for mental health support, and a lack of specialist beds means they continue to be cared for in inappropriate environments.

It is promising that people, including staff, are aware of the drivers that can lead to a closed culture developing. But we are still concerned that too many abusive and closed cultures persist in mental health services.

Research corner: an RCT into open doors on psychiatric wards

A interesting article appeared recently in the Lancet Psychiatry describing the results of a randomised control trial that must have been a challenge to get ethical clearance for: *Indregard, A. M. R., Nussle, H. M., Hagen, M., Vandvik, P. O., Tesli, M., Gather, J., & Kunøe, N. (2024). Open-door policy versus treatment-as-usual in urban psychiatric inpatient wards: a pragmatic, randomised controlled, non-inferiority trial in Norway.*

A Norwegian team conduct a controlled trial to compare the use of coercive practices in open-door psychiatric wards and 'treatment-as-usual' (locked) wards in an urban hospital setting. 556 patients were randomly allocated between the different types of settings, and the primary outcome measured was 'the proportion of patient stays with one or more coercive measures, including involuntary medication, isolation or seclusion, and physical and mechanical restraints.' The trial found that 'the proportion of patient stays with exposure to coercion was 65 (26.5%) in open-door policy wards and 104 (33.4%) in treatment-as-usual wards...with a similar trend for specific measures of coercion. Reported incidents of violence against staff were 0.15 per patient stay in open-door policy wards and 0.18 in treatment-as-usual wards. There were no suicides during the randomised controlled trial period.' The authors consider that '[t]he open-door policy could be safely implemented without increased use of coercive measures. Our findings underscore the need for more reliable and relevant randomised trials to investigate how a complex intervention, such as open-door policy, can be efficiently implemented across health-care systems and contexts.'

Government response to the rapid review into data on mental health inpatient settings

On 23 January 2023, the government launched an independent 'rapid review' into mental health patient safety, chaired by Dr Geraldine Strathdee. The purpose of the rapid review was to produce recommendations to improve the way data and information are used in relation to patient safety in mental health inpatient care settings and pathways, including for people with a learning disability and autistic people. The report was published on 28 June 2023. The Government's response was published on 21 March 2024, including a set of steps to gather better quality data, overseen by a ministerial-led bespoke steering group to oversee a work programme.

THE WIDER CONTEXT

Principles of care in practice

Re YR (Deprivation of Liberty - Care Order - Principles of Care) [2024] EWHC 564 (Fam) (Family Division (Lieven J))

Article 5 ECHR – children and young persons – family – public law

Summary

This matter related to JR, a 16-year-old boy who had diagnoses of Autism Spectrum Disorder and Attention Deficit Hyperactivity Disorder. The court considered applications to make a care order and to authorise JR's deprivation of liberty in a registered placement. The local authority sought to withdraw its application for a care order, but this was opposed by the Child's Guardian. All parties agreed that the court should authorise JR's deprivation of liberty.

JR had experienced a traumatic early life and had been adopted at the age of 4. *"In March 2021 the parents raised concerns that JR, then aged 13, was beyond parental control by reason of his physically aggressive and sexually inappropriate behaviours that were placing them and other members of the household at risk. I note from the chronology of criminal justice involvement that even by this early stage there had been a number of occasions when the police were called because of JR's behaviour"* (paragraph 5).

JR was accommodated under s.20 Children Act 1989 from April 2021, initially at a residential school. The school gave notice on the placement in October 2022 on the basis that JR was trying to cause fires and was verbally abusive and aggressive. He was then cared for in a series of ad hoc placements, ultimately moving to an unregistered placement with 'X Provider' in May 2023. A deprivation of liberty authorisation was obtained, but the provider was not willing to

impose the restrictions in place. JR frequently absconded and placed himself and others at risk of harm.

The matter came before Lieven J in 2023 due to concerns that because there were no care proceedings, *"it was not possible to properly consider JR's wider welfare interests and to obtain a psychological assessment of his needs. We were also concerned that despite the palpable unsuitability of his placement with X Provider, not least because of their inability to prevent his absconding and putting himself at risk, no progress had been made in finding another placement"* (paragraph 10). Lieven J noted that *"[a]lthough I fully accept the difficulty of finding suitable placements for children as challenging as JR, it was the clear view of HHJ Walker, the Guardian and myself, that the LA were tolerating an inappropriate and unsafe placement for far longer than should have been the case"* (paragraph 10).

The local authority issued public law proceedings in October 2023. The evidence set out that *"throughout October – November 2023 JR was regularly absconding from the placement with the DoLs not being imposed in any meaningful way. In reality, reading those statements, JR was simply doing as he pleased, including threatening staff, abusing them and there are various reports of him carrying a knife. It was entirely clear that the staff were incapable of controlling JR. There were also a series of racially aggravated incidents, both in the property and in public places"* (paragraph 12). There were also reports of JR being sexually exploited. A registered placement, 'Z Provider', was found and JR moved there in late January 2024, with the intention that he will remain until his 18th birthday. His behaviour appeared to have improved in this setting. There had been some conflict as between the local authority and JR's parents about whether they could take him on a

skiing holiday shortly prior to his move to Z Provider. While this was ultimately resolved by agreement, JR's parents had told him about the planned holiday and he had become very distressed when he was prevented from going.

In the public law proceedings, the court obtained a psychological report from Dr Bryn Williams. Lieven J cited this report at length in her judgment "because much of it resonates in many cases concerning children and young people subject to DoLs orders" (paragraph 29). At paragraph 32, Lieven J set out how Dr Williams emphasised the need to help JR find his own identity and build on his strengths:

"3.46. In general, across all environments there needs to be a strategic Approach – First and foremost, young people with non-verbal weaknesses have strengths and the most important recommendation is to find those strengths, to build on them, use them, cherish and celebrate them. Finding a place for [JR] in the world has to be a long-term priority and using his strengths will help him achieve this to the best of his ability. It is so normal for us to focus on what is going wrong, but we are more likely to succeed if we focus on what is good and right. For example, quite often [JR's] left brain is working far more efficiently than his right brain, so be creative, verbal, and use his strengths to master any weaknesses. I observed him talking to himself frequently during the assessment. This is a key marker for everyone that he needs to talk about everything to be able to process and problem solve those things that are expected of him.

3.47. Managing [JR's] Anxiety – Perhaps the greatest challenge for [JR] is coping with his anxiety, which has grown to such an extent he sometimes feels quite self-destructive. Engaging [JR] in psychological therapies to manage anxiety is likely to be necessary, and the most effective approach from clinical experience appears to be helping him to maintain a close, stable and reliable relationship with a therapist who he can revisit when necessary, supported by attuned parenting and a special person at school. Short-term, one-off interventions are less helpful unless they are augmented by repeated intervention and a solid therapeutic relationship. He will struggle to retain what he has learned, but do not give up."

33. Dr Williams then sets out under a series of headings, JR's needs and the support and services that he requires. These cover managing his anxiety; consistency and clarity; supporting social interaction; helping him to overcome barriers to new learning; visual spatial strategies; motor co-ordination and sensory integration; and helping him to manage new and complex situations.

34. Although this report is specific to JR, there are many elements which apply to many of the children who are subject to DoLs orders.'

The judgment also cited the recent Nuffield Family Justice Observatory Report on Principles of Care for Children with Complex Needs, which echoed these findings. The judgment reproduced the summary sheet of the principles at paragraph 36:

<i>5 Principles of Care</i>	<i>What children currently experience</i>
<i>1. All children need valued, trusted relationships. They should be actively supported to maintain relationships with people that are important to them.</i>	<i>Perpetually disrupted, often temporary, non-robust relationships with insufficient attention paid to the relationships that children identify as important to them.</i>
<i>2. Every child should have a holistic, multidimensional, high-quality assessment of their mental health, social care, education, and well-being needs. This should be followed by a detailed formulation and plan of the interventions and support required to address the child's short, medium, and long-term needs. This should be co-produced with the child and their family.</i>	<i>Repeat assessments that are siloed. No holistic care. Undiagnosed and unmet treatable mental health needs.</i>
<i>3. Long-term support that is tailored to the child's needs: Services and professionals working with the child should be flexible and dynamic, and able to respond to changing circumstances. All decisions about a child's care should explicitly consider their short, medium, and long-term needs.</i>	<i>Short term crisis interventions, focused on managing risk rather than supporting healthy development. Services unable to flex to changing circumstances.</i>
<i>4. Children should be supported by experienced staff within multidisciplinary teams who are highly</i>	<i>Poorly paid and undervalued staff, often inexperienced.</i>

<i>attuned to their needs. Staff with such skills should be the most highly trained, rewarded and valued in the children's sector.</i>	<i>Services in dispute over who has responsibility for a child.</i>
<i>5. Children should be able to express a view about what happens to them and be listened to. Decisions should be clearly communicated to them and (if safe to do so) their family.</i>	<i>Children have limited agency in their day-to-day lives and decisions made about them.</i>

Lieven J observed that:

37. These principles of care are what every child subject to a DoLs needs, and against which any proposed provision for these children should, in my view, be tested. It would be unrealistic to suggest that placements could simply be rejected because they do not meet these principles. It is extremely well known, and recorded in numerous judgments, that there is a dire shortage of suitable placements for children with complex needs who are subject to DoLs restrictions. However, the Principles of Care are important because they set out the benchmarks against which all provisions should be tested, and which all those involved in these cases should be trying to meet.

In JR's case, Lieven J considered that while his current placement appeared to be appropriate, "he has in the recent past suffered from many of the problems set out in the NFJO Report" (paragraph 38). Lieven J decided in this case that it was necessary and proportionate to make a Care Order notwithstanding the local authority's wish to withdraw its application in order to give certainty as to how decisions will be made about JR's care, and because the court considered that there would be greater oversight if JR were under a care order. Lieven J noted that

44 [...] The reality is that the level of oversight of JR was significantly increased when HHJ Walker and I became involved. My judgement is that in practical terms, rather than necessarily legal theory, a Care Order will give greater confidence in the LA taking responsibility for his care. Although the Independent Reviewing Officer is involved even if JR is only accommodated under s.20, it appears that there is more likely to be liaison with Cafcass if there is a Care Order in place. However I accept that the likelihood of this happening is actually very slight.

45. Although the services would probably be the same whether or not there is a Care Order, I am confident that the practical level of involvement and oversight will be greater. This is particularly important in a case such as JR's, where his needs are complex and difficult to meet, and he is approaching his 17th birthday.

46. In reaching this conclusion I am influenced by the fact that without the intervention of the Court and the Guardian, it seems quite possible that JR would have been left in inappropriate placements with a lack of attention to his holistic needs. Whatever the legal position may be, the reality is that the LA had a prolonged period when they did not focus on JR's needs. Without the LA holding parental responsibility I am very concerned that disagreements with the parents may again lead to delays in the provision of the necessary support.

Comment

The judgment is an important reminder of the potential for harm which can arise when children are placed in inappropriate settings and have

inappropriate care. It is a tragically common state of affairs that children in crisis are placed in hastily arranged, ad hoc settings because there is simply nowhere else that is available for them to live and have even the most basic care. The NFJO report emphasises the potential for harm when children's care arrangements simply become a process of 'crisis management' with care delivered by an ever-changing set of professionals and carers who often lack the skills, training and support to support their growth and development. The stark paucity of appropriate care for children with complex needs has been the subject of dozens of reported judgments by High Court judges over the last decade, denouncing the systemic failures to plan and make provision for children like JR, without any evidence that the situation is improving. It is stunning failure to care for some of the most vulnerable children in society which is rightly brought in the spotlight by judgments such as this.

We would note that the comments of Lieven J that she felt she could not obtain sufficient evidence and consideration of JR's welfare without care proceedings being brought. We would note that this in some respects reflects the differences in the way that cases of this nature are often considered by the former 'National DOLS Court' and the Court of Protection. We would note that in complex Court of Protection cases, it is far more typical to bring in the level of detail and multi-professional involvement seen here only after the care proceedings had started, and to take a consideration not only for the immediate situation of the person, but the longer-term risks and benefits of the person of care arrangements.

Litigation capacity – a rare snapshot

For some reason, the judgment in the directions hearing in Tonstate Group Ltd v Wojakovski & Ors [2022] EWHC 448 (Ch) has appeared on Bailii. It

is of interest as a rare reported snapshot of a civil court grappling with the question of how to determine whether or not a party (in this case, the defendant) has the capacity to conduct the proceedings in question. Precisely what legal representatives and courts are supposed to, and how they are supposed to do it, is an issue under the spotlight at the moment. The Civil Justice Council's consultation on its [proposals](#) for determining capacity in civil proceedings has just closed. As part of that consultation process, a one day seminar was held, the minutes of which can be found [here](#).

The PHSO and DNACPR recommendations

An important (but depressingly familiar) report from the Parliamentary Health Service Ombudsman on DNACPR decision making was published on 14 March 2024. The full report, called *End of life care: improving DNACPR conversations for everyone* can be found [here](#).

Its key findings include:

- a lack of accessible information given at the time or before DNACPR conversations take place
- issues with record-keeping and documenting decisions, with up-to-date information not following a patient through the medical system
- a lack of public awareness about CPR and who is responsible for making a DNACPR decision.

For Alex's video on how to get advance care planning right, see [here](#). and for a discussion with Dr Zoë Fritz about advance care planning and ReSPECT, see [here](#).

It is slightly unfortunate that in an otherwise excellent report, the legal position in relation to DNACPR notices is slightly misstated (and the

dread term 'next of kin' appears in the context of those lacking capacity to participate). As the report notes, the *Tracey* case made clear that it is a legal requirement for doctors to consult with a patient about a DNACPR decision if they have capacity. However, the report does not go on to quote this passage from the Court of Appeal's judgment:

54. There can be little doubt that it is inappropriate (and therefore not a requirement of article 8) to involve the patient in the process if the clinician considers that to do so is likely to cause her to suffer physical or psychological harm. There was some debate before us as to whether it is inappropriate to involve the patient if the clinician forms the view that to do so is likely to distress her. In my view, doctors should be wary of being too ready to exclude patients from the process on the grounds that their involvement is likely to distress them. Many patients may find it distressing to discuss the question whether CPR should be withheld from them in the event of a cardio-respiratory arrest. If however the clinician forms the view that the patient will not suffer harm if she is consulted, the fact that she may find the topic distressing is unlikely to make it inappropriate to involve her. I recognise that these are difficult issues which require clinicians to make sensitive decisions sometimes in very stressful circumstances. I would add that the court should be very slow to find that such decisions, if conscientiously taken, violate a patient's rights under article 8 of the Convention.

The report also states (at page 13) that "[p]atients will be resuscitated unless they have a DNACPR notice on their records." That is a somewhat problematic statement. Absent a valid and applicable decision to refuse CPR, then, assuming that there is a prospect that CPR would actually work, a decision whether or not to

start it is always a best interests decision. If there is in place a DNACPR notice, then the person making the decision on the spot will be strongly guided by the recommendation (but could still not follow it if there were a good reason not to). If no DNACPR notice is in place, then the person making the decision will have to determine what is in the person's best interests on the basis of the information that they have at the time. That is likely, but not inevitably, going to be that resuscitation should be attempted. For a discussion of the position in relation to paramedics attending at home, see here. We also note in this regard that NHS England has recently published [guidance](#) to support the decision-making process of when not to perform cardiopulmonary resuscitation in prisons and immigration removal centres, addressing the issue of *"inappropriate resuscitation following a sudden death in a prison, immigration removal centre (IRC), or residential short-term holding facility in the absence of a signed do not attempt cardiopulmonary resuscitation (DNACPR) document. It is designed to support prison, detention, and healthcare staff in making a decision as to whether resuscitation would be futile and therefore compromise the dignity of the deceased individual."* That guidance is equally applicable in other settings.

These two points are not meant to sound nit-picking, but simply to bolster what is otherwise an excellent, evidence-based report, with whose conclusions it is impossible to disagree.

Assisted dying / assisted suicide – concrete British realities

Reading some of the recent media coverage of the issue of assisted dying / assisted suicide, people could be forgiven for thinking that resolving the debate is a simple matter. Whatever's one's views about the principle, that implementation is not going to be simple can be

seen from [proposals](#) put before the States Assembly in Jersey on 22 March 2024 to enable a decision to be taken whether to progress legislation providing (as they describe it) for assisted dying.

The proposals put before the States Assembly do not set out legislation, but, running to some 245 pages, they set out in very great detail much of what is required for States Assembly to be able to decide whether to take the proposal for legislation forwards. Any such legislation would be very significantly longer than the 14 clause bill before the Tynwald in the Isle of Man, the 13 clause [bill](#) that was put most recently before the House of Lords in England, or the 33 clause [bill](#) introduced in Scotland in March 2024, and discussed by Adrian in the Scotland section of this report. As the proposals note at paragraph 582, "[g]iven the detail and complexity of these proposals, it is anticipated that the law drafting process will take 12-18 months. It is anticipated that debate on the draft law will take place before the end of 2025, but this may be subject to change."

The proposals also include details of matters that, to date, have been the subject of little detailed 'operational' consideration in the British context. Some of these might be said to be limited to the specific proposals in Jersey, which (as discussed [here](#)) go further than any proposals advanced in England & Wales or Scotland). But the majority of the matters are of relevance to any model. The proposals cover such matters as:

1. The components of the decision-making capacity required, the proposals specifically proceeding on the basis of a presumption of capacity, a requirement to support the person to make a decision, and an approach to fluctuating capacity which provides that:

[a] person with fluctuating capacity may be assessed for capacity on more than one occasion. If the person can demonstrate a voluntary, clear, settled and informed wish for assisted dying and that they have decision-making capacity to make the request for assisted dying one any one occasion, the assessing doctor is able to determine that at the point of assessment they did have decision-making capacity (paragraph 301)¹⁷

2. A discussion of precisely how to identify 'unbearable suffering;'
3. What a tribunal might look like (required for purposes of the second, unbearable suffering route), and what an appeal route from such a tribunal might look like;
4. The actual process from start to finish, including addressing the circumstances where complications set in;¹⁸
5. Organ donation;
6. Regulatory obligations on healthcare practitioners;
7. How to integrate assistance with dying within the Jersey healthcare system (the proposals rejecting a 'civic' model such as that in Switzerland);
8. The scope of the ability of individuals / bodies to decline to provide assistance on the basis of objection (going more widely than just conscientious objection);

¹⁷ For more on capacity, see [here](#).

¹⁸ As the report notes at paragraph 475, "[i]n Western Australia, for example, 2.7% of assisted deaths in 2021-22 reported complications. All complications related to practitioner-assisted oral ingestion and involved regurgitation/vomiting, coughing or an extended length of time for the substance to take effect."

¹⁹ The proposals note (at paragraph 562) that: "[e]vidence from other jurisdictions suggests that assisted

9. The fact that simply making assisted dying / suicide legal is not actually the end of the story, the proposals noting at paragraph 136 that:

It is possible that the Jersey Assisted Dying Service may be unable to recruit or contract the necessary staff (although it is important to recognise that this eventuality has not occurred in any other jurisdiction that permits assisted dying). In the event this were to happen, whilst assisted dying would be permitted in law, there would be no service and hence people could not have assisted deaths in Jersey.

Therefore, in placing a duty on the Minister to provide the Jersey Assisted Dying Service, the law must also provide that the Minister can only do so if the service can be appropriately and safely staffed.

10. Costs;¹⁹
11. The numbers of those who might seek assistance;
12. How insurance companies will respond; and
13. Implementation requirements.

Many might find useful the summary of the risks identified to date, and the potential response, controls or mitigation that is to be found in the table at paragraph 579. Again, whilst some of these may be relevant to the approach being advanced in Jersey, very many are equally

dying could result in a cost neutral position (or cost savings) in overall health and care expenditure in the long-term.⁵⁰ However, such an intent does not accord with the core principles of these assisted dying proposals and hence there has been no attempt to quantify any potential cost reductions in other areas of health and care spend in Jersey."

relevant to the terminal illness / person carrying out the final act model which has formed the focus of most attention in England & Wales, and Scotland.

The proposals also helpfully include scenarios which concretise matters. Some may find particularly useful to tease out how they feel both about assisted dying / assisted suicide more broadly and about the particular model being advanced in Jersey Scenario 3 (Sean, a 59 year old with a moderate learning disability, and who has recently been diagnosed with vascular dementia) and Scenario 10 (Sadie, 31, living with anorexia since 15, and diagnosed with end-stage heart failure as a result of her anorexia).

The recent Health and Social Care Committee [report](#) to the Westminster Parliament provided invaluable evidence for those wishing to inform themselves in relation to the assisted dying / assisted suicide debate. The Jersey proposals are very important not just for those on Jersey, but for those in England & Wales (and, indeed, Scotland) who want to understand what is actually involved in any move towards assisted dying.

SCOTLAND

Assisted Dying Bill published

On 27th March 2024 the Assisted Dying for Terminally Ill Adults (Scotland) Bill was introduced in the Scottish Parliament by Liam McArthur, Liberal Democrat MSP for Orkney. It and the accompanying documents have been prepared by Mr McArthur's team, working in conjunction with the Parliament's Non-Government Bills Unit. What stands out immediately is the high quality of drafting throughout, the massive but well organised amount of supporting information,²⁰ and the clarity and impartiality with which it has been presented. It is not for a commentator, or for this Report, to take a stance in general terms on whether this Bill is "a good thing" or not. I seek to provide an outline of the current human rights and public opinion context; the extent of difference from previous similar proposals, which appears to be significant, with a narrower scope and – within that scope – more robust safeguards; and an outline of the main provisions of the draft Bill, narrated selectively. Of particular interest to this readership is likely to be consideration of the robustness of the intended safeguards, and the provisions regarding proxies, those being likely to be points of focus for professional comment, whether individually or on behalf of professional organisations which would be likely to be neutral as to the merits of the proposal, but to consider carefully the comments that they might wish to make on the content and practical operation of the Bill if it were to be passed.

²⁰ It is a coincidence, but relevant, that only a few days before introduction of the Scottish Bill, a Proposition on Assisted Dying was presented to the States Assembly of Jersey. See the coverage by Alex in the wider context section of

One starts with the general observation that if we are in an environment where it is increasingly accepted that professional and ethical responsibilities should be based in concepts of human rights, including rights to autonomy and self-determination where these do not impinge on the rights of others, there has to be a clear distinction between private views applicable to oneself, and public acknowledgement that one's own right to take one view implies acknowledgement of the right of others to take either the same or a different view.

For many practising lawyers there may also have been uncomfortable experiences, such as I myself have had, of being consulted by a client with a progressive terminal condition who gave very rational reasons why he feared the final stages, and asked whether anyone assisting him to hasten his inevitable death would be committing a crime. The answer, of course, had to be yes. His response: *"So the law forces me to contemplate ending my own life while I am still able to do so, which would be sooner than I would otherwise wish to?"* A pragmatic observation has to be that the availability of cutting short the extreme distress of a slow death can be a great comfort to those facing that prospect, even if they do not in fact ever take up the option; and indeed can make them more content to accept all available palliative care and more relaxed about deferring decisions such as this Bill would make available. There are of course likely to be those who may listen politely to all of that, but then assert strong arguments in principle against facilitating that option for anyone. One can only hope that such arguments will avoid lurid misleading headlines, and will rationally and

this Report. Proposed as a preliminary to any legislative process, in its 245 pages it addresses carefully and in detail a wide range of relevant issues.

courteously address what the present Bill actually does propose, and not what it doesn't.

Among Mr McArthur's reasons for proposing the Bill, as narrated in the Policy Memorandum, is that: "The current legal position is unacceptably unclear as there is currently no specific legislation in Scotland which makes assisted dying a criminal offence, yet it is also possible to be prosecuted for murder or culpable homicide for assisting the death of another person." One of the purposes of the Bill is that it "improves legal clarity by making it lawful for a person to voluntarily access assisted dying if they meet the various criteria set out in the Bill". It provides "for health professionals to assist in that process, while continuing to ensure that assisted death outwith the provisions of the Bill remains unlawful." As we shall see, the nature, extent and frequency of medical involvement and safeguards is a particular feature of the Bill. Against the above background, the Bill would establish a lawful process for an eligible person to access assisted dying, "which is safe, controlled and transparent, and which [Mr McArthur] believes will enable people to avoid the existential pain, suffering and symptoms associated with terminal illness, which will in turn afford the person autonomy, dignity and control over their end-of-life". Mr McArthur "believes that the current de facto prohibition on such assistance has been proven to be unjust, unsafe, and unacceptable, causing needless suffering for many dying people and their families".

That there have been three previous proposals "related to this general policy area" is to an extent misleading. In 2005 there was a public consultation on a draft proposal, a final proposal to introduce a Bill was lodged, but it failed to gather sufficient parliamentary support to enable it to be introduced in the Parliament. Bills introduced in 2010 and 2013 both fell at Stage 1. The Policy Memorandum asserts that: "*There are*

several key and fundamental differences between this Bill and the previous Bills introduced in the Parliament, particularly in the details of the process for accessing assisted dying and the extent of the safeguards in place to protect those involved. In addition, previous Bills focused on the decriminalisation of providing assistance to a person to end their life, but did not establish a legal, health professional led process for assisted dying to take place."

The 2010 Bill would have permitted access to assisted dying not only by a person who is terminally ill, but also a person who was "*permanently physically incapacitated to such an extent as not to be able to live independently and finds life intolerable*". The 2013 Bill limited access to those with an illness, from which there was "*no prospect of any improvement in the person's quality of life*", that was either "*terminal or life-shortening*", or a condition that was, for the person, "*progressive and either terminal or life-shortening*". Mr McArthur's Bill only permits access for those who have an advanced and progressive terminal illness which is expected to cause their premature death.

The Policy Memorandum contains a significant amount of comparative analysis from other parts of the British Isles (including, for example, Jersey and the Isle of Man) and internationally. This includes an analysis of differences in the methods of assistance provided in different countries across the world.

A relevant factor is the extent to which public opinion has shifted. The Policy Memorandum narrates various reputable polls over the period of 2019 – 2023 showing support for assisted dying ranging from 72% to 87%. The lowest figure of 72% has to be set against opposition from 14%, and another 14% "don't knows" recorded in that poll. There were 14,038 responses (the highest number of responses to

date to a consultation on a Member's Bill in the Scottish Parliament) to Mr McArthur's 2021 consultation on his draft proposal. A clear majority of respondents (10,687 - 76%) were fully supportive of the proposal, with a further 244 - 2% partially supportive.

Regardless of personal views, lawyers are likely to be interested in process and safeguards, including safeguards within the well-known categories in Article 12.4 of the United Nations Convention on the Rights of Persons with Disabilities: protection against undue influence, respect for will and preferences, and so on.

If the Bill as drafted came into force, to be eligible for the process a person must be terminally ill; aged 16 or over; ordinarily resident in Scotland for at least 12 continuous months; registered with a GP in Scotland; and to have the mental capacity to request assistance to end their life. It is interesting that the proposal is for ordinary residence, with ordinary residence for this purpose not defined in the Bill or by reference to other legislation, rather than some other linking factor. It is not obvious why habitual residence was not preferred, for greater clarity where someone has moved to (or back to) Scotland more than 12 months previously. There appear to be differences between Scotland and England & Wales in official guidance on when ordinary residence (for purposes of social work responsibilities) follows a physical move, which could create uncertainty, whereas greater certainty is likely as to habitual residence where a person has moved from England & Wales or elsewhere²¹. Expect this to be addressed if the Bill reaches Stage 2.

It is asserted that the definition of "terminally ill" in the Bill "requires a person to be in an advanced

stage of terminal illness (i.e. close to death)". The Memorandum states that while Mr McArthur "has deep empathy for, and understanding of, people suffering intolerably for many years who are not at the end of life, he believes parameters must be drawn that are most appropriate for the diseases, illnesses and conditions affecting the people of Scotland, and after careful reflection decided that assisted dying for people in the end stages of life is most appropriate. It is not the intention that people suffering from a progressive disease/illness/condition which is not at an advanced stage but may be expected to cause their death (but which they may live with for many months/years) would be able to access assisted dying." That appears to be one of the key limitations which could shift the boundaries of acceptability; with the possibility, again, of proposed amendments at Stage 2.

The proposed safeguards are however extensive, requiring two doctors, independently of each other, to determine eligibility. The person must have been informed and preferably have discussed their situation, and the opinions open to them (for example palliative, hospice and other care options), with a registered medical practitioner before deciding to apply. That is just one aspect of extensive requirements to ensure that the person makes a truly informed decision.

The envisaged process includes requirements for a "first declaration" and a "second declaration", with a "period for reflection" between them. The first declaration is a request by a terminally ill adult to be lawfully provided with assistance to end their own life. There is a specified form. The adult's signature must be witnessed by "the coordinating registered medical practitioner" (the medical practitioner first approached by the adult to say that the adult

²¹ Habitual residence is the primary criterion under Hague Convention 2000 on the International Protection of Adults, and also in the private international law of

many states which have not (yet) ratified the 2000 Convention.

wishes to make such a request) and “another person”. There are requirements that both witnesses must see the declaration being signed, and there are disqualification provisions. The “coordinating registered medical practitioner” must carry out an assessment to ascertain whether the adult is terminally ill, is eligible, and made the declaration voluntarily, without being “*coerced or pressured by any other person into making it*”. If satisfied on these points, that practitioner must refer the person to an “independent registered medical practitioner”, who independently assesses the same points. The independent practitioner requires to have “*such qualifications and experience as the Scottish Ministers may by regulation specify*”, not have provided treatment or care to the adult in relation to the terminal illness, and not have any disqualifying relationships, as well as not having been a witness to the first declaration. There are detailed provisions as to the requirements for the assessment, including for discussion with the adult and information to be given to the adult. The first declaration must be recorded in the adult’s medical records, as must other key items.

The normal period for reflection will be 14 days, except where both medical practitioners “reasonably believe that the adult’s death is likely to occur before the end of that period”, in which case it should be a “*shorter period (being not less than 48 hours) beginning with the day on which the first declaration is made*”.

It is open to the adult to cancel the first declaration. If the adult has not cancelled, and if both medical practitioners have carried out the required assessments and made specified statements, then once the period for reflection has ended the adult may make a second declaration, signed and dated by the adult, and witnessed by the coordinating registered medical practitioner, and either another person or the independent registered medical

practitioner. Similar requirements apply. The second declaration must also be recorded in the adult’s medical records. There is, again, provision for the adult to cancel the declaration.

There are provisions for signature of either or both declarations by a proxy, who is able to declare that the adult is unable to sign their own name and has authorised the proxy to sign the declaration. There are detailed provisions regarding this and – perhaps rather surprisingly – a fixed list of who might be a proxy: a practising solicitor, a member of the Faculty of Advocates, or a Justice of the Peace in Scotland. If the Bill proceeds, it might be a matter for debate whether an attorney holding express powers to sign such a declaration should be added, and whether Scottish Ministers should be empowered by regulation to add to the list.

Following provisions of the Bill regulate the provision to the adult of “*an approved substance with which the adult may end their own life*” by either the coordinating registered medical practitioner or an authorised health professional. The coordinating registered medical practitioner or authorised health professional must remain with the adult until the adult decides whether to use the substance, and if so, until the adult has died. If the adult decides not to use the substance, the medical practitioner must “*remove it from the premises at which it was provided*”. If the adult uses it and dies, there are detailed provisions about the “final statement” that the medical practitioner must complete. Further provisions include a “conscientious objection” section making it clear that “*an individual is not under any duty (whether arising from any statutory or other legal requirement) to participate in anything authorised by this Act to which that individual has a conscientious objection*”. There are explicit provisions regarding exemption from criminal and civil liability, and also creation of an offence for

coercing or pressurising the adult into making a first or second declaration. The explicit provision for such an offence thus goes further than the consequences of proven undue influence for other purposes. See the published Bill for all relevant provisions, including ancillary provisions, not narrated here, the purpose of this item being to give a general indication, not a detailed narration.

The next step will be for the Parliament to consider in principle, at Stage 1, whether the Bill should proceed to further consideration.

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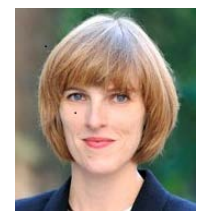
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Conferences

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

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](#).

Adrian will be speaking at the following open events: the World Congress on Adult Support and Care in Buenos Aires (August 27-30, 2024, details [here](#)) and the European Law Institute Annual Conference in Dublin (10 October, details [here](#)).

Peter Edwards Law has announced its spring training schedule, [here](#), including an introduction – MCA and Deprivation of Liberty, and introduction to using Court of Protection including s. 21A Appeals, and a Court of Protection / MCA Masterclass - Legal Update.

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

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