



Welcome to the April 2019 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: an update on the Mental Capacity (Amendment) Bill; the DoLS backlog and the obligations on local authorities; capacity and social media (again); best interests and the 'institutional echo;' and judicial endorsement of the BMA/RCP guidance on CANH.

(2) In the Property and Affairs Report: a major new report on supported will-making;

(3) In the Practice and Procedure Report: a pilot designed to get the Accredited Legal Representatives scheme further off the starting block; the need for the early involvement of the court in medical treatment cases; transparency and committal; and DNA testing and the courts;

(4) In the Wider Context Report: oral care and learning disability; important consultations on criminal procedure/sentencing and those with mental disorders; the dangers of assessing in a vacuum; and a round-up of recent useful research articles.

(5) In the Scotland Report: major developments regarding the Mental Health (Care and Treatment) Scotland Act, the Adults with Incapacity Act and the Adult Support and Protection Act and a Scottish perspective on the English MHA review and compliance with the CRPD;

You can find all our past issues, our case summaries, and more on our dedicated sub-site [here](#). With thanks to all of those who have been in touch with useful observations about (and enthusiasm for the update of our [capacity assessment guide](#)), and as promised, an updated version of our [best interests guide](#) is now out.

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

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HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

Capacity, residence, sex and social media – on the way to the Court of Appeal

With thanks to David Lock QC, we understand that North Yorkshire County Council have been given permission to appeal against the Court of Protection decision of Cobb J in *B (Capacity: Social Media: Care and Contact)* [2019] EWCOP 3 on the test for capacity to decide upon residence. The Official Solicitor has also obtained permission to appeal on the Judge's findings on her capacity in relation to sex and access to social media. The hearing has been expedited and will be on 14/15 May 2019.

LPS update

The very slow-motion game of Parliamentary ping-pong in the final stages of the Mental Capacity (Amendment) Bill continues, with the Bill returning to the Lords on 24 April. At that point, the Lords will have to consider whether to accept the Government's [proposals](#) (accepted by the Commons):

1. Not to have a statutory definition of deprivation of liberty (other than the reference to Article 5 ECHR), and to have guidance in the LPS Code, to be reviewed regularly;
(1) In relation to the provision of information upon authorisation.

For more on the LPS and its implications, see Alex's briefing paper [here](#).

Capacity, best interests and the institutional echo

LB of Hackney v SJF [2019] EWCOP 8 (SJ Hilder)

Best interests – mental capacity – residence – contact

Summary

This case concerned the care and residence of a 56 year old woman with significant physical health problems as well as schizophrenia and a learning disability. She had lived for many years in a first floor flat, shared with her son JJF who is described in the judgment as having his own difficulties, having attended a special needs school, and having been in prison including for assaulting his mother. Health professionals had been unwilling to enter the flat due to hostility and threats of violence from SJF's son and she had ultimately been moved to a care home on an urgent basis. Notwithstanding these problems, SJF wanted to return to her flat to live with her son.

There were practical difficulties in providing care for SF in her flat - she needed 3 insulin injections a day, kidney dialysis 3 times a week, and by the end of the proceedings, her mobility had deteriorated to such an extent that she could only manage a few steps.

Nevertheless, the court was presented with a range of options for SF's care and residence which included a return to her flat, a supported living placement, a care home, and a new ground floor flat. The proceedings had been going on for some two years by the time of the final hearing. SJF contended that she had capacity to make the relevant decisions. and professionals including her IMCA and two psychiatrists involved in DOLS assessments had agreed with her. The Official Solicitor as her litigation friend disagreed, relying on the evidence of the joint expert instructed for the proceedings, and supported declarations being made that SF lacked capacity to decide where to live, what care to receive and whether to have contact with her son, by reason of her mild learning disability. The central issue was whether SF was unable to understand or weigh information about the risk to her health of living with her son, with the negative impact that was likely to have on the ability of health professionals to attend the property to provide care. Was SF unable to understand those risks, or was she simply affording them less weight than the professionals because of her devotion to her son and her concerns as his mother about what would happen to him if he did not live with her? The court accepted the expert's view that

she believes as a mum that her son's behaviour is going to improve. That's not necessarily because of her learning disability – many people in difficult relationships have a positive outlook of their relative's behaviour. But she does not understand the impact of him not being able to provide good enough care...[or] the impact it has on her access to professionals and support mechanisms.

.... SJF's learning disability has "several different effects – it prevents her from understanding the consequences of living with JJF, [it means] she is not able to appreciate the risks of not having appropriate care, [and] it prevents her from generating other possibilities for her son, other than living with her." When questioned by Ms. Hearnden, Dr Rippon said "[SJF] is in a difficult position. I've reflected a lot about whether her wish to return [to her flat] is a lack of capacity or the concerns of a mum. On the balance of probabilities, I believe that learning disability impacts on her decision-making... I don't believe that she understands the impact in the care she'll receive if she lives with her son – and that's secondary to the learning disability... I don't think she adequately understands the impact on her physical health.

Senior Judge Hilder found it was in SJF's best interests, on discharge from hospital, not to return to her flat, despite her strongly held wish to do so:

The magnetic factor in this matter is SJF's need for healthcare by professionals. She is once again taking Novorapid injections, administered twice a day by care home staff; and Lantos injections, administered each morning by district nurses. Additionally her ulcers require frequent dressing and she attend dialysis three times a week. There is no realistic prospect that these healthcare needs could be met adequately or at all if she lives in first floor accommodation or with her son. The effect of failure to meet these needs will clearly be, at best, further and rapid deterioration in her health, and increased hospitalisation.

Comment

This case illustrates the difficulty in making decisions about capacity and best interests where certain familiar factors are present:

- a mild learning disability
- complex physical health needs which fluctuate and change
- a breakdown in relationships which becomes infected by what the judge called 'institutional echo', closing minds to alternative solutions to problems

Though the decision ultimately reached was perhaps inevitable given SJF's deterioration in her physical condition, one cannot help wondering whether a trial period of care at home might have been possible at an earlier date, and whether imposing stricter timetables on COP proceedings might encourage increased use of trial periods even in apparently risky scenarios.

ADRTs, medical obligations and decision-making in relation to CANH

NHS Cumbria CCG v Rushton [2018] EWCOP 41 (Hayden J)

Best interests – medical treatment – advance decisions

Summary

Hayden J has both given clear endorsement to the BMA/RCP [guidance](#) on decisions about clinically assisted nutrition and hydration ('CANH') and reiterated the obligations imposed on medical practitioners in relation to advance decisions to refuse treatment ('ADRTs'). The judgment was delivered in December 2018, but delayed until a month after the individual in question had died.

The application before Hayden J was for the proposed withdrawal of CANH from an 85 year old former nurse, Jillian Rushton. She had sustained a traumatic head injury in December 2015, and then was in in prolonged period of disorder of consciousness, lasting 3 years by the time that the case came to be determined. A year before she sustained the head injury, she had created an ADRT that provided that

"on collapse, I do not wish to be resuscitated by any means," that "I am refusing all treatment. Even if my life is at risk as a result," and that "in all circumstances of collapse that put my life at risk, this direction is to be applied." Although the judgment does not record this, given the way in which Hayden J then approached it, it appears clear that the ADRT must have been witnessed (as is required in respect of one concerning life-sustaining treatment). Mrs Rushton also sent the ADRT to her GP.

On the 21 December 2015, Mrs Rushton fell and suffered a major trauma to her head. It was so significant that she was not expected to survive and she was placed on a palliative care plan. On admission, a naso-gastric tube was inserted to feed her. Hayden J considered that this was *"was done instinctively by conscientious medical staff, whose every instinct would have been to promote her welfare."* When, contrary to how the position appeared upon admission, her condition improved, the NG tube was replaced by a percutaneous endoscopic gastrostomy (PEG) which was inserted at the end of January 2016, in part in order to facilitate her care back at home with her son.

Hayden J considered that it was clear that the insertion of the PEG *"in the circumstances of this case, was an essentially life-sustaining treatment in circumstances where there was little, if any, prospect of meaningful recovery."* He therefore held that *"the initial insertion of the naso-gastric tube was arguably incompatible with Mrs Rushton's wishes. There can be little doubt, to my mind, that the insertion of the PEG was contrary to Mrs Rushton's written decision."*

Hayden J was taken to the clinical notes that provided the background to the decision-making. The ADRT was not available at the hospital, and *"there [was] no reason why it should have been."*

"However, the existence of the document and the identity of the GP came to light. A telephone call was made to the GP at 10.25am of the morning of 26th Jan 2016. In response to a message, the GP contacted the ward. He told them he had checked the systems and that he knew Mrs Rushton and her family. The record of the call reads, "the only ADR (Advance Directive) in place is in regards to do not resuscitate." The GP is reported as having said that he had no knowledge of any other document. There was only one document in existence and, I must infer, that at some point in relaying its contents, it has been incorrectly interpreted. [...] Having heard from Mrs Rushton's family I have not the slightest doubt that she intended that her directive would have applied to the insertion of the PEG.

Largely, it appears, because of the way in which Mrs Rushton's family wished to approach matters, Hayden J did not then go on to examine responsibility for the incorrect interpretation of the ADRT, but noted that her circumstances:

25. [...] *provide an opportunity for this Court to emphasise the importance of compliance both with the statutory provisions and the Codes of Practice, when preparing an Advance Decision. Manifestly, these are documents of the utmost importance; the statute and the codes provide essential safeguards. They are intending to strike a balance between giving proper respect and recognition to the autonomy of a competent adult and identifying the risk that a person might find himself locked into an advance refusal which he or she might wish to resile from but can no longer do so. The balance is pivoted on the emphasis, in the case of life-sustaining treatment, given to compliance with the form*

specified by statute and codes. The Court has highlighted the profound consequences of non-compliance with the requirements: W v M and S and A NHS Primary Care Trust [2012] COPLR 222; Re D 2012 COPLR 493.

26. It perhaps requires to be said, though in my view it should be regarded as axiomatic, that the medical profession must give these advanced decisions the utmost care, attention and scrutiny. I am confident the profession does but I regret to say that I do not think sufficient care and scrutiny took place here. The lesson is an obvious one and needs no amplification. Where advanced decisions have been drawn up and placed with GP records there is an onerous burden on the GP to ensure, wherever possible, that they are made available to clinicians in hospital. By this I mean a copy of the decision should be made available and placed within the hospital records with the objective that the document should follow the patient. It need hardly be said that it will rarely, if ever, be sufficient to summarise an advance decision in a telephone conversation.

Hayden J then turned to the question of whether the continuation of CANH was in Mrs Rushton's best interests in circumstances where it appears that the son who had been providing her almost exclusively with care was opposed to its withdrawal, in particular because he considered her to be responsive.

Professor Wade, an expert in neurorehabilitation, was instructed, and gave evidence to the court. He indicated that he was resistant to identifying Mrs Rushton's condition as "a persistent vegetative state" because "he concluded that what was truly required was a holistic evaluation of her best interests, in the context of her wishes and feelings, in which her level of consciousness played a part." Hayden J observed that:

29 [...] That approach, very much chimes with the guidance issued [...] by the Royal College of Physicians and the BMA: "Clinically-assisted nutrition and hydration (CANH) and adults who lack the capacity to consent". At section 5 of that guidance, consideration is given to decisions concerning CANH in previously healthy patients now in a vegetative state or a minimally conscious state, following a sudden onset of brain injury. I am conscious that the phrase "vegetative state" is distressing to family members, but while it remains a medical term I am constrained to use it. The Guidance is, in my view, an extremely helpful piece of work which reflects the breadth of experience, both in the core group of representatives of the British Medical Association, Royal College of Physicians and General Medical Council as well as the multi-disciplinary advice that was drawn upon. I take the opportunity in this judgment to highlight the following:

5.1 Clinical assessments

Where patients are in Prolonged Disorder of Consciousness, PDOC, (i.e. for longer than four weeks) following a sudden-onset brain injury, providing accurate prognostic information is a very important part of the decision-making process. Assessing levels of awareness – and in particular the prospect of it increasing – however, is not a simple task and there is no single clinical sign or laboratory test of awareness. Its presence must be deduced from a range of behaviours which indicate that an individual can perceive self and surroundings, frame intentions and interact with others. These observations need to be repeated over a

period of time, with specialist analysis of the results. It is essential, therefore, that these patients have a thorough, expert assessment according to the RCP guidelines to provide a detailed evaluation of their level of awareness of themselves or their environment and to record any trajectory towards future recovery or deterioration.

There may be some cases in which there is clear evidence that the findings of detailed assessments will not affect the outcome of the best interests decision because, for example, even the most optimistic prediction of recovery would not constitute a quality of life they would find acceptable. Where this is the case, a decision can be made before these assessments have been completed.

In most cases, while these investigations are being made, careful consideration should be given to reducing or stopping sedating drugs, to ascertain the extent to which they are reducing responsiveness (if at all). This may involve risks, for example of pain or seizures, which can be distressing for those close to the patient. It is crucial that doctors clearly explain the steps they are taking, why they are taking them and what to expect during that time. If withdrawal or reduction of medication is likely to have significant consequences for the patient, the doctor will need to weigh up the balance of benefits and harms between optimal assessment conditions and adequate symptom-control. This will include an assessment of how important a clear diagnosis of permanent VS versus MCS would be for the patient in terms of the best interests assessment.

Diagnosis and prognosis

The perceived importance of obtaining a precise and definitive diagnosis has reduced over time, as it is increasingly recognised, by clinicians and the courts, that drawing a firm distinction between VS and MCS is often artificial and unnecessary. In practice, when assessing best interests, information about the patient's current condition and prognosis for functional recovery and the level of certainty with which these can be assessed is often more important than achieving a precise diagnosis.

Hayden J continued:

30. These paragraphs are apposite. The perceived importance of a definitive diagnosis has reduced over time. As is increasingly recognised by clinicians and the Courts, drawing a firm distinction between vegetative state or a minimally conscious state is often artificial and unnecessary. In practice, when assessing 'best interests' and analysing the information relating to the patient's current condition and prognosis for cognitive recovery, the level of certainty to which these can be assessed is often more important than an actual diagnosis. Many patients would want CANH continued until there is a clear sense of the level of recovery that can be achieved. In these patients the prognosis is important as it allows those concerned to make best interest decisions. For example, they may have refused treatment if the Prolonged Disorder of Consciousness (PDOC) assessment showed that they were likely to be left permanently unconscious, but not if they were likely to regain consciousness.

On the facts of the case before him, Hayden J was clear that Mrs Rushton “*would have hoped that her wishes in her advance decision would have applied to her present situation. I cannot easily contemplate circumstances in which the views of an adult with this degree of disorder of consciousness could be communicated more volubly or unambiguously.*”

Hayden J then, finally, had to consider the care plan in circumstances where one of her sons had cared for her almost exclusively, with no intention to shut out family or medical professionals, but where it appeared that he was scared of losing his mother and so “*battened down the hatches as best as he could to try and prevent it.*” The consequence was that:

36. There is a rigid, inflexible regime of care at the moment. It must be said, that is obvious that Mrs Rushton has been very well cared for. Ms Paterson, on behalf of the OS, submits that the present circumstances do not promote or sufficiently protect either Mrs Rushton's autonomy or her dignity. Dignity at the end of life is elusive both conceptually and practically. For Mrs Rushton's life to conclude with dignity, she needs what all of us would need in that situation, peace, care, proper medical attention and the presence around her of those she has loved. I have concluded that though she would have wished to die at home, true respect of her dignity can only be achieved in a hospice and under a regime which, as her son Hugh says, "allows her some space and privacy". Tellingly, in my judgment, insightfully, Mr Hugh Rushton went on to say that his mother needed to be in a place where she was no longer "prodded and poked" by those undoubtedly well intentioned to care for her, but rather she needed a place "to rest". I entirely agree and consider that the care plan contemplates precisely this. Accordingly, I endorse it.

Comment

ADRTs

At the level of principle, the judgment is an important reminder of the intended power of ADRTs. Their utility in practice is all too often diminished by the fact that there is no central repository akin to the register of LPAs, but in this case the problem was compounded by the fact that (for whatever reason) the effect of the document was simply misunderstood in the unfortunate Chinese Whispers approach that was taken. That would have negated even the workaround that can be taken to the absence of a registry by carrying a card to indicate that a person has an ADRT has it and where it is to be found (see, for a way in which to do this, and for a (free) process to create an ADRT, the excellent website of [Compassion in Dying](#)).

On the face of the judgment, it is a little odd that, having identified that, in fact, the insertion of the PEG was contrary to the ADRT that Mrs Rushton had made, Hayden J did not then go to hold that this gave the answer to the question of whether CANH should be continued. An ADRT does not just apply to the question of whether treatment should be carried out in the first place, but also “*at the time when the question arises whether the treatment should be [...] continued*” (see s.26(1) MCA 2005). The relief that a court can grant in relation to an ADRT is not provided for under ss.15/16 MCA but rather under s.26(4), i.e. declaring whether the ADRT exists, and/or is applicable to the treatment. It is only if the court finds

that there is no valid and applicable ADRT in place that it can then go on to exercise its normal welfare jurisdiction under s.16 to determine what decision to make on the person's behalf and in their best interests. In other words, one might ask whether there was even a best interests decision for Hayden J to make. If there was not, then regardless of the family's (laudable) desire not to dig into what had happened in 2015 in terms of why CANH had been started in the first place, Hayden J had no power to undertake the best interests decision-making process he did to determine whether it should continue.

As is so often the case in Court of Protection cases, one suspects that more may have been going on than is expressly recorded on the face of the judgment. One explanation (although this is speculation) might be that Mrs Rushton's ADRT was interpreted as applying solely to the initial administration of any form of medical treatment (perhaps because of her use of the term "upon collapse"). If this was the case, it might therefore then be said that Mrs Rushton had not expressly catered for the position where life-sustaining treatment had, in fact, been started, such that the ADRT did not strictly govern the situation. Nonetheless, as Hayden J observed, it was difficult to imagine a situation "*in which the views of an adult with this degree of disorder of consciousness could be communicated more volubly or unambiguously.*"

Whatever the unanswered questions as to the precise way in which Hayden J approached his own task as Court of Protection judge on the facts of this case, however, the wider point as to the obligations upon doctors arising from ADRTs are clear and unambiguous.

The approach to decision-making in PDOC

At a purely selfish level, the endorsement by Hayden J of the BMA guidance is welcome to Alex as one of the two legal advisers to the working group. More broadly, and importantly, it is an important judicial confirmation of the message of that guidance that the approach adopted in the earlier cases of a close focus on the diagnosis and prognosis as important in and of themselves is simply incorrect; the focus should be on the extent to which the diagnosis and prognosis (and the level of certainty as to both) would have been of importance to the patient themselves.

It is important to note, however, that on the facts of the case as presented in the judgment, it is not obvious that Mrs Rushton fell within the category of circumstances covered by the paragraphs of the guidance identified by the judge. These paragraphs address decisions about CANH in previously healthy patients in vegetative state or minimally conscious state following a sudden-onset brain injury. On the facts of the case, Mrs Rushton would appear much more likely, in fact, to have fallen into the sections of the guidance relating to patients with a sudden-onset or rapidly progressing brain injury where they have multiple comorbidities or frailty (either pre-existing or as a result of the incident that led to the brain injury) which is also likely to shorten life expectancy. The case was issued prior to the publication of the guidance, and it is not clear whether the judge was addressed on the precise application of the guidance to the facts of Mrs Rushton's case. Within the framework of the (useful) judicial endorsement of the guidance as a whole, clinicians will need to consider how the facts of any patient's case before them best fit the terms of the guidance.

The extremity of care

Hounslow CCG v RW [2019] EWCOP 12 (Hayden J)

Best interests – medical treatment

Summary¹

In the sequel to the case of *Re RW* Hayden J had to consider what arrangements should be made for RW, a 78 year old with vascular dementia, many months after the Court of Appeal had upheld the conclusion that it was not in his best interests to continue to receive Clinically Assisted Nutrition and Hydration (CANH), via a naso-gastric tube (NG tube). Parker J concluded that it was not in his best interest and made a declaration to that effect. RW had continued to live in his home, cared for by his youngest son, PT, almost single-handedly. As Hayden J observed, “[e]very act of care has been an act of love and requires to be identified as such.” PT “strenuously objected to a regime that he regarded as slowly starving his father to death. This he sees to be the reality of the earlier court orders. For PT the preservation of his father’s life is a moral obligation. It matters not, to him, that his father’s condition is futile nor that the preservation of it may merely serve to continue pain. Since RW returned home to his son’s care without any means of artificial nutrition or hydration PT has provided these by any means he could. He prepares small syringes of water, moist trifles, soft custard tarts which he considers his father enjoys. His objective is to keep his father alive.”

The number of professionals admitted to RW’s home began to fall away in May 2018 in circumstances where PW’s conduct became increasingly intimidating out of his “stress, anxiety and [...] fear for his father’s survival.” The CCG became increasingly concerned about the management of RW’s condition at home, and in January concluded that it would seek legal advice with a view to bringing the matter before the court, although

17. There then followed a period of significant and wholly unacceptable delay. Delay in bringing proceedings is far too common. It is entirely unacceptable and it is not to be tolerated. Delay is itself entirely inconsistent with the obligation on the CCG to protect RW’s welfare interests. Urgent decisions need to be made today because RW’s circumstances are so profoundly grave. I do not have the time to investigate the reasons for the delay in bringing this matter to court but I can say that there can be no justifiable reason for it.

An application came before the court in March, at which point the judge was primarily concerned about necrosis of RW’s leg. “To her direct question (as I understand it) PT responded that about 10 days ago ‘the leg detached completely’ when he was turning his father. This was, to say the least, disturbing and shocking evidence. I have never heard of a situation like this and I sensed the doctors were equally alarmed. When I asked PT about it today, I was concerned that nobody had been able to identify where the leg is. PT told me he had wrapped it in cling film and put it in the freezer.” When Gwynneth Knowles J heard this, it was not

¹ Katie Scott having been involved in the case, she has not contributed to this report.

surprising that she decided that RW should be removed to hospital immediately. He was admitted to hospital, where the doctors commented upon how well kept he was, and how well looked after; all were clear, however, that he had reached the very end of his life.

Against that backdrop, Hayden J had to determine what was in RW's best interests in endorsing a palliative care plan for him. Hayden:

27. [...] would very much have liked to have been able to endorse a plan which permitted RW to return home. There is no doubt at all, as the history of this case shows, that RW would want to die at home. I do not know whether he would survive the transition but I should have been prepared to take that risk. However, PT would, in my judgement, continue to try to give his father food and water. As I speak these words he indicates to me that this is precisely what he would do. I have been told by Ms I that, at this stage, if PT were to attempt to feed his father there is a real risk that he would asphyxiate on any food given. I cannot permit RW to be exposed to the risk of ending his life in this way and, if I may say so, I would not be prepared to take that risk for PT either, especially having regard to all the loving care he has provided for his father.

28. I endorse the applicant's plan. I indicate that it is in RW's best interest to have his sons with him as much as possible. I am not prepared to be prescriptive of the times and the circumstances in which the sons may visit. In this I reject the applicant's proposals in this respect.

Comment

Even in the summary form set out above, the facts of this case are stark, and (in a different fashion to the *Rushton* case also covered in this Report) show the emotional and physical consequences of familial care at the end of life. At least some may be left with asking whether situations such as this are really best addressed in the courtroom, or whether the court is being left to pick up the pieces of jigsaw that were broken a very long time ago.

However, as with the *PW* case also covered in this Report, this case emphasises that where recourse to the court is required in the interests of the person, it is vital that it is not delayed.

Short note: covert medication, surgery and deprivation of liberty

Kings College London NHS Trust v FG [2019] EWCOP 7 concerned FG, a 37 year old man with schizophrenia, who was being cared for at SLAM, apparently detained under the MHA 1983. He sustained a fracture and dislocation to his shoulder, which required treatment under general anaesthetic, but he refused to consent to the operation. His reasons included that he was worried about the effect of the general anaesthetic on his heart, its potential interplay with the medication clozapine which he was taking, and that the surgery had been ordered by M15. The court found no difficulty in concluding that he lacked capacity to make a decision about the operation given the influence of his paranoid and persecutory beliefs.

It was similarly clear that treatment was in his best interests, notwithstanding his expressed wishes - he was in pain, and without treatment would be unable to participate in activities he enjoyed in the future such as fishing and wood chopping. Francis J approved the care plan, including the administration of sedating medication covertly, saying in respect of that issue:

I accept that there can be exceptional circumstances in which the administration of covert medication is better than forced chemical injection under restraint. There would be very few circumstances in which it will be appropriate to administer covert medication in this kind of way and each case will have to be decided on its own facts. I do not imagine there are any rules or specific guidance that one could set out. A judge would have to decide it on a case by case basis. But having regard to the mental health and physical health matters to which I have just referred, I am satisfied that if the surgery is to take place there should be permission to the treating team to administer covert medication in this way to sedate him.

In a further reminder that deprivation of liberty has not been entirely removed from the hospital setting by *Ferreira*, Francis J accepted – as it was by the Official Solicitor – that “*the proposed procedure will amount to a deprivation of his liberty and I authorise that deprivation of his liberty to the extent that is necessary and on the basis that any measure used to facilitate or provide the arrangements shall be the minimum necessary and that all reasonable and proportionate steps are taken to minimise distress to FG and to maintain his dignity.*”

Short note: balancing privacy and the press

In *Southern Health NHS Foundation Trust v AB & Ors* [2019] EWCOP 11, Lieven J on an ex parte application granted an application to prevent publication of a video of a patient, AB, in her treating hospital, and publication of any story which identifies her in that hospital. AB was detained under s.3 MHA 1983, suffering from a conversion disorder with comorbid acquired brain injury. Her AB's presentation and indeed capacity varies. As Lieven J recorded, “[a]t times she is catatonic and lies in a foetal position on the floor. She has a history during these periods of self-harm, and for that reason she wears protective headgear at all times. In the light of AB's condition and the difficulties in accommodating her appropriately, the Trust has had to adapt the room in which she has been living urgently, and it is true to say that the condition of the room therefore looks somewhat poor.”

AB's son took a video recording of his mother, from which she was plainly identifiable. It having been briefly on YouTube, it appeared that it was then going to be given to the Mail Online with a view to them publishing it with her face pixelated out, AB's son “*hoping [...] that this will draw attention to his mother's condition and to the problems with the mental health provision generally in the NHS or in this hospital in particular.*”

Lieven J granted the application on the basis that AB could be identified, that it was very unlikely that she had regained the capacity to give consent to her son to publish it, and that it would be an interference with her privacy and her private life – “*they are potentially degrading for AB, and clearly have*

the potential to cause her distress in the future." In holding that it was not in AB's best interests to publish at that time, Lieven J also gave permission to her son to apply at a full hearing if he wished to do so to seek to lift the injunction; she also noted that AB might well regain capacity relatively shortly, and that, if she did, publication would be a matter for her. Lieven J was also clearly struck by the fact that there was no immediate urgency in favour of publication.

DoLS, the backlog and the consequences – the LGO reports

The Local Government & Social Care Ombudsman has published a [report](#) into Staffordshire County Council's triaging of DoLS applications, where, since May 2016, the authority had not been carrying out assessment of low and medium priority applications, and had significantly delayed in the carrying out assessments in high priority cases. Whilst recognising the extent to which this situation was not necessarily of Staffordshire's own making, the LGO found that the approach constituted fault causing injustice.

The report makes important reading at a number of levels, including as a snapshot of the pressures that local authorities are under and the decisions that they are having to take in consequence – as well as the real-life implications for the individuals concerned.

Whilst investigating another complaint, it came to the LGO's attention that Staffordshire:

- decided in May 2016 not to carry out assessments for most of the DoLS requests it receives;
- was aware this did not comply with relevant legislation and statutory guidance;
- made the decision during an informal cabinet meeting, because of lack of financial resources; and
- had a backlog of 2,927 unassessed DoLS requests at the end of March 2018 (rising to 3,033 in June 2018, with the oldest assessed request dated 11 August 2014).

The LGO decided, of its own motion, that this may have caused an injustice to members of the public and therefore decided to investigate. Staffordshire noted that no one had complained about the policy, that its triage system ensured no harm to individuals was likely because it assessed those cases where there was a real possibility that a person may be deprived of their liberty inappropriately, and that in the unlikely event a person was deprived of their liberty inappropriately, they would have a court remedy and would probably be entitled to compensation. Importantly, the LGO decided to investigate individual complaints being brought "because the people who are likely to be affected are vulnerable, may not be aware of their rights to complain or go to court, and may not be able to complain either in their own right or through representatives."

The LGO's investigation found that Staffordshire was using a version of the ADASS [screening tool](#) to triage requests, but modified so that, in practice, fewer requests were categorised as high priority. The report outlines how Staffordshire were operating their triage policy, and noted that:

The Council says the priority tool “is not designed to exclude individuals but prioritise the order in which assessments are completed”. However, by deciding not to assess anything but high priority requests, excluding individuals is precisely what the Council is doing.

Staffordshire told the LGO that it would cost about £3.5 million to clear the backlog and deal with all of its incoming DoLS requests within statutory timescales, money which could only be found by reducing spending on other essential services.

Importantly, the LGO examined a sample of the 57 requests that Staffordshire had received in one week. Of these, 16 had been closed because the person had moved or died; 18 were in the unassessed backlog because they were of low or medium priority, 21 had been granted, and 2 were not granted (after 7 weeks and about 12 weeks) because the individuals concerned had regained capacity. In one case, the LGO had “significant concerns” about how the person was being deprived of their liberty and whether it was having a potentially detrimental effect on them. However, as their circumstances were now before the Court of Protection, the LGO could not investigate further. In percentage terms, this means that almost a third of the sample applications had not been considered beyond prioritising based on “the limited information provided by the managing authorities making the request.”

The LGO concluded that Staffordshire were at fault not complying with the legislation and guidance currently in place, causing a potential injustice to about 3,000 people who have had no or delayed access to the proper legal process designed to check that any decision to deprive a person of their liberty is: properly made, lawful; and implemented for only as long as necessary.

The LGO noted that

44. Applying the process properly would not change the outcome for most of the people affected, other than confirming that it is in their best interests to be deprived of liberty. However, it is possible that some of the people stuck in the backlog for years should never have been deprived of their liberty.

The LGO acknowledged the wider context, including the potential for the law to be changed by way of the Mental Capacity (Amendment) Bill,² but noted that:

46. [...] the current legislation is still in force. At the time of writing, it is the main legal protection available to vulnerable people deprived of their liberty in care home settings. Resource constraints are not a legitimate reason for failing to carry out assessments required by law or statutory guidance. It is only legitimate for public bodies to deviate from relevant guidance where they have cogent reasons for doing so; a lack of money is not such a reason.

² Although in this appears to have understood that most of the responsibility would automatically be going to care homes, when this is not the case unless the local authorities/CCGs in question decide this is appropriate.

47. We do not criticise the approach of prioritising applications as suggested by ADASS and endorsed by the Government. We also recognise the effort the Council is making to tackle the incoming high priority applications. But it is not acceptable that the only way low and medium priority applications are resolved is because the people involved move away or die.

The LGO set out a series of recommendations, including an action plan to be produced within 3 months of the LPS scheme being finalised by Parliament, including *"a mechanism for addressing those cases where the request is eventually not approved, and an unlawful deprivation of liberty has had a potentially harmful impact on that person."*

Its decision was therefore that:

The Council has acted with fault in deciding not to assess low and medium priority Deprivation of Liberty Safeguards applications. The Council is also taking too long to deal with urgent applications. This is causing a potential injustice to the thousands of people in its area who are being deprived of their liberty without the proper checks that the restrictions they are subject to are in their best interests.

It is important to note that not all local authorities do have a backlog, but it is difficult to escape the impression that many other local authorities will be reading this decision with the twin emotions of (1) simple frustration at the position; (2) relief that they were not the ones singled out in this report which could, with variations, have been written about many others in England & Wales.

PROPERTY AND AFFAIRS

Supported will-making

[The Everyday Decisions research project team at the University of Birmingham has published a follow-up to their Everyday Decisions project, exploring how disabled people with impairments that affect their mental capacity could be better supported to make a will. We reproduce, with permission, the executive summary to their Supported Will-Making Report, together with their recommendations for reform]

This report was prepared to inform the review of the law of wills being conducted by the Law Commission of England and Wales. It is an empirically grounded, socio-legal inquiry into the potential for, and challenges involved in, supported will-making. The report is founded on the Everyday Decisions project and a follow-up study which explored intellectually disabled people's views about, and experiences of, will-making in more depth. Our research explored how supported will-making works in practice and areas where legal reform, practical changes and shifts in professional attitudes are needed to secure effective levels of support for disabled people.

Our main legal focus has been on how supported will-making would intersect with and supplement existing legal frameworks like testamentary capacity, mental capacity, statutory wills, and intestacy as well as international approaches to supported decision-making following the UN Convention on the Rights of Persons with Disabilities (CRPD). We found that, internationally, supported decision-making frameworks are becoming increasingly prevalent, and generally operate to formalise existing informal support practice. However, in alignment with our findings in the original Everyday Decisions project (Harding & Taşcioğlu, 2017, 2018), existing supported decision-making practice is focused on everyday decisions rather than more complex life choices. Overall, we found that while pockets of good practice do exist, there is tendency under the current Mental Capacity Act 2005 (MCA) framework to fall back on best interests decisions, rather than to support people to make their own decisions.

Findings from the Everyday Decisions project revealed that only a small number of care and support professionals had direct experience of supporting their clients to make a will. There was a general lack of knowledge and understanding of wills by frontline care staff who took part in this research. These care professionals often thought that supporting clients with will-making was beyond their competence and identified family members, lawyers and financial deputies as persons responsible for supporting intellectually disabled persons with will-making. There was, further, some evidence of confusion in the approach that care professionals (with appropriate responsibilities to do so) took to assessing testamentary capacity. Overall, we found that wills and will-making were not well understood by care and support professionals. We consider that there is a training need in this area within the care sector.

The experiences of intellectually disabled people with will-making were at the heart of this project. In the report, we introduce key socio-legal issues in will-making by people with intellectual disabilities through two case studies, Penny and Gareth, who have both been supported to make a will. Through this empirical research, we found a gap in access to appropriate support to make a will for intellectually

disabled people of modest means, particularly for those whose relationships and networks mean that the intestacy rules do not fit with their wishes and testamentary preferences.

Penny's experience highlights the need to review wills regularly to account for changes in circumstances. Her story also highlights a theme, found across these data, that disability sometimes interrupts normative patterns of succession, with a preference for leaving greater provision to disabled children. This disability difference sometimes creates discord between family members. Penny's story further highlights the need for support from a range of different sources, including legal professionals, family members and advocates to allow disabled individuals to navigate this complex area of law and social relationships, and to have access to a broad range of information.

The importance of appropriate safeguards when making a will cannot be underestimated. Through Gareth's story we emphasise the need for appropriate and effective safeguards to protect vulnerable testators from abuse. This has proven especially challenging for testators who do not have good relationships with their families. We found that safeguarding and ensuring the right to legal capacity is a major challenge for developing CRPD compliant supported decision-making frameworks. Gareth's story also draws attention to the importance of accessible information in helping disabled people to protect themselves from financial abuse, manipulation or coercion, and the need for solicitors to be able to communicate with disabled people. Gareth's story highlights the failings of the current law in this regard, and offers an important rationale for change.

Additional analysis of the empirical data from the projects provides three guiding concepts for the reform on the law of wills and supported will-making. These are: trust, communication and accessible information. We found that enabling disabled people to be supported by someone that they know and trust holds the key to ensuring that a will reflects their testamentary wishes. We recognise, however, that it is also important to ensure vulnerable testators have sufficient protection from abuse of their trust through non-discriminatory safeguards. Effective communication between all parties is vital to supporting intellectually disabled people to make a will. Failures in communication can lead to inappropriate outcomes, and potentially open up opportunities for abuse of trust. Accessible information is also key to ensuring that intellectually disabled people can make a will that accurately reflects their wishes and preferences, and we recommend the introduction of an Accessible Information Standard for legal services.

In the final part of the report, we evaluate potential policy options for reform to better support will-making by intellectually disabled people, balancing possible options with the safeguards that would be required. We discuss the potential for reform through amendment of the Mental Capacity Act 2005 Code of Practice, the potential of different approaches to a 'bespoke' Supported Will-Making Scheme, and the difference that a formal nominated supporter scheme (our preferred option) could make in this area.

Recommendations for Reform

1. Substantive updating of the Mental Capacity Act 2005 Code of Practice is needed to include more examples of how to support decision-making in general, and supporting will-making in particular.

2. Clarification of how the Mental Capacity Act 2005 principles (especially principles 1, 2 and 3), interact with conflicting approaches in common law capacity tests is required.
3. Training for frontline care staff and statutory advocates on the importance and practicalities of will-making is required to better support testamentary choices.
4. Training for legal professionals who provide will-making services (including solicitors, legal executives and will-writers) on effective communication with people with intellectual and sensory disabilities is needed to ensure legal services are accessible.
5. Clear, non-discriminatory, appropriate and effective legal safeguards against abuse are needed to protect vulnerable testators.
6. The introduction of an Accessible Information Standard for Legal Services would be extremely helpful in increasing the accessibility of legal services.
7. The creation of a formal nominated supporter scheme, with supervision from a public body, is likely to be the best way to balance choice, support and safeguards.

PRACTICE AND PROCEDURE

Appointment of new Official Solicitor and Public Trustee

As we went to press, we learned that Sarah Castle has been appointed as the new OSPT. We will have more details in the next edition, but congratulate her on her appointment and wish her luck!

Accredited Legal Representatives – pilot

The Law Society have been in discussions with HMCTS regarding the issues related to the appointment process for ALRs, which has been far from smooth.

In a response to the concerns raised, HMCTS has agreed to run a pilot as of 1 April 2019. As of this date, where a nominated ALR is already involved within proceedings, they can seek appointment within the proceedings and be appointed by the judge. Where an ALR seeks to be nominated within application, they will need to provide reasons for their appointment to the judge.

If there is no nominated ALR within the proceedings, the judge will continue to appoint ALR's from the ALR list.

The pilot will run for a period of 3 months, where after HMCTS will take a view as to whether allowing direct nominations has been successful. The Law Society – and us – are encouraging all ALRs to put themselves forward for direct nomination during the period of the pilot, in order to demonstrate the effectiveness of the process.

The current list of ALRs can always be found on the Law Society website [here](#).

Will, preferences, amputation – and the need for early involvement of the court

East Lancashire Hospitals NHS Trust v PW [2019] EWCOP 10 (Lieven J)

Best interests – medical treatment

Summary

The decision in this case is of real importance for its reminder of the obligations on treating hospitals where an application may need to be made in relation to medical treatment. It also of real interest as regards the application of a “will and preferences” approach to best interests decision-making.

Timing of application

For 9-12 months from the middle of 2018, it had been recognised by the treating team that an application might need to be made in relation to PW, a 60 year old with paranoid schizophrenia, to address the consequences of a diabetic infection in his foot. By mid-February 2019, the application was being prepared. It was then lodged with the court on 12 March (the Official Solicitor receiving the

draft application at around 4:00 pm on that day) on the basis that the application needed to be considered within one day and an operation required to address the high risk of sepsis within 48 hours. Lieven J heard the application on 13 March, but – understandably – observed that:

4. [...] *this application could and should have been made some weeks ago, even if at that stage it was on a slightly more precautionary basis. The effect of the delay has been detrimental to PW's interests and to a fair process which could fully take into account his wishes. The timing of the application has meant that the Official Solicitor had no time to visit PW and discuss the operation and his views with him; it has meant that there has been no time for the Independent Mental Capacity Advocate (IMCA) to visit him before the hearing, the last visit was in July 2018; and the OS has had no time to instruct an independent doctor for another opinion if he had felt one was justified.*

5. *Although I spoke to PW over the phone, in order to try to understand his wishes and feelings, it would have been much better for the Court and PW if the OS had been able to visit him and prepare a report for the Court. The delay in making the application has therefore been contrary to PW's interests.*

Lieven J considered that it had been possible to achieve a fair process, not least because her view was ultimately that the decisions she had to make were fairly clear-cut, but "*this application should have been made weeks ago.*"

Lieven J expressly endorsed the guidance given by Keehan J in *NHS Trust v G* [2014] EWCOP 30 and Baker J in *A University Hospital v CA* [2016] EWCOP 51 as to the need for timely applications, expressly endorsing the annex to the judgment in *G* as to the steps that need to be taken. She noted that, as in *CA*, the Trust was to carry out an investigation into the delay and provide the court and the Official Solicitor with the outcome.³

The substantive decisions

Lieven J had little hesitation in finding that PW lacked capacity to decide whether to have his foot amputated. He was, she found, delusional in his belief that his foot could be treated by antibiotics and that his GP surgery could heal his foot (indeed, the IMCA report prepared in July 2018 recorded him referring to a belief that his toes could grow back, in circumstances where said he did not have diabetes and that his leg was not infected).

As regards best interests, Lieven J considered that the medical evidence was overwhelming that if PW did not have a below the knee amputation in very short order then certain consequences will follow. Either the infection would spread and he would need a much more debilitating operation and in a worst case scenario die from sepsis spreading before it can be controlled; or in a best case there would be a brief improvement from the IV antibiotics but his foot would inevitably become infected again. She

³ Note, no report of the investigation in *CA*'s case ever seems to have been published by the court.

further accepted the medical evidence that if he did have the operation, there was a good prospect that he would be able to cope well with the prosthetic leg below the knee.

Importantly, Lieven J was:

32. [...] very aware of the fact that PW is strongly opposed to having an amputation. This is based at least in part on having had the previous amputation and not wanting an operation. Those are perfectly understandable feelings that would be shared by many. However, the medical evidence shows that PW is either going to have to have an amputation, or the infection will spread and he will die (though in an uncertain time frame). In my view, following Peter Jackson J in B⁴ it is appropriate to give weight to PW's wishes and feelings, even though he does not have capacity, and given that those wishes are clearly expressed, strongly and consistently held, give them considerable weight. However, unlike B, PW does not want to die. He does not understand the choices he faces - he is labouring under a delusion that there is an alternative, namely IV antibiotics, which the medical evidence shows will not solve or materially alleviate the condition.

PW is a 60 year old man, so significantly younger than Mr B, and who if he has the below the knee amputation has a good prospect of regaining mobility, and indeed be in better physical health than he has been in the recent past. I also do not think, though I cannot be totally confident on this, that PW's opposition to the operation is as deep seated, or as fundamental to his dignity, as was Mr B's. I am therefore hopeful that the impact of him having the operation, albeit against his wishes will not fundamentally undermine his dignity and his independence.

Lieven J therefore reached the clear conclusion that it was in PW's best interests to have the operation.

Comment

One hopes that the investigation into the delay will be published as a follow-up to the judgment, as, on the face of it, Lieven J appears to have been entirely justified in her criticisms. What is particularly important about them was the extent to which they recognise the fact of the delay both prejudiced the Official Solicitor (and hence the court) in terms of potential investigations, but also, more significantly, risked denying PW a fair crack of the whip in terms of participation in a decision of such moment to him. There is a significant body of research which highlights how much worse it is for a person who has been subject to (benign) coercion not to have been able to have any say in the process underpinning that coercion. One would like to hope that the fact that Lieven J was able to speak directly to PW undoubtedly went some way to remedying this aspect of the problem, but the emphasis here is on remedying; it was in reality no proper substitute for proper participation from a much earlier stage.

As regards the substantive best interests decision, the contrast that Lieven J drew with the *Wye Valley* case is of some interest. Not all would necessarily have identified Mr B as actively wanting to die – as he told Peter Jackson J: "*m not afraid of dying, I know where I'm going. The angels have told me I am going to heaven. I have no regrets. It would be a better life than this.*" In any event, however, Lieven J was clearly

⁴ *Wye Valley NHS Trust v B* [2015] EWCOP 60

right to identify that this appeared to be a qualitatively different position – PW appeared clear that he did not want to die, but incapable of appreciating both that his refusal was making that prospect very much more likely, and that his chosen means of trying to secure his life were simply going to be ineffective (insofar as anyone can ever predict anything in medical science).

Framed in CRPD terms, this case could therefore be seen as an example of the tension between a person's will and their preferences,⁵ and a situation in which it is both legally and ethically right to override a person's preference to secure their will.

Short note: transparency and committal

In *Office of the Public Guardian v Stalter* [2018] EWCOP 27, Williams J heard two applications to commit brought by the Public Guardian in relation to breaches of two transparency orders by publishing information about P's identity and whereabouts. The breaches were admitted but there had been failures of procedure in that one of the committal notices referred to the wrong order and, more seriously, one of the orders had not been served personally.

The court waived the defect in the committal notice and dispensed with service of the order not served on the basis that no injustice was caused as the terms of each order were similar and the respondent was aware of what was alleged against him and having been present at the hearing where the order that was not served was made, was aware of its terms and that he must obey it.

The end result was that the breaches were proved but the court decided that no order on the application was necessary because the respondent had confirmed he would thereafter obey the orders and the situation underlying the case had already caused him significant suffering.

The case contains a helpful summary of the procedural and substantive law of committal in the Court of Protection, as well as a reminder that "*applications to commit individuals to prison are essentially criminal in nature,*" and that "*when applications are brought by public authorities [...] the burden on them to ensure that procedurally those applications are sound is even more onerous than it might be in applications brought by a private individual*" (paragraph 34).

Short note: DNA testing and the Court of Protection

In *DCC v NLH* [2019] EWCOP 9 Baker J (as he then was, although the judgment was given after he had become a Court of Appeal judge) considered an application for an order permitting the taking of samples from NLH to assist with DNA testing. Whilst the application was not contentious (it was not disputed that the order was in NLH's best interests), it contains some important reminders for practitioners and decision-makers.

⁵ See here, in particular, the writings of George Szukler: <http://georgeszukler.org/2015/10/about-george-szukler/>.

NHL was suffering in the late stages of a degenerative neurological disease known as Prion disease. The local authority applied to the Court for an order permitting the taken of samples from NLH to assist with DNA testing. A judge sitting in the family court had declared that the outcome of the DNA tests would be of vital importance to the resolution of proceedings to establish the paternity of a child and because there was a possibility that the child might have inherited the disease from NLH.

The application was listed for a hearing before a circuit judge but NLH's condition deteriorated rapidly and it was decided to make the application as a matter of urgency to the out of hours judge sitting in the Family Division. The Official Solicitor, appointed to act as NLH's litigation friend, agreed to the order being made. However, before the order was made, it emerged that a member of staff from a DNA testing company had already attended at the nursing home and taken the sample with the agreement of NLH's family but without either the formal consent of NHL or approval of the court.

Baker J was entirely satisfied that approval should be given for the taking of the sample and that no injustice or harm was perpetrated in this case. However, the court emphasised the following points:

- Where the patient lacks capacity, an application has to be made to the Court of Protection for an order authorising the taking of a sample; it will be unlawful for the sample to be taken without the Court's permission (although Baker J did not specify the precise basis of this unlawfulness, this must be because it falls outside the scope of 'care and treatment' for purposes of s.5 MCA 2005).
- There is always a judge of the Family Division on duty available to sit in the court of Protection twenty-four hours a day, seven days a week, every day of the year, to deal with urgent applications, usually by telephone.
- There is no excuse for failure to comply with the obligations to obtain the court's permission in circumstances such as these.
- Any infringement in future will run the risk of not only attracting severe criticism from the Court but also potentially incurring liability for damages if a breach of human rights occurred.

Baker J made an order "retrospectively authorising the taking of the sample" (although, perhaps, this should better characterised as a determination that there had been a breach of NLH's rights, but without causing him any loss).

Deputy statistics

In the context of the application recently before the Vice-President challenging the effective presumption against appointment of health and welfare deputies, the OPG provided a [letter](#) on an open basis with some interesting statistics regarding personal welfare deputyships, including numbers over time, age profile, and the (small) numbers of those discharged where the person has regained capacity.

Court of Protection statistics

The most recent statistics (covering the period October to December 2018) have been published by the MoJ. They show that there were 8,626 applications under the MCA, up 10% on the same quarter for 2017. Over the longer term, there was a 2% increase in 2018 compared to 2017, continuing the upward trend seen since 2009. Half of applications made in 2018 related to applications for appointment of a property and affairs deputy. There were 1,052 Deprivation of Liberty applications in October to December 2018, broken down into 140 s.16 applications (presumably deprivation of liberty in the context of wider welfare matters), 663 community DoL applications, and 249 s.21A challenges. Only 780 orders were made in the same quarter, though, and unfortunately the tables do not show how many of these are community DoL orders. We have the distinct impression that the court system is finding it difficult to progress with suitable speed those community DoL applications that are being made (whether that be down to lack of suitable representatives, Visitor resource or judicial resource is not clear).

Short Note: experts and delay

In *Re X & Y (Delay: Professional Conduct of Expert)* [2019] EWHC B9, HHJ Bellamy – unusually – named a jointly instructed expert in family proceedings who had so singularly failed to report in a timely fashion that her instruction had to be terminated. Whilst the following observations were made in the context of family proceedings governed by statutory time-frames that do not (yet) apply in the Court of Protection proceedings, they are nonetheless apposite by analogy:

49. The Family Court is heavily dependent upon medical experts from a wide range of specialties to assist it in dealing with some of the cases that come before the court. Experts are required to assist the court in determining threshold issues – for example, in determining whether a child's injuries have been sustained accidentally or whether they are inflicted injuries, in identifying the likely mechanism by which injuries were caused, in identifying the likely window of time within which the injuries were sustained. Experts are also required to assist the court in making welfare decision – for example, as to whether the child is suffering from any mental or psychological difficulties and as to her treatment or therapeutic needs. The Family Court simply could not operate without the assistance of medical expert witnesses.

50. However, it is also the case that although the Family Court needs the assistance of medical experts it also owes a duty to the child concerned to determine the proceedings without delay. That is a statutory obligation clearly set out in s.32 of the Children Act 1989. As Paediatricians as expert witnesses in the Family Courts in England and Wales: Standards, competencies and expectations makes clear, it is also an obligation that is placed on medical expert witnesses.

51. There will always be occasions when, despite an expert having genuinely believed that he or she could complete a report by the date set by the court, circumstances change and that is no longer possible. Where that happens, the expert should let his or her instructing solicitor know promptly, giving reasons for the delay and indicating the new date by which the report can be completed. An

application should be made to the court for the timetable to be varied. Where there are justifiable reasons for adjusting the timetable it is unlikely that the court would refuse. What is not acceptable is what has happened in this case where the expert has given a succession of dates by which her reports would be delivered but, as is patently obvious, with no genuine or realistic expectation that any of the dates suggested could, in fact, be met. Courts and experts must work together in a co-operative co-ordinated way. That simply has not happened in this case.

THE WIDER CONTEXT

ENGLAND AND WALES

Oral care and learning disability

In the context of cases such as that of Rachel Johnston, who died two weeks after all her teeth were taken out, it is all the more important to draw attention to the guidance from Public Health England on oral care and people with learning disabilities, together with the resources at the end for family carers, paid professionals and dental professionals.

Deemed organ consent in England

Following in the footsteps of Wales, the passage of the Organ Donation (Deemed Consent) Act 2019 means that there is now a statutory presumption in England that consent to organ and tissue donation in England has been given by a potential adult organ donor before their death unless they had expressly stated that they did not wish to be a donor or an exception applies. One of the categories of those excepted from the presumption is those adults who *“for a significant period before dying lacked capacity to understand the effect of [the deemed consent provision].”* Interestingly, and possibly tellingly, the Explanatory Notes described this group (wrongly) as *“people who lack the capacity to fully understand the consequences of deemed consent for a significant period before dying”* (emphasis added). We also note that precisely what “significantly” means in this context is not fleshed out by the Explanatory Notes.

Caring about complaints

The Local Government and Social Care Ombudsman has issued a good practice guide for care providers. The guide shares lessons from complaints to help adult social care providers improve their services. Common issues that arise in complaints include:

- A lack of clear information about fees, charges and contracts;
- Charges and contracts;
- Problems with billing and invoices;
- Ensuring people’s belongings are looked after properly; and
- Dealing with challenging behaviour from friends and relatives.

The guide provides a number of case studies exemplifying the common problems. A few specific examples relate to people who lack mental capacity. In one case, there was no assessment of the person’s mental capacity regarding residence and no discussion with the family about the person’s best interests. The Ombudsman recommended (and the care provider accepted) that the care provider

review its care plans and add a section to specifically address mental capacity. In another example, the care provider put in place staff training on mental capacity.

The Ombudsman's advice echoes findings from the Competition and Markets Authority (CMA) when it recently published [guidance](#) for care homes on their responsibilities under consumer law. The clarity of information given to care users about fees, funding arrangements and charging policies, is a key issue in many complaints about care providers.

Criminal proceedings and mental disorders

The CPS has published [Mental Health Conditions and Disorders: Draft Prosecution Guidance](#). This is out for consultation until 4 June 2019, and we hope that at least some will take the opportunity to assist the CPS flesh out this passage:

Prosecutors should also be aware that reasonable adjustments may need to be made by the court in order to realise the right to access justice under Article 6 of the European Convention on Human Rights, as incorporated by the Human Rights Act 1998, and Article 13 of the United Nations Convention on the Rights of Persons with Disabilities.

At the same time, proposed guidance for sentencing offenders with mental health conditions and disorders was published in a [consultation](#) launched by the Sentencing Council, designed to give judges and magistrates in England and Wales a clear structure and process to follow when sentencing people with mental health conditions and disorders, and those with learning disabilities, autism, brain injury, substance misuse disorders and dementia. The consultation, taking into account the work of the MHA review, runs until 9 July. Of no little interest is the proposed annex containing information on common mental health conditions and disorders.

Short note – competence and the vacuum

In *CS v SBH* [2019] EWHC 634 (Fam), Williams J undertook an interesting review of the law governing the competence of a child to instruct a solicitor and to conduct an appeal without a children's Guardian, emphasising that there had been a "shift away from a paternalistic approach in favour of an approach which gives significantly more weight to the autonomy of the child in the evaluation of whether they have sufficient understanding."

Of broader significance are the observations that Williams J made in relation to the different assessments made by two solicitors as to whether the child in question had sufficient understanding. These observations are equally applicable to assessments of mental capacity under the MCA 2005:

The views of Ms Hopkin on the one side and Ms Coyle on the other are diametrically opposed. There is however an immediate and obvious difference between them. That is not the age and experience of the solicitor conducting the evaluation but rather the extent to which the evaluation is an informed evaluation. Ms Hopkin's evaluation is based primarily on her meeting with the child supported by what

she can glean from communications that she has had with the child or which she has been sent by the child and some other modest exposure to information. Although her evaluation has not taken place in a vacuum it is very much in a low pressure vessel in terms of the material that has been available to her to assist in the evaluation. Ms Coyle's evaluation has been taken with exposure to the full atmosphere of information which bears upon the issue. As Ms Hopkin accepted in submissions, an initial evaluation of a child may very well have to be reassessed the light of further information that becomes available. This is far from a simple case given the history of it. Thus initial impressions almost certainly would have to be reassessed.

Finally, this provides us with the opportunity to note that we await the decision of the Supreme Court in *Re D* as to (inter alia) whether competence remains the test for decision-making post-16, or whether it is the MCA 2005. The need for that decision becomes increasingly pressing as work progresses on both the LPS Code of Practice and the review of the main MCA Code of Practice, both of which will need to give guidance (endorsed by Parliament) on the approach to take to 16-17 year olds with impaired decision-making ability.

INTERNATIONAL DEVELOPMENTS

Saving the CRPD from itself?

The psychiatrist Paul Appelbaum, writing in *World Psychiatry*, the Official Journal of the World Psychiatric Association,⁶ has sparked controversy with his editorial "*Saving the UN Convention on the Rights of Persons with Disabilities – from itself*". He describes the UN Convention on the Rights of Persons with Disabilities (CRPD) the "*problem child of international human rights law*"; the problem being that "*the CRPD is being interpreted by the Committee as precluding any involuntary intervention targeted at people with disabilities*". The examples he gives are striking:

...elderly persons with dementia, no longer able to care for their own needs but unwilling to accept management of their finances, health, or living situations by a guardian, could not be compelled to do so. People intending to end their lives as a result of major depression could not be hospitalized against their will, nor could persons suffering from psychosis who are refusing to eat because their food is poisoned. Someone in the manic stage of bipolar disorder would be free to dissipate his family's savings or wreck her business. In the name of protecting these people from discrimination, they would be free to destroy their own lives and ruin the lives of their loved ones.

Appelbaum lays the blame squarely on the drafting of the CPRD:

In short, blame is due to a drafting process that was captured by some of the most radical elements of the patients' rights movement, which are willing to sacrifice the well-being of persons with disabilities to achieve what they see as their long-term political goals. It falls as well on the many

⁶ In an issue which has a useful set of short articles highlighting some of the key issues in this area.

governments around the world that thoughtlessly ratified the CRPD without considering its implications.

Appelbaum's answer to this "problem child" is to "ignore the CPRD, reinterpret it, or amend it". According to Appelbaum, amending the CPRD "may be the most effective long-term solution to the problems that so many governments and comments have identified" but "it will not be an easy process", considering that drafting the CRPD itself took roughly five years. For Appelbaum, "Only amending Article 12 can definitively reverse the extreme interpretation of the Committee and remove the spectre of international condemnation of any country that fails to comply with its approach."

Until such a time comes, Appelbaum suggests that governments and others responsible for the welfare of people rendered vulnerable by their disabilities will – and indeed should – "ignore the Convention when it would interfere with a commonsense approach to protecting citizens who in one way or another are incapable of protecting themselves".

In response to Appelbaum's editorial, an [open letter](#) has been written to the editors of *World Psychiatry* "from the perspectives of those who have been denied legal capacity, whose will and preferences have been ignored and their "best interests defined by experts." The writers explain:

...we write from the perspectives of those who have been abused by forced psychiatric treatment and are traditionally and purposefully being excluded from spaces such as this journal, where our lives are being debated. Indeed, the CRPD is precisely there to ensure that what we have to say is not silenced and marginalised any longer."

The authors of the open letter take issue with the suggestion that States should openly flout international law and ignore the hard-won rights of persons with disabilities. Far from being the product of a radical movement to sacrifice the well-being of persons with disabilities, the authors describe the Convention as "a milestone achievement in our shared humanity and belief in freedom". It represents a new paradigm which is a "human rights based, non-discrimination and social approach to all disabilities".

The open letter concludes with a call to WPA members who do not agree with the call to amend the CRPD and in the meantime to ignore it, and are willing to "break from the old, controlling paradigm", to speak up.

One thing that is striking, other than the depth of the fault-lines here, is the extent to which – again – the debate in relation to Article 12 is being addressed through the prism (essentially) of the validity of psychiatry as a response to "madness and distress."⁷ Does this characterisation of the debate fully capture all the interests of those concerned – for instance, does it capture the interests of those with dementia, or those in a prolonged disorder of consciousness after a brain injury?

⁷ See in this regard Mohammed Rashed's fascinating book [Madness and the demand for recognition](#) (OUP, 2019)

The right to independent living framework

The European Union Agency for Fundamental Rights (FRA) has published its [human rights indicators](#) to assess compliance with Article 19 of the Convention on the Rights of Persons with Disabilities. Article 19 sets out the right of persons with disabilities to live independently and to be included in the community by ensuring that:

(a) Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;

(b) Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community; and

(c) Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.

The EU and its 28 Member States (for the time being) have ratified the CRPD and the indicators in the report aim to assist in monitoring the extent to which EU Member States fulfil their obligations under Article 19. The human rights indicators will be used by the FRA undertaking a project to collect and analyse comparable data on the transition from institutional care to community-based support in the 28 EU Member States.

The objective of the project is to provide evidence-based assistance and expertise to EU institutions and Member States when they take measures or formulate courses of action to fulfil the right of persons with disabilities to live independently and to be included in the community as set out in Article 19. Whilst the UK may not continue to be an EU Member State for much longer, it will continue to be bound by the CRPD, having ratified the Convention in July 2009. The outcome of the FRA project will therefore continue to be of interest and highly relevant to the UK even if/when it is no longer a member of the EU. We will continue to keep our readers updated.

Austria, guardianship and the CRPD

Austria has recently modernised its guardianship system in order to bring it into line (Austria considers) with Article 12 of the UN Convention on the Rights of Disabled Persons. The reforms came five years after, and in response to, the UN Disability Committee's 2013 on Austria which described its guardianship system as "old-fashioned and out-of-step with the provisions of article 12 of the Convention". Article 12 provides that persons with disabilities shall have equal recognition before the law. The Committee's experts recommended that Austria "replace substituted decision-making with supported decision-making for persons with disabilities".

The new Austrian law is significant in two ways:

- First, the traditional “best interests” rule for decision-making involving adults with intellectual disabilities is put aside. Decisions must now respect their will and preferences. Only where a decision would put their welfare in “serious and significant danger” can the adult’s will and preferences be overridden.
- Second, where a person does not have the capacity to make a formal power of attorney because of an intellectual disability, they can nevertheless make their wishes known by designating a trusted relative or friend to assist and represent them in financial, legal and personal affairs (excluding important financial affairs involving real estate and investments).

The UN Disabilities Committee will soon have the opportunity to examine these new developments in Austria when it reviews Austria’s second national report. It will be interesting to see whether the Committee considers that the reforms are now compliant with Article 12 of the CPRD. The greater prominence now being given to the adult’s “will and preferences” certainly represents a significant step towards the supported decision-making approach and principle of equal recognition before the law. The changes in Austria are reminiscent of the Law Commission’s recommendation in this jurisdiction that 4(6) MCA 2005 should be amended so that, in making any best interests determination, particular weight must be given to P’s past and present wishes and feelings. The opportunity to give effect to this recommendation was not taken up in the Mental Capacity Amendment Bill.

To read more about the reforms in Austria, see this [article](#) by Andre Bzdera.

RESEARCH CORNER

In the first of a regular feature, we highlight here recent research articles of interest to practitioners. If you want your article highlighted in a future edition, do please let us know – the only criterion is that it must be open access, both because many readers will not have access to material hidden behind paywalls, and on principle.

Research supporting the Mental Health Act Review

Papers are now being published from research conducted to support the Mental Health Act review. So far, these include:

Barnett, Phoebe, et al. "[Compulsory community treatment to reduce readmission to hospital and increase engagement with community care in people with mental illness: a systematic review and meta-analysis.](#)" *The Lancet Psychiatry* 5.12 (2018): 1013-1022.

Bone, Jessica K., et al. "[Psychosocial Interventions to Reduce Compulsory Psychiatric Admissions: A Rapid Evidence Synthesis.](#)" *EClinicalMedicine* (2019).

Rains, Luke Sheridan, et al. "[Variations in patterns of involuntary hospitalisation and in legal frameworks: an international comparative study.](#)" *The Lancet Psychiatry* (2019).

Owen, Gareth et al. "Advance decision-making in mental health – Suggestions for legal reform in England and Wales" *International Journal of Law and Psychiatry* 64 (2019): 162-177.

Mental Health and Justice

The challenge to mental capacity on the basis that it is not objective is just one of the issues considered in the article by Matthew Burch and Katherine Furman. "Objectivity in science and law: A shared rescue strategy." *International Journal of Law and Psychiatry* 64 (2019): 60-70 (research supported in part by the Mental Health and Justice project).

When deprivation of liberty is ever justified in the mental health and disability context is addressed in a further MHJ supported paper: Martin, Wayne, and Sándor Gurbai. "Surveying the Geneva impasse: Coercive care and human rights." *International Journal of Law and Psychiatry* 64 (2019): 117-128.

SCOTLAND

Scottish Government review extended and delayed

On 19th March 2019 Ms Clare Haughey MSP, Minister for Mental Health, announced a review of the Mental Health (Care and Treatment) (Scotland) Act 2003. This will substantially broaden the review already being conducted of the Adults with Incapacity (Scotland) Act 2000, and is likely to have the effect of delaying completion of the review of that Act. In my view, however, the Ministerial Statement is to be welcomed. Ever since passage of the 2000 Act, incapacity legislation and mental health legislation have been contained in separate statutes, preceded by separate law reform procedures. The third main relevant area of legislation, covering adult support and protection, is also separate. The Law Society of Scotland has consistently urged comprehensive review. Indeed, the original representations that led ultimately to the 2000 Act urged a comprehensive view of both mental health and adult incapacity law. That was in 1986!

Because of understandable constraints on resources, exacerbated by Brexit, the current Scottish Government review has so far addressed adult incapacity legislation only. Much excellent work has been done. There will be understandable disappointment that the adult incapacity review will now inevitably be slower to reach fruition. Until recently the target was that legislation should be introduced in the Scottish Parliament by the end of 2019. With the widening of the remit, that is now unlikely to happen. Necessary reform of the 2000 Act will be delayed. Nevertheless, I am firmly of the view that the Minister has got it right, for two reasons.

Firstly, the reasons why the Law Society of Scotland has advocated a comprehensive review of all three areas of legislation are sound and substantial. Compliance with modern human rights standards draws them together. The differences have always been troublesome, and have led to contested litigation in which the question “which Act prevails?” proved to be difficult and debatable. There are cultural differences in the ways in which the different regimes are delivered. There is not even a single integrated forum for dealing with cases that may often cross boundaries between different areas of legislation.

The second reason for welcoming the change is that delivering consistently on modern human rights standards requires not only compliance in legislation, but delivery in practice. Relevant Scottish legislation, and in particular Scotland’s adult incapacity legislation, was originally world-leading, and is still highly regarded internationally. It has fallen behind modern human rights standards, but a greater deficit is the result of outdated attitudes in practice. There seems to be a tendency to stick with old ways pending amended legislation. With the likely delay in amending legislation, there can now be no excuse for failure to update attitudes and practice in ways that – within the framework of existing legislation – can better achieve human rights compliance. Delay in law reform provides a space in which the deficits in practice under current legislation must now be tackled.

As noted in the next item, the remit for the review of the 2003 Act will be finalised in conjunction with the chair, once a chair for the review has been identified. In the meantime, there will be a strong “push” to improve practice under existing legislation. There will be consultation on a draft updated code of practice on powers of attorney, followed by consultation on a draft updated code of practice for guardianship and intervention orders. Scottish Ministers are keen to press forward without unnecessary delay, but it is acknowledged that the task will be a massive one.

Adrian D Ward

Mental Health Act review in Scotland: some initial observations

The announcement and scope of the Mental health Act review: a welcome opportunity

As noted above, on 19th March 2019 the Scottish Minister for Mental Health, Clare Haughey, announced what appears to be an ambitious and comprehensive independent review of the Mental Health (Care and Treatment) (Scotland) Act 2003 (the 2003 Act) which aims to improve all categories of rights and protections of those with mental illness, ensure mental and physical health parity and consider the future shape of incapacity, mental health and adult support and protection legislation. In doing so, it will gather the views from a wide a range of people including, importantly, those of service users and carers which will be central to the work. At the time of writing the review chair has not been announced but, once appointed, will decide how the review will proceed.

Before the Public Petitions Committee in the Scottish Parliament on 21st March, Ms Haughey stated:

...the principal aim of the review of the mental health legislation, ...is to improve the rights of and protections for a person with a mental disorder and to remove barriers to those caring for their health and welfare. It will do that by reviewing developments in mental health law and practice on compulsory detention and care and treatment since the Mental Health (Care and Treatment) (Scotland) Act 2003 came into force and by making recommendations that give effect to the rights, will and preferences of the individual by ensuring that mental health, incapacity and adult support and protection legislation reflects people's social, economic and cultural rights, including requirements under the United Nations Convention on the Rights of Persons with Disabilities and the European convention on Human Rights, and by considering the need for convergence of incapacity, mental health and adult support and protection legislation.”

Such review will build on the current reviews of the Adults with Incapacity (Scotland) Act 2000 (further comment on this can be found in Adrian Ward’s commentary in this issue) and of learning disability and autism under the 2003 Act. It should also be noted that on 8th March 2019 a review of the delivery of forensic mental health services was announced by the Scottish Government.

This is an exciting opportunity for Scotland. It not only provides a space for consideration of how to make our law and related practice work better for persons with mental disabilities and their families and carers and improved European Convention on Human Rights (ECHR) rights implementation (both in civil and criminal justice settings). It also provides a space to give serious consideration to what a

UN Convention on the Rights of Persons with Disabilities (CRPD) approach to psychiatric care and treatment really looks like.

It is impossible to tell at present which way the review will go. However, the context within which it will take place is informative as to the issues that it will need to address. The following contains a fairly brief discussion and some observations on this.

Context to the review

(1) Mental Health (Care and Treatment) (Scotland) Act 2003

The objective of Scotland's principled and rights based mental health and incapacity legislation was to limit restrict interventions concerning persons with mental disorder and to maximise individual autonomy even where such interventions were deemed necessary.⁸ In this it was considered to be world leading at the time of its enactment. However, largely owing to inevitable operational issues and to developments in international human rights standards - notably ECHR jurisprudence and particularly following the adoption of the CRPD – a certain amount of slippage has occurred since then. The Mental Health (Scotland) Act 2015 made some amendments to the 2003 Act – for example, extending the reach of its excessive security provisions, bolstering (to some extent) psychiatric advance statements and independent advocacy, and removing the appointment of 'default' named persons for persons over 16 years of age – but for those who had wished for a more extensive 'root and branch' overhaul of the Act it was a disappointment.

In common with many other jurisdictions these recent human rights developments have called into question some of the fundamental assumptions upon which our mental health and incapacity legislation has been based. For example, the European Court of Human Rights has increasingly expansively interpreted the individual autonomy of persons with mental disabilities, particularly in relation to Articles 5 (liberty) and 8 (respect for private and family life) ECHR rights.⁹ This has included challenging the conflation of detention and compulsory treatment, arguing that each requires separate justification and safeguards.¹⁰ The CRPD Committee's interpretation of what it means for persons with mental disabilities to enjoy rights on an equal and non-discriminatory basis with others is also requiring states and society to reconceptualise how care, treatment, support and protection is justified and

⁸ See Scottish Law Commission, *Report on Incapable Adults* (Scot Law Com No 151, September 1995) and Scottish Executive, *New Directions: Review of the Mental Health (Scotland) Act 1984* (SE/2001/56, January 2001) both of which strongly influenced the content and nature of both pieces of legislation.

⁹ For example, *Shtukaturv v Russia* (App no 44009/05) (2012) 54 EHRR 27, paras 87-89; *Sykora v Czech Republic* (App no 23419/07) (2012) ECHR 1960, paras 101-103; *HL v UK* (2005) 40 EHRR 32 (see also how this was interpreted in *P (by his litigation friend the Official Solicitor) (Appellant) v Cheshire West and Chester Council and another (Respondents); P and Q (by their litigation friend, the Official Solicitor)(Appellants) v Surrey County Council (Respondent)* [2014] UKSC 19 (Cheshire West)); *A-MV v Finland* (App no 53251/13) (ECtHR, 23 March 2017).

¹⁰ *X v Finland* (App no 34806/040) (2012) ECHR 1371, para 220.

delivered.¹¹ Part of this requires that ‘supported decision-making’ that gives effect to [“gives effect to” or, per CRPD, “respects”?] the rights, will and preferences of the individual replaces arrangements, such as laws allowing for non-consultation psychiatric treatment and guardianship, that authorise others to make decisions for and about persons with mental disabilities based on diagnosis, capacity assessments and related impairment.¹²

(2) Scotland's Mental Health and Capacity Law: the Case for Reform

There have been several stakeholder calls for reform of the 2003 Act. Additionally, in May 2017, following a mental health and incapacity law reform scoping exercise, the Mental Welfare Commission for Scotland and Centre for Mental Health and Capacity Law (Edinburgh Napier University) published a report *Scotland's Mental Health and Capacity Law: the Case for Reform*. This also took into account the Commission report *Capacity, Detention, Supported Decision Making and Mental Ill Health* that was published following meetings with service user and carer groups.

The Case for Reform noted the international human rights developments. It also noted that although there still appeared to be widespread support for the principles of the Adults with Incapacity and Mental Health Acts these are not necessarily working in the way that was intended for persons with mental disabilities. Concerns existed that individuals may remain disempowered and that resource constraints were undermining the balancing of safeguards and rights. In this context, it should be noted that compulsion under the 2003 Act is rising. The Mental Welfare Commission 2017/18 *Mental Health Act Monitoring Data* report noted the highest number of new compulsory episodes since the 2003 Act was implemented and a general increase in new incidences of compulsion over the last ten years. Similarly, guardianship applications are also on the rise.¹³

The report came to a number of broad conclusions including:

1. The need to revisit and, where necessary reframe, our mental health and capacity law (also paying attention to its implementation).
2. The need to do more to maximise the autonomy and exercise of legal capacity of individuals with mental disorder (even where significant impairments of decision-making capacity exist).

¹¹ Clough, Beverley A (2018) ‘New Legal Landscapes: (Re)Constructing the Boundaries of Mental Capacity Law’ 26 *Medical Law Review* 246; Stavert, J (2018) Paradigm Shift or Paradigm Paralysis? National Mental Health and Capacity Law and Implementing the CRPD in Scotland 7(3) *Laws* 26.

¹² Committee on the Rights of Persons with Disabilities, *General Comment No 1 (2014) Article 12 Equal Recognition before the Law* (CRPD/C/GC/1, 19 May 2014).

¹³ Mental Welfare Commission for Scotland *Adults with Incapacity Statistical Monitoring 2017/18* https://www.mwscot.org.uk/media/433118/10.09.2018_2017-18_awi_monitoring_report_0709_with_appendix_b.pdf

3. Capacity assessments are potentially discriminatory and there is therefore a need to revisit how 'capacity' and 'significantly impaired decision-making ability' (the 2003 Act 'capacity' test) are assessed by clinicians and practitioners.
4. The need to rationalise and provide greater synergy between the Adults with Incapacity, Mental Health and Adult Support and Protection Acts.
5. It was unclear whether there was currently an overwhelming appetite for unified mental health and capacity legislation in Scotland. There did, however, appear to be enthusiasm for short to mid-term incremental changes which might ultimately pave the way for such legislation.

In summary, the report's recommendations, many of which appear to be reflected in the Minister for Mental Health's recent announcement, included that:

1. There should be a long-term programme of law reform working towards a coherent and non-discriminatory legislative framework that reflects CRPD and ECHR requirements and actively consults persons with lived experience in the process.¹⁴
2. Increased convergence of the legislation over time should be an explicit aim of this reform process, particularly in relation to the criteria justifying intervention.
3. There should be a single judicial forum to oversee non-consensual interventions.¹⁵
4. Consideration should be given to the replacement of the 2003 Act 'significantly impaired decision-making ability' test by a capacity test but that '...the priorities before considering such legislative change should be (a) to improve practice and develop consistent standards across medicine, psychology and the law on the assessment of capacity and (b) to identify and implement practical steps to enhance decision making autonomy whenever non-consensual interventions are being considered.'

(3) The review of the Mental Health Act in England and Wales

Of course, the announced review of Scotland's mental health legislation comes very soon after the Wessely Review of the Mental Health Act in England and Wales which reported in December 2018.

The review report recommended a new Mental Health Act underpinned by the four principles of choice and autonomy, least restriction, therapeutic benefit and the person as an individual. Informal treatment, detention as a last resort, statutory care and treatment plans, shared decision-making, greater legal effect for refusals of treatment, advance planning and independent advocacy are all seen as integral

¹⁴ Specifically noting this requirement in Article 4(3) CRPD.

¹⁵ The balance of views in the scoping exercise appeared to favour the Mental Health Chamber of the new devolved tribunals structure in Scotland although this was not necessarily borne out by responses to the subsequent Scottish Government Consultation on Adults with Incapacity (Scotland) Act 2000 reform (see <https://consult.gov.scot/health-and-social-care/adults-with-incapacity-reform/>).

components of such principles. Amongst other things, it also recommends that community treatment orders be revisited, alternatives to coercion be promoted and better support, care and treatment environments tailored to the specific needs and characteristics of patients (including, notably, those from ethnic minorities, children and young persons and persons with learning disability and/or autism) be created in both the civil and criminal justice spheres. It also recommends that use of the Mental Capacity Act 2005 for admission to hospital and treatment for mental disorder should be confined to persons who lack capacity and who are not resisting this, otherwise the mental health legislation must be used.

Whilst some elements of these recommended principles go beyond those in the Scottish 2003 Act they very much broadly reflect the same principles. There is much to commend the English and Welsh review and it is important to acknowledge the enormity of its task and appreciate the remit and time constraints it was working to. Respect for ECHR, and to some extent, CRPD rights are reflected its findings and recommendations but it largely promotes a medical model of disability albeit arguably a more enlightened one that currently operates around the Mental Health Act in England and Wales. The challenge now for the Scottish Government and Parliament is whether or not they are prepared to build on and enhance this or go even further and reconceptualise the approach to laws that allow for the care and treatment of persons with mental disabilities in Scotland.

Certainly, the English and Welsh review had its reservations about fully giving effect to the CRPD Committee requirements regarding Article 12 CRPD (the right to equal recognition before the law)¹⁶ in the context of psychiatric care and treatment. The review does go some way in endeavouring to take the CRPD's requirements into account, notably in relation to reducing the incidence of coercion in psychiatric care and treatment. However, its recommendations are influenced by concern that to give full effect to the CRPD Committee's requirements regarding Article 12 may leave persons who are deemed to lack capacity to take decisions for themselves without protection against exploitation, excessive detention and other abuses and from causing harm to themselves and to others. It is suggested, however, that such concern – which in fairness the review is not alone in expressing - is to misunderstand what the CRPD or its Committee are actually saying.

The CRPD: myth busting in the context of psychiatric care and treatment

Without doubt the CRPD message, particularly as articulated by the CRPD Committee, is challenging to the status quo concerning psychiatric care and treatment. It quite rightly gets to the heart of what equal human rights enjoyment by persons with mental disabilities actually means and this requires a break with traditional understandings of rights enjoyment in this context.¹⁷ It is no longer acceptable

¹⁶ *General Comment No 1 (2014)* (see note 5 above).

¹⁷ *General Comment No 1 (2014)* (see note 5 above); Committee on the Rights of Persons with Disabilities, *Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities: the Right to Liberty and Security of Persons with Disabilities* (September 2015); Committee on the Rights of Persons with Disabilities *General comment No. 5 (2017) on living independently and being included in the community* (CRPD/C/GC/5, 27 October 2017); Committee on the Rights

that the existence of a disability can be regarded as a reasonable and objective justification for the denial of rights.¹⁸ The approach to rights realisation must be one of removing state and societal obstacles which effectively 'disable' persons with mental disabilities for enjoying their rights on an equal basis with others and also providing the necessary support to achieve this.

This new understanding – the so-called 'CRPD paradigm shift' - does not mean that those with mental disabilities will potentially and effectively be deprived of the necessary support and protection they may from time to time require. Nor does it mean that the public will be placed at greater risk. It is about recognising that persons with mental disabilities are entitled to enjoy the exercise of rights - and this includes the limitation of such rights - on an equal and non-discriminatory basis with others. In other words, parity of treatment in the same circumstances which cannot be achieved if disability or related impairment are used as justification for rights being restricted. This requires asking whether, and what, action be taken in particular circumstances if the person concerned did not have a mental disability and/or related impairment. It also prompts difficult questions about the potentially discriminatory effect of the means by which persons with mental disabilities are assessed in terms of requiring care, treatment, support and protection, or as presenting a risk to others, and how these might be improved or replaced. This includes, amongst other things, giving serious consideration as to when the state may or may not have a positive duty to protect an individual's right to life where the actual or potential harm comes from that individual.¹⁹

Recognising, however, that not everyone starts from the same baseline the CRPD requires that persons with mental disabilities may need support for the exercise of legal capacity (or 'supported decision-making') and reasonable accommodation in order to achieve this equal enjoyment of rights. Supported decision-making allows for a person's will and preferences to be given effect, either by the person themselves or by others on their behalf. Moreover, the CRPD Committee states that where it is impossible, despite significant efforts to do so, to ascertain a person's will and preferences then decisions can indeed be made on behalf of that person based on a 'best interpretation' of what these would be. The CRPD approach also acknowledges that where a person with a mental disability is at

of Persons with Disabilities *General Comment No. 6 (2018) on equality and non-discrimination* (CRPD/C/GC/6, 26 April 2018).

¹⁸ *General Comment No. 6 (2018)* (above).

¹⁹ Article 2 ECHR and Article 10 CRPD. To start this discussion it is well worth reading A Ruck Keene 'Deprivation of liberty and disability – its meaning and (il)legitimacy', *Mental Capacity Law and Policy* (22 February 2019)

<http://www.mentalcapacitylawandpolicy.org.uk/deprivation-of-liberty-and-disability-its-meaning-and-illegitimacy/>; K

Wilson 'The Call for the Abolition of Mental

Health Law: The Challenges of Suicide,

Accidental Death and the Equal

Enjoyment of the Right to Life' (2018) (volume 18, issue 4) *Human Rights Law Review*; and E Flynn 'Disability,

Deprivation of Liberty and Human Rights Norms: Reconciling European and International Approaches' (2016) (issue 22) *International Journal of Mental Health and Capacity Law*

<http://journals.northumbria.ac.uk/index.php/IJMHMCL/article/view/503>

risk or poses a risk to others then interventions, under civil or criminal law (as appropriate), are permissible provided such interventions would be applied in the case of persons without mental disabilities in the same circumstances. It further requires that environments causing or human perpetrators of actual or potential harm to a person with a mental disability are targeted rather than the person themselves. Finally, although disability cannot be used to decide whether or not an intervention takes place the CRPD advocates that equal enjoyment of rights requires that support and reasonable accommodation appropriate to such disability is provided whilst that intervention is implemented.

It would, of course, be a mistake to underestimate the enormity of the task of achieving the CRPD paradigm shift in any meaningful sense. However, if Scotland is serious about giving effect to the CRPD then this must be embraced. It requires appropriately tailored resources to be allocated at the point of need so that this can be achieved for persons with mental disabilities. At a cultural, policy and practice level, it further requires both the state and society to adopt and respect a wider range of individual behaviour, choices and personality which will also necessitate a re-examining of existing notions of acceptable and unacceptable risk.

CRPD and ECHR: tension or enhancement?

Scottish devolved law must be enacted and implemented with ECHR compliance in mind.²⁰ Admittedly, despite it increasingly adopting an expansive approach to the autonomy of persons with mental disabilities, the European Court of Human Rights' approach is more aligned to the medical model of disability which seeks to merely define the perimeters of psychiatric and other intervention rather break down the obstacles to equal rights enjoyment this presents.

The tension between the ECHR approach and CRPD social model of disability, together with the fact that the ECHR constitutionally carries greater legal weight in Scotland, can sometimes be seen as an impediment to full CRPD implementation but there is no reason why this needs to be so. In fact, Scottish devolved legislation and policy must not violate the UK's international obligations, and this includes those as a CRPD state party,²¹ and the Scottish Government is already engaging with this treaty.²² It is possible for the ECHR and CRPD – if the CRPD model of equal and non-discriminatory rights enjoyment is properly operationalised – to complement each other. However, if the CRPD is to be given genuine effect then it is necessary to view the rights of persons with mental disabilities through its lens of achieving equal and non-discriminatory enjoyment of such rights. This will not be achieved through a medical model lens.

Conclusion

²⁰ ss 29(2)(d) and 57(2) Scotland Act 1998; ss 2, 3 and 6 Human Rights Act 1998.

²¹ ss 35(1)(a) and 58(1) Scotland Act 1998.

²² See the Adults with Incapacity Act review (and related provision in the Scottish Government *Mental Health Strategy 2017-2027*) and Scottish Government December 2016 CRPD Delivery Plan.

Many issues will have to be addressed by the Scottish mental health legislation review quite apart from what will inevitably be a range of competing views on the role and purpose of mental health law in Scotland. These include, but are not to confined to, whether capacity and decision-making assessments – given that they trigger interventions - can be better done and truly be non-discriminatory or need to be replaced, whether unified legislation (such as that in Northern Ireland) will be the way forward and how the interface between the law and practice relating to capacity, mental health, adult support and protection and criminal justice can be improved. Continued research into what works in terms of alternatives to physical and psychological restraint and coercion, and supported decision-making, so that the voice of the individual is genuinely heard and drives the nature and implementation of any interventions will be required. The role of the courts and Mental Health Tribunal/Mental Health Chamber as guardians of the rights of persons with mental disabilities and how these will need adapt to developing human rights requirements must be examined.²³

It is impossible at this stage to speculate just how radical the outcome of the proposed review will ultimately be. The possibilities in theory are almost endless and, given the international attention paid to our current mental health and incapacity legislation when originally enacted, it is highly likely the review will be observed with interest elsewhere. As mentioned earlier, *The Case for Reform* report noted that despite the best intentions leading to the principles that underpin our existing mental health, and incapacity, legislation the reality is that these principles are not necessarily being realised for persons with lived experience of mental disorder. The Scottish review thus provides a valuable opportunity to re-examine how adequately our law and practice caters for the real needs of persons with mental disabilities and their families and carers and how we can enhance human rights compliance.

Jill Stavert

Who pays? Yet again!

On a number of occasions, we have reported cases where there have been difficulties relating to movements of adults between Scotland and England. In the *Milton Keynes* case (reported upon in our [December 2015](#) newsletter) an adult was permanently settled in a nursing home in Scotland, ordinary residence might well have been held to have moved to Scotland under English ministerial guidance, but the Scottish court arrived at a similar conclusion to the Scottish ministerial guidance and held that the English local authority was obliged to continue to pay.

The case of *Priory Healthcare Limited v Highland Health Board* ([2019] CSOH 17; 2019 SLT 356) is rather different. The adult in that case had been receiving care and support in Scotland under section 25 of the Mental Health (Care and Treatment) (Scotland) Act 2003. There is a significant difference between paragraphs (a) and (b) of section 25(1). Under section 25(1)(a), the relevant local authority has a duty

²³ Noting here the ongoing Centre for Mental Health and Capacity Law (Edinburgh Napier University) led *Mental Health Tribunal for Scotland: The views and experiences of patients, Named Persons, Practitioners and Tribunal members* project.

to provide care and support for persons who are not in hospital and who have or have had a mental disorder (or must secure the provision of such services). Under section 25(1)(b), if the adult is in hospital then the local authority “may” provide such services.

The adult travelled to England voluntarily in or about early October 2016. She had been ordinarily resident in Scotland. She took a taxi to Cambridge. She was initially admitted to Addenbrookes Hospital, Cambridge. She was detained under the (English) Mental Health Act 1983. She was assessed as being a vulnerable adult and at risk of self-neglect, due to non-compliance with medication and delusional beliefs. NHS Cambridgeshire, who managed Addenbrookes Hospital, transferred her to a facility operated by Priory Healthcare Limited.

Some time after the adult’s transfer to the Priory facility, Highland Health Board started paying Priory’s invoices without challenge. They did so until 25th April 2017, when they advised Priory that they would no longer pay fees incurred after 30th April 2017. Priory maintained that Highland Health Board were obliged to continue paying. There were three strands to Priory’s case. The first was an assertion that the contract with Priory was entered into by NHS Cambridgeshire as agents for Highland Health Board. The second was that Highland Health Board had adopted and ratified the funding agreement. The third was that Highland Health Board were personally barred from disputing their contractual liability. All three arguments failed.

It was not disputed that Highland Health Board was the relevant “local authority” for the purposes of section 25.

Priory contended that the contract that Priory alleged to have entered between the parties contained an implied term that the contract could not be terminated by Highland Health Board if such termination breached the statutory duties that Highland Health Board owed to the adult under section 25, and would place her at material risk of harm. In his decision, Lord Bannatyne stated that he “initially found the arguments, very powerfully and eloquently advanced by Senior Counsel for the Pursuer, in respect of the primary issue of contract formation to be attractive ones”. Lord Bannatyne’s lengthy and careful narration of the arguments, and his analysis of them, should be referred to. Ultimately, however, the following relatively simple point was crucial to Priory’s claim failing. At the time of formation of the alleged contract, the adult was an adult already in hospital to whom the discretionary provisions of section 25(1)(b) applied. She was not an adult in the community to whom the mandatory provisions of section 25(1)(a) were applicable.

Adrian D Ward

Caution for powers of attorney?

Concern has been expressed by some practitioners who became aware of apparent moves towards requiring caution for powers of attorney. Upon enquiry, the Scottish Government team conducting the review of the Adults with Incapacity (Scotland) Act 2000 has provided helpful clarification. They have

explained that the general concept of caution for powers of attorney has been mooted for some years. Before any proposal could be made about such caution, it is necessary to assess whether there would be a viable market product. The Scottish Government team have initiated such an assessment. They are liaising with current providers of caution to assess product availability, and associated caveats and limitations that might be placed on such a product. Those providers have been clearly advised that this is a fact-finding exercise only, and that nothing should be inferred from the enquiry.

The Scottish Government team intend that, following this exploratory exercise, a report will be prepared covering the wider matters that ought properly to be considered in the course of such a deliberation. If thereafter any decision is made to make any proposal regarding caution for powers of attorney, that will be formally disseminated and consulted upon.

It is accordingly premature to comment beyond making the obvious points that (firstly) some granters might, particularly when properly advised, welcome the opportunity to stipulate that their attorneys should find caution, but (secondly) this would obviously be a matter for such granters, and it would be contrary to the basic human rights principles of autonomy and self-determination to impose such requirements upon granters who opted not to require caution.

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Conferences

Conferences at which editors/contributors are speaking

Essex Autonomy Project summer school

Alex will be a speaker at the annual EAP Summer School on 11-13 July, this year's theme being: "All Change Please: New Developments, New Directions, New Standards in Human Rights and the Vocation of Care: Historical, legal, clinical perspectives." For more details, and to book, see [here](#).

Local Authorities & Mediation: Two Reports on Mediation in SEND and Court of Protection

Katie Scott is speaking about the soon to be launched Court of Protection mediation scheme at the launch event of 'Local Authorities & Mediation - Mediation in SEND and Court of Protection Reports' on 4 June 2018 at Garden Court Chambers, in central London, on Tuesday, 4 June 2019, from 2.30pm to 5pm, followed by a drinks reception. For more information and to book, see [here](#).

Advertising conferences and training events

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

Our 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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