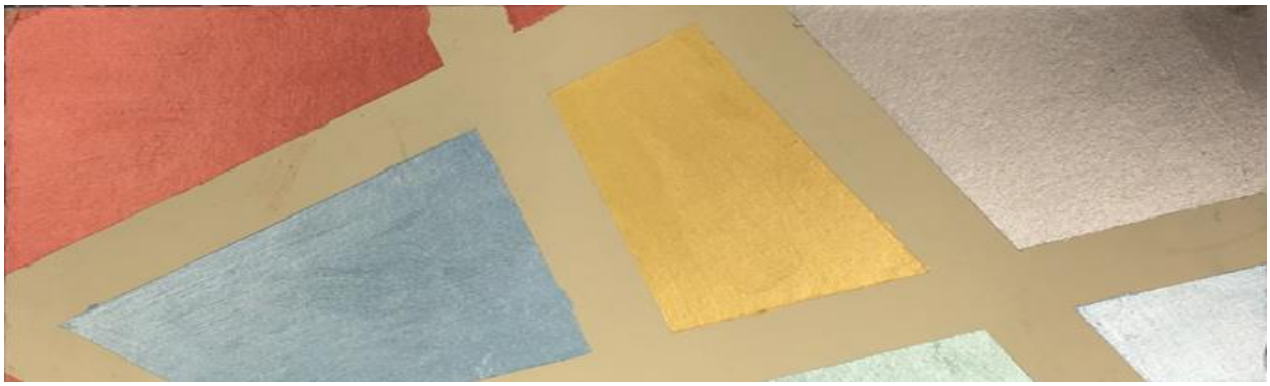

Welcome to the April 2022 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: Draft MCA and LPS Code published; capacity to terminate a pregnancy; the (limited) role of the Inherent Jurisdiction; and is an application needed in all vaccine disputes?

(2) In the Property and Affairs Report: the Court of Appeal weighs in on testamentary capacity, and the evidence used to prove it; and an invitation to the pilot for digital submission of property and affairs cases

(3) In the Practice and Procedure Report: reporting restrictions; the role of COP in MHA discharge planning; costs; and notable conferences on capacity;

(4) In the Wider Context Report: the impact of s.49 reports on mental health professionals; Article 2 and 3 damages claim; the *M'Naghten* test considered; and is having a deputy an Article 14 'status'?

(5) In the Scotland Report: Guardians' remuneration; open justice or anonymisation; and still time to contribute to the Scott Review or sign up to the World Congress on Adult Capacity in Edinburgh;

You can find our past issues, our case summaries, and more on our dedicated sub-site here, where you can also find updated versions of both our capacity and best interests guides.

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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

New MCA Code and LPS Consultation Published

On 17 March 2022 the DHSC published, on its own behalf, and that of MOJ and DfE, the long-awaited draft Code for consultation. The

consultation runs until 7 July 2022. There is a detailed consultation document, together with two easy read summary booklets, one focusing on the wider MCA guidance, and one on the LPS guidance, both available on the consultation page here, and Alex has provided a video walkthrough here.

At the same time, there is also a consultation on 6 sets of draft regulations which will underpin the new system. When enacted, 4 of these sets of regulations would apply in England only. The remaining 2 sets of regulations would apply to both England and Wales. Separately, the Welsh Government has published 4 sets of regulations which would apply in Wales. The DHSC is also publishing a number of documents to help the sector prepare for implementation. These products are not subject to formal consultation, but feedback is invited as part of the consultation process. These are:

- The impact assessment – this constitutes the government's assessment of the financial impact of LPS, including the Code and regulations, as proposed for consultation
- LPS workforce and training strategy – this covers:
    - workforce planning
    - the learning, development and training on offer
    - what different organisations and sectors can do now to begin preparing for LPS
- LPS training framework – which makes recommendations about subject areas that LPS training should cover
- LPS National Minimum Data Set – which will be used to standardise the collection and submission of notification data that is sent to the monitoring bodies and NHS Digital
- Equalities impact assessment – which assesses the potential equality impact of the design of LPS overall, including the Mental Capacity (Amendment) Act 2019, the LPS regulations and the Code

Welsh Government is also conducting its own consultation on specific aspects in Wales (which includes an interesting additional set of criteria for people to be eligible to carry out the assessments and determinations for LPS purposes).

Many people will no doubt be writing many things in the coming weeks, but the purpose of this rapid reaction overview is to highlight what seem to be particularly important things to know about the draft Code to help in how you respond. For more on LPS, see Alex's resources page here.

The status of the Code

As before, it will be a statutory Code, i.e. laid before and approved by Parliament. Whilst it cannot create the law, the Code provides important amplification about how the MCA applies in practice. The MCA, in turn, sets out in (s.42) the categories of people who have to have regard to it when they are acting in relation to a person who lacks (or may lack) capacity, and – importantly – that any court (not just the Court of Protection) must take both the provisions of the Code and any failure to comply with it if relevant to a question before it.

A combined Code

First and foremost, this is a combined Code. Unlike the previous position where there was a separate Code for the 'main' MCA 2005, and an entirely separate Code for the Deprivation of Liberty Safeguards, this Code integrates the sections relating to the Liberty Protection Safeguards and the sections relating to the main MCA into one document. This obviously brings with it complexities – above all of navigation around what is now inevitably a lengthy document (although it should be remembered that the previous Codes, together, ran to 426 pages). However, it gives the important message that the Liberty Protection Safeguards are founded upon the MCA, and require a proper understanding of the concepts of capacity and best interests by those applying them. Some

may ask how LPS can require a proper understanding of best interests if they do not make 'best interests' a part of the criteria for the grant of an authorisation: this is because best interests comes in at the earlier stage of the decision-making, i.e. choosing between the options available to the person. By the time thought is being given to whether one of the options will give rise to confinement, the laser-like focus should be upon whether it can be said to be truly necessary and proportionate to the risk of harm that the person would suffer otherwise.

The first 11 chapters of the Code will look broadly familiar in chapter headings terms to those familiar with the original 2007 Code. They provide an overview of the Act, before moving in stages through the principles, the concepts of capacity, best interests, the defence in s.5, the role of the Court of Protection, LPAs, IMCAs and advance decisions to refuse treatment. The LPS chapters then follow before chapters 21-26 then pick up the themes from the original Code of how the Act applies to children and young people, the relationship between the MHA and the MCA, the protection of people lacking capacity to make decisions for themselves, disagreement/dispute resolution, information access and research.

The core MCA chapters

DO NOT BE FOOLED by the similarity in chapter titles where these relate to the core MCA provisions: the content has been significantly revised in many places, to take account – broadly – of two matters:

- The fact that the original MCA Code was drafted prior to the Act coming into force so represented in many ways the 'best guess' as to what situations were most likely to arise in practice;
- That we now have a significant body of case-law both applying and, more importantly, interpreting the MCA, which has made clear that the original Code was wrong in a number of ways (as to this, see this guidance note).

Key changes to the core chapters include the following (over and above the weaving in of express LPS cross-references where relevant):

- The alignment of what the Code says (in paragraph 3) about what it means to lack capacity with what the Act says. The previous version talked about two-stage test, starting with what is often (but wrongly) called a 'diagnostic' test. The courts have, however, made clear this is incorrect because ss.2-3 require analysis of, first, whether the person is able to make their own decision (i.e. to understand, retain, use and weigh their relevant information and to communicate their decision).[1] It is only if the person cannot do so that you move on to considering whether they have an impairment or disturbance in the functioning of their mind or brain, and, if so – and importantly – whether their inability to make the decision is **because of** that impairment or disturbance. This last point is of particular importance given that, since the original MCA Code was drafted, the courts have made clear that the High Court's inherent jurisdiction has survived (in rather ill-defined form) to secure the interests of those who have capacity to make a decision but are under coercion.
- More 'granularity' in how to think about capacity assessments. Although the Code is not a substitute for professional guidance documents, which translate the specific requirements of the Act into approaches directly relevant to the particular discipline(s) in question, the Code does tackle head-on in more detail some of the problems that have been identified in practice, such as fluctuating

[1] Although note that the draft Code does not refer to the decision of the Supreme Court in *JB*, which put this beyond doubt. This will undoubtedly be rectified in the final version.

capacity and so-called 'executive dysfunction;'

- Clearer guidance about the role of wishes and feelings, beliefs and values in the making of best interests decisions in light of the extensive body of case-law determined under the MCA. The guidance also reflects the considerable evolution of the approach to making decisions about life-sustaining treatment since the Act came into force;
- Clearer guidance about how s.5 MCA 2005 operates in a context where the MCA on the one hand expressly does not provide for surrogate decision-makers where no deputy or attorney (or Court of Protection judge) is involved, but on the other hand has to be applied, in most contexts, by a person or body. The Code also makes clear the categories of care and treatment which involve more serious interventions, and the more rigorous steps required before the person or body can properly say that they are able to rely upon the defence;
- The Code also reflects the development of the case-law to outline the circumstances when it is possible to proceed to give (or where relevant) withhold medical treatment without going to court. The Code also provides more detail about when and how the Court either must or should be involved in medical treatment cases, welfare cases and situations involving a person's property and affairs;
- In relation to deputies, the Code picks up, in particular, the decision in *Lawson & Mottram* relating to the appointment of health and welfare deputies, making clear that, whilst there is no presumption against appointing a deputy, the operation of s.5 MCA 2005 means that, in practice, fewer health and welfare deputies will be appointed than property and affairs deputies;
- The chapter on Advance Decisions to Refuse Treatment includes, most significantly, consideration of how subsequent doubts about whether the person had capacity to make the ADRT are to be resolved, which is to be read together with the chapter on capacity, which makes that the presumption of capacity is not retrospective, such that if proper reasons are identified to suggest that the person did not have capacity, it will be for them, or someone on their behalf, to show why those doubts are ill-founded;
- The chapter on children and young people reflects the fact that there is now a body of case-law explaining the interaction between the MCA and the concept of *Gillick* competence post-16, and also makes clearer that decision-makers need to be aware that, where a 16-17 year old lacks capacity to make a relevant decision, they may in many cases have a choice as to whether to proceed under s.5 MCA 2005 or by way of obtaining consent from a person with parental responsibility. They need, however, both to be aware that they are making a choice, and that the choice will have consequences for how they proceed, and what happens if there is a disagreement. The chapter also addresses the increased – express – interaction between the MCA and other pieces of legislation relating to children arising both out of the fact that much of that legislation expressly now refers to the MCA 2005 (e.g. the Children and Families Act 2014) and because of the operation of LPS from age 16;
- The 'interface' chapter reflects the fact that underlying policy interface between the MCA and the MHA relating both to treatment and detention is unchanged as a result of the MCA(A) 2019, albeit reframed in perhaps more comprehensible language. It also makes clear that there will be many situations in the community in which s.17(3) MHA 1983 will provide sufficient authority to

deprive the person of their liberty, such that it is not necessary to have parallel authorisations.

Many may feel that the scenarios in the Code could do with work – if that is your response, then the obligation upon you is to provide sufficiently gritty scenarios for the civil servants to work up into case studies.

The CRPD

One thing that readers might expect to see express reference to is the Convention on the Rights of Persons with Disabilities. The introduction makes clear that the MCA and the Code "are important parts of the UK's commitment to the United Nations Convention on the Rights of Persons with Disabilities regarding promoting and protecting the rights and freedoms of people who may lack capacity to make decisions." However, the Code does not then make express reference to the CRPD throughout. This is because the CRPD is not binding upon public authorities and courts in the same way as (for instance) the European Convention on Human Rights (which is expressly referred to in a number of places). However, the effect of Article 12 CRPD – the right to legal capacity – can be felt in the significantly greater emphasis throughout the Code on (1) supporting individuals to make their own decisions at the time; (2) supporting individuals to make their own decisions in advance of potential incapacity; and (3) ensuring proper consideration of the person's wishes, feelings, beliefs and values in best interests decision-making.

The LPS chapters

Chapter 12 is likely to be one of the chapters most closely scrutinised. It contains the Government's (non-statutory) definition of deprivation of liberty promised during the passage of the MCA(A) 2019. It contains a number of strong statements, including:

- The Government's interpretation of the 'acid test' set down by Lady Hale in *Cheshire West*;
- The Government's view of the essentially unlimited potential for a person to give advance consent so as to prevent a confinement (including in a psychiatric hospital for purposes of assessment / treatment under the MHA 1983) being seen in law as a deprivation of liberty;
- A wide interpretation of the so-called *Ferreira* carve-out in relation to medical treatment for physical health problems.

The LPS chapters then move through an outline of the overall process, discussion of the responsible body, the appropriate person, the assessment conditions, consultation, the role of the Approved Mental Capacity Professional, the operation of the interim/emergency power in s.4B MCA 2005, and monitoring the reporting.

It is perhaps important to emphasise that the purpose of a Code is not to set out an operational protocol, but rather to outline how the Act is intended to work in practice. In particular, given the enormous range of situations within which LPS can apply, and the different types of organisations which will be Responsible Bodies, the Code could not seek to prescribe how, operationally, obligations should be discharged. Rather, it is to make clear expectations about the way in which tasks are to be done, for instance, the expectation that the process of authorisation will be complete within 21 days (para 13.26), and steps that can sensibly be expected to be seen to secure both appropriate levels of operational independence and appropriate levels of expertise amongst those undertaking different tasks.

The Code answers, at least in draft, the following key questions that are regularly asked about LPS:

- Who can carry out key tasks (in each case subject to further eligibility requirements set out in the relevant regulations), the draft Code identifies the following professionals as eligible to carry out the following functions:

1. Capacity/necessity and proportionality assessment/determination: (1) medical practitioner; (2) nurse; (3) occupational therapist; (4) social worker; (5) psychologist; (6) speech and language therapist.
2. Medical assessment: registered medical practitioner or registered psychologist.
3. Approved Mental Capacity Professional: (1) nurse; (2) social worker; (3) psychologist; (4) speech and language therapist; (5) occupational therapist.

One question that will no doubt feature heavily in the minds of some during consultation is whether, if these are cemented into law in the final version of the regulations, it will be possible to secure the policy goal of thinking about LPS at the same time as thinking about care planning – to avoid duplication, and to avoid the DOLS problem of decisions being made and then checked afterwards, when it is all too late. Many local authorities, for instance, do not use qualified social workers to undertake care and support planning work under the Care Act, so would not be able to use materials gathered during this directly for LPS purposes. One question that some may want to think about is whether it would be appropriate to distinguish between 'assessment' and 'determination' and require that at least one part of these two tasks is carried out by a qualified social worker.

- Who can be an Appropriate Person. The draft Code makes clear that, although the Act is silent about who can be an Appropriate Person, the DHSC expects that it to be an unpaid role. There will therefore be no role for the equivalent of paid RPRs under DOLS. Where there is no person who can be an unpaid Appropriate Person, a (paid) IMCA will be required throughout so long as it is in the person's best interests (it is difficult to imagine circumstances when it will not).

- How many people need to be involved. The draft Code makes clear that the DHSC expects that there should be at least two professionals involved in carrying out the three assessments and determinations required, with a degree of independence from each other. The draft Code provides a set of principles for Responsible Bodies to consider in setting up their arrangements to facilitate this independence.

- How long the process should take. There is no statutory time-frame for completion of the process of assessment, unlike under DOLS. However, the draft Code makes clear that the DHSC expects that the LPS process should be completed within 21 calendar days of receipt of referral. It is likely that CQC / Ofsted will use this as a marker against which to stress-test the performance of Responsible Bodies.

- Whether legal aid is available. The draft Code makes clear that non-means-tested legal aid will be available where the person is subject to an LPS authorisation, for the person themselves, for their Appropriate Person. Importantly, it also makes clear that non-means-tested legal aid will be available "in relation to s.4B of the Act," which means that it is possible for the person / their Appropriate Person to challenge the situation where an LPS authorisation has been applied for but not yet granted.

Refusing a deprivation of liberty order

An NHS Trust v ST (Refusal of Deprivation of Liberty Order) [2022] EWHC 719 (Fam): (MacDonald J)

Article 5 ECHR – Children and young persons

Summary

This is another shocking case concerning the acute shortage of suitable residential therapeutic placements to meet the needs of children and young people.

ST was an extremely vulnerable child with highly complex needs. She was 14, autistic, had a moderate learning disability and her distressed behaviour included physical violence and damage to property. She was living with her parents and two younger siblings whilst having 6:1 staff support at school pursuant to an education, health and care plan. Her behaviour escalated, resulting in her siblings having to lock themselves in their bedrooms for safety and the school placement was terminated. She made regular and determined efforts to run away from home, lacking road sense and any sense of stranger danger.

On 21 January 2022, following a previous attempt by the family to present ST to hospital, Dr S advised that ST should not be admitted to hospital unless there was a medical need as "*there is clear risk of harm to her and others if she is admitted and this is not an appropriate place of safety in a crisis*". [11] Her family was still unable to care for her at home, with her parents resorting to locking her in the dining room, and on 15 February 2022 her father presented her to hospital. She was admitted to a general paediatric ward solely as a place of safety, there being no physical or psychiatric need for medical treatment, following which the local authority employed a private company to provide two security guards and two carers to supervise her on a 4:1 basis. There followed a litany of incidents in which her welfare was fundamentally compromised, including:

(i) On 17th March 2022, ST was held down by security guards and a support worker. Nurses witnessed the security guards on top of ST's legs and holding down her arms while she was laying upset in her bed, there was also a male support worker holding her head from above pressing her head into the mattress with fingers coming over her forehead. ST was screaming very loudly and sounded very scared. Nursing staff advised that restraint of the head was not appropriate.

(ii) On 18 March 2022, two security guards attempted to force ST back into her room, during which incident ST slapped and kicked both guards. ST was tranquilised with Lorazepam.

(iii) On 18 March 2022, ST was placed in a hold and was thrashing and kicking out. She was thereafter held as she was taken back to her room and placed on in a hold on the bed. ST was again tranquilised with Lorazepam.

(iv) On 19 March 2022, ST was subjected to what are described in the hospital records as "multiple assisted walks and minimal safe holds". She was again tranquilised with Lorazepam.

(v) On 20 March 2022, ST was subject to three restraints and was required to walk around the ward in a restraint hold by two security guards. ST was also placed in a hold on the ward floor on three occasions.

(vi) On 21 March 2022, ST was placed in restraint involving two security guards and two carers. Again, her head was restrained. She was also later held in a restraint on the floor of the ward twice.

(vii) On 22 March 2022, ST became distressed whilst restrained when walking and fell to the floor kicking and screaming. This was witnessed by other patients and parents on the ward becoming upset and scared. ST was subjected to a restraint hold by five people comprising four security guards and a mental health support worker.

(viii) *On 22 March 2022 ST had to be further restrained twice by 11am and had received two doses of chemical restraint by 1pm.*

(ix) *On 23 March 2022 ST was the subject of restraint and escort back to her room after she hit a District Nurse.*

(x) *On 23 March 2022 ST was the subject of further restraint by two security guards and two carers after she had refused to co-operate and urinated on the floor. A further restraint hold was later required. ST was tranquilised with Promethazine.*

(xi) *On 24 March 2022 (i.e. today) ST was placed in a hold by two security guards and two carers and then held on the floor of the ward. ST was tranquilised with Promethazine.*

(xii) *On one occasion ST managed to break into a treatment room in which a dying infant was receiving palliative care and had to be restrained in that room by three security guards.*[16]

The hospital made an application under the inherent jurisdiction to authorise what was an undisputed deprivation of ST's liberty, but the court declined to authorise the arrangements at this interim hearing. In his *ex tempore* judgment, MacDonald J held:

> *32. I have decided that I cannot, in all good conscious, conclude that it is in ST's best interests to authorise the deprivation of her liberty constituted by the regime that is being applied to her on the hospital ward. I cannot, in good conscience, conclude that it is in the best interest of a 14 year old child with a diagnosis of Autistic Spectrum Disorder and moderate learning disability to be subject to a regime that includes regular physical restraint by multiple adults, the identity of whom changes from day to day under a rolling commercial contract. I cannot, in all good conscience, conclude that it is in ST's best interests for the distress and fear consequent upon her current regime to be played out in view of members of the public, doctors, nurses and others. I cannot, in good conscience, conclude that it is in ST's best interests to be subject to a regime whose only benefit is to provide her with a place to be, beyond which none of her considerable and complex needs are being met to any extent and which is, moreover, positively harmful to her.*

Indeed, the situation was described as '*a brutal and abusive one for ST*,' so much so '*that not even the necessity of keeping ST safe in circumstances where no alternative placement is available can justify such authorisation, because it simply cannot be said on the evidence before the court that the placement she is in currently is keeping her safe*.' [34] To authorise the arrangements '*would be to grossly pervert the application of best interests principle*.'[36]

On a late application by the local authority, the court made an interim care order and set the scene for a human rights claim:

> *43. Manchester City Council has been aware at least since 24 February 2022 that ST is in a placement that is manifestly ill equipped to meet her needs and which is depriving her of her liberty for the purposes of Art 5 of the ECHR. Further, the NHS Trust acknowledges that ST has been deprived of her liberty in extremely challenging situations for over a month before the matter was brought before this court. On the face of the evidence before the court, neither Manchester City Council or the NHS Trust has taken any steps to seek to bring the matter before the court in a timely manner to seek authorisation for the consequent breach of ST's Art 5 rights.*

> *With respect to that omission, it is simply not an answer to say that there have been "multiple meetings". It is likewise not an answer to say that there is a shortage of suitable placements and that "searches have been ongoing". The bottom line is that ST has, on the evidence currently available to the court, been deprived of her liberty without authorisation in a manifestly unsuitable placement for over a month prior to 18 March 2022, due to the apparent inaction of Manchester City Council and the NHS Trust.*

Witness statements were called for from the local authority directors of Children's Services and Legal Services and a senior member of staff at the Trust. Over the subsequent weekend, the local authority identified a bespoke, short-term placement for ST and applied for a declaration authorising her deprivation of liberty in that placement. It continues to search for a residential educational placement.

Comment

This is another example of the courts' willingness in a children's context to give proper meaning to the concept of best interests by refusing to authorise interim arrangements which deprive liberty in manifestly unsuitable circumstances, despite the absence of other available options. As such, it demonstrates the human rights baseline below which public bodies cannot venture. Given the interim nature of this hearing, there are other interesting issues which might be subsequently considered. These include whether rapid tranquilisation itself amounts to a deprivation of liberty requiring authorisation (paragraph 37), and the remit of parental responsibility and Article 5 ECHR when a child requires 6:1 staff at school and is displaying escalating behavioural distress at home.

Capacity to terminate a pregnancy, and to litigate about it

S v Birmingham Women's And Children's NHS Trust [2022] EWCOP 10 (07 March 2022) (HHJ Hilder, sitting as a Tier 3 judge)

Mental capacity - medical treatment

Mental capacity – litigation

Summary

In *S v (1) Birmingham Women's and Children's NHS Trust (2) Birmingham and Solihull Mental Health Trust* [2022] EWCOP 10, SJ Hilder, sitting as a Deputy High Court Judge, determined that S has capacity to consent to a termination of her pregnancy. The proceedings were heard on an urgent basis, given the time limit for the lawful termination of the pregnancy pursuant to the Abortion Act 1967.

S was 38 years old and 23 weeks pregnant. She was, at the time of the hearing, detained under section 3 of the Mental Health Act 1983. In 2010, S was diagnosed with bipolar affective disorder in relation to which she had had four hospital admissions but she had responded well to Lithium treatment. SJ Hilder observed that S had achieved much in her life, having obtained a degree in modern languages from Cambridge University and having her own business in language tutoring. S had a strong wish to become a mother but felt that time was running out. After a relationship ending, she decided to conceive a child by IVF using a sperm donor.

SJ Hilder set out the relevant provisions of the Abortion Act 1967 ("AA 1967") and the Mental Capacity Act 2005. In relation to AA 1967, the court noted that, whilst consent (either by a capacitous pregnant woman or by the Court of Protection in the best interest of a non-capacitous pregnant woman) is fundamental to the lawfulness of abortion, it is not sufficient: it

also depends upon two medical practitioners being satisfied that the conditions of the AA 1967 are met. The Court of Protection cannot require a clinician to perform a procedure who is unwilling to do so. SJ Hilder acknowledged that it was unknown whether the availability of termination as a practical option, but accepted that, given the statutory time limits, the court needed to consider the evidence and make a determination.

After setting out the relevant provisions of the MCA 2005, SJ Hilder noted the following from the case law:

1. *"There is a space between an unwise decision and one which an individual does not have the mental capacity to take and … it is important to respect that space, and to ensure that it is preserved, for it is within that space that an individual's autonomy operates*." PC v. City of York [2013] EWCA Civ 478, para 54

2. The ability to use and weight the relevant information is concerned with "*the capacity actually to engage in the decision-making process itself and to be able to see the various parts of the argument and to relate one to another*." PCT v. P [2011] 1 FLR 287, para 35

3. A person need only weight the salient features, it might be that they are unable to use or weigh some of information objectively relevant to the decision in question. "*It is not necessary to have every piece of the jigsaw to see the overall picture*" (London Borough of Tower Hamlets v. PB [2020] EWCOP 34, para 13).

4. *"Even when an individual fails to give appropriate weight to features of a decision that professionals might consider to be determinative, this will not in itself justify a conclusion that P lacks capacity. Smoking, for example, is demonstrably injurious to health and potentially a risk to life. Objectively, these facts would logically indicate that nobody should smoke. Nonetheless, many still do*" (PB, para 14).

She also carefully considered the case of Re SB (A patient; capacity to consent to termination) [2013] EWHC 1417 (COP), but noted the test for capacity to a decision to terminate pregnancy had not yet been comprehensively set out in the case law.

The trusts relied, in particular, on two capacity assessments: one from an Obstetric Consultant and the other from a Perinatal Consultant Psychiatrist. Both clinicians had indicated that the decision as to capacity lay with the other specialty. The psychiatrist noted that S had laid out the pros and cons in relation to termination – the most prominent con was the lack of a father figure, but she was also concerned about her finances and lifestyle. In terms pros, she wanted to be a mother. The psychiatrist concluded that S's mental illness was, on the balance of probabilities, having a significant impact on her ability to weigh the pros and cons of the decision. The obstetrician discussed the surgical and medical methods of termination. She was concerned about S's ability to use and weigh the information because this had changed since a deterioration in her mental health and that S was unsure about termination. SJ Hilder summarised their evidence at [57]:

> *The clinicians note that S's wish for a termination is a marked change of position to her wish to become pregnant in the first place; and that this change of position coincides with a deterioration in her mental health. They conclude that the wish for termination is a reflection of the negative cognitions of S's mental health condition and therefore S lacks capacity to make the*

decision.

S and her sister also gave evidence. S took the affirmation and confirmed her statement, given she was assessed by her representatives as having capacity to conduct the proceedings. She explained that she felt guilty about the lack of a father figure and how the IVF was a mistake. She described that she was not psychologically ready to be a parent now and she was reassured by having her eggs frozen. She was also clear that she cannot say she was 100% sure that she wants a termination; and questioned whether it was ever possible to be 100% sure about this type of decision.

SJ Hilder observed that neither clinician could set out the information relevant to this decision. She determined that, specifically on the facts of this case, the relevant information for the purposes of assessing whether S has or lacks capacity to decide to undergo termination of her pregnancy was at [52]:

> *a. what the termination procedures involve for S ('what it is');*
> *b. the effect of the termination procedure / the finality of the event ('what it does');*
> *c. the risks to S's physical and mental health in undergoing the termination procedure ('what it risks');*
> *d. the possibility of safeguarding measures in the event of a live birth.*

The court considered that discussions with S were more wide ranging, but that they were *'exploration of reasons for deciding one way or the other, rather than information foundational to making the decision.'*[54]

SJ Hilder did not consider that the reasoning of the clinicians was sufficient. She observed, in particular, that S had maintained her position for at least a month and that she had articulated reasons for her current stance. She was satisfied that she *'has amply enough "pieces of the jigsaw to see the whole picture."'* [58] In relation to S being only 70 or 75% sure about whether to terminate or not, SJ Hilder noted that that *'reflects S's understanding of the magnitude of the decision she contemplates.'* [59] She was not therefore satisfied that the presumption of capacity had been rebutted.

Comment

The case serves as an important reminder to health providers, commissioners and professionals of considering as early as possible whether an application to court is required; and if it is, then, it should be done so promptly. SJ Hilder referred to Vice-President's guidance of 17th January 2020, which applies where a decision relating to medical treatment arises ("Guidance"). Providers/commissioners should be responsible for bringing any application that is required (Guidance, para 9); and the guidance sets out when consideration should be given to bringing an application to court (Guidance, paras 8-12). In a post-script to the judgment, SJ Hilder observed that the proceedings should have been brought to court much more promptly and by one of the health bodies. This matter falls squarely within paragraph 10 of the Guidance – the decision whether or not to terminate a pregnancy must *'surely involve one of the most serious interferences with a person's rights under the ECHR'.*[64]

The consequences of the delay were that (i) the court had to consider matters under an intense time pressure and (ii) the hearing was remote.

SJ Hilder also made important observations in relation to the process of assessing P's capacity, which is different to a record of such assessment. She noted at [47]:

> *It is important that such distinction is borne in mind because conflating the two risks both forgetting that assessment is a process which needs to be continued until it is possible to draw a conclusion and also*

> *giving an impression that the outcome was pre-loaded.*

On the facts, she considered that the two clinicians should have undertaken the assessment together; and that it quite clearly should have preceded the best interest meeting - the psychiatrist's assessment followed that meeting.

Finally, it is worth noting that S's legal representatives had determined that she has capacity to conduct the proceedings; and therefore, she instructed them directly. Thus, S gave evidence (taking the affirmation and confirming her evidence). Whilst SJ Hilder observed that both solicitor and counsel were very experienced, their position was that if the court concluded that S lacks capacity to consent to termination of pregnancy then they would welcome the chance to reconsider the position.

The (limited) role of the Inherent Jurisdiction: Part 1

PH v Betsi Cadwaladr University Health Board [2022] EWCOP 16 (31 March 2022) (Hayden J)

COP jurisdiction and powers – Interface with inherent jurisdiction

Summary

In *PH v Betsi Cadwaladr University Health Board* [2022] EWCOP 16 (31 March 2022), Vice President Mr Justice Hayden refused to make an order under the Inherent Jurisdiction to the effect that PH should be provided with supplements if he requested them. [15]

The application concerned PH, a 41-year-old man with longstanding medical difficulties. PH required PEG feeding as the result of a 2016 episode in which he drank hydrogen peroxide sustaining significant gastric injuries; PH also required round-the-clock in-patient care following a fit in 2019 in which he sustained a hypoxic brain injury.

PH had been involved in long-running proceedings in which his previous care had been roundly criticised by the court. The court observed that he had been diagnosed as having a personality disorder which *'served historically to eclipse both the recognition of PH's symptoms as well as features of his personality'* [2]. Following the engagement of a new clinical team, there was a "sea change" in his care and presentation and an apparently positive outlook towards the future. PH retained the love and support of a partner, N, and a longstanding wish to move out of hospital into a home in Wales which had been prepared for his care.

As the judgment records, however, PH's outlook became increasingly desolate. He considered his life had become 'a living hell' [9] and that he was a 'burden to others.' As a result, he had begun to refuse the PEG feed which was his sole source of nutrition. PH had, by the time judgment was handed down, refused to take nutrition for 41 days.

Following his brain injury, PH had difficulties in speaking. Nonetheless, he was able to communicate 'clearly and unambiguously.' [5] The parties agreed, and the court heard oral evidence to the effect that PH retained capacity to accept – or refuse – feeding. Despite refusing nutrition, however, PH continued to accept water and antibiotics as required. The view was taken that he had effectively constructed his own palliative care regime. [14]

The question before the court was whether it should make orders under the Inherent Jurisdiction that PH should receive supplements should he request them. The court rejected this application.:

> *15…In London Borough of Redbridge v SNA [2015] EWHC 2140 (Fam), I made the following observations which strike me as having resonance here:*

"[33] The concept of the 'inherent jurisdiction' is by its nature illusive to definition. Certainly, it is 'amorphous' (see paragraph 14 above) and, to the extent that the High Court has repeatedly been able to utilise it to make provision for children and vulnerable adults not otherwise protected by statute, can, I suppose be described as 'pervasive'. But it is not 'ubiquitous' in the sense that its reach is all-pervasive or unlimited. Precisely because its powers are not based either in statute or in the common law it requires to be used sparingly and in a way that is faithful to its evolution. It is for this reason that any application by a Local Authority to invoke the inherent jurisdiction may not be made as of right but must surmount the hurdle of an application for leave pursuant to s100 (4) and meet the criteria there.

[36] The development of Judicial Review, as illustrated by ex parte T (supra), has also served to curtail the exercise of the powers of the inherent jurisdiction. No power be it statutory, common law or under the prerogative is, in principle, unreviewable. The High Court's inherent powers are limited both by the constitutional role of the court and by its institutional capacity. The principle of separation of powers confers the remit of economic and social policy on the legislature and on the executive, not on the Judiciary. It follows that the inherent jurisdiction cannot be regarded as a lawless void permitting judges to do whatever we consider to be right for children or the vulnerable, be that in a particular case or more generally (as contended for here) towards unspecified categories of children or vulnerable adults."

16. It is also important to highlight the applicable statutory framework:

15 Power to make declarations
(1) The court may make declarations as to—
a) whether a person has or lacks capacity to make a decision specified in the declaration;
b) whether a person has or lacks capacity to make decisions on such matters as are described in the declaration;
c) the lawfulness or otherwise of any act done, or yet to be done, in relation to that person.
(2) "Act" includes an omission and a course of conduct.

17. Whilst the court may not make interim declarations, it may make orders and directions:

48 Interim orders and directions
1. The court may, pending the determination of an application to it in relation to a person ("P"), make an order or give directions in respect of any matter if—
a) there is reason to believe that P lacks capacity in relation to the matter,
b) the matter is one to which its powers under this Act extend, and
c) it is in P's best interests to make the order, or give the directions, without delay.

18. The above must be placed in the context of the overarching principles of the Act:

The principles
1. The following principles apply for the purposes of this Act.

2. A person must be assumed to have capacity unless it is established that he lacks capacity.
3. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
4. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
5. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
6. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

19. Thus, in the absence of a lack of capacity within the scope of Section 15 MCA, or any reasons for believing that P might lack capacity, as prescribed within the ambit of Section 48, there is no other gateway to a best interests' decision. There are good reasons for this. The court has no business in telling capacitious individuals what is in their best interests nor any locus from which to compel others to bend to the will either of what capacitious individuals may want or what the court might consider they require. Such a regime would be fundamentally unhealthy in a mature democratic society and would have the collateral impact of undermining the principle of autonomy which is central to the philosophy of the MCA. 20. The limited scope of the inherent jurisdiction is circumscribed by particular, albeit nonexhaustive, criteria which relate to vulnerable adults whose capacity for decision taking is being overborne in some way (see Re SA [2005] EWHC 2942 (Fam); Southend-On-Sea Borough Council v Meyers [2019] EWHC 399 (Fam) (20 February 2019). Nobody has suggested that that is the case here. Additionally, and practically speaking, it is difficult to formulate a declaration which is flexible enough to incorporate a turning point (which may not be immediately clear), where provision of supplements, upon request, is contraindicated medically. Taking of blood samples e.g., to assess serum levels, will not be appropriate if the deterioration of skin tissue makes that difficult and potentially painful for no clinical benefit."

While making no criticism of the Health Board – particularly given the difficult history of the case – for having brought the application, the court was clear that it had been *'no jurisdictional basis for bringing the case to court.'* [13] All parties agreed that PH had capacity to make decisions regarding his feeding regime, and in the absence of any external force such as may have required an intervention under the Inherent Jurisdiction, the court made no orders but left the ultimate management of PH's care to his treating staff and himself. [22]

Comment

This judgment builds on the growing body of case law, all of which points towards a very firmly defined and limited role for the Inherent Jurisdiction: a power which has limited – if any – role to play in the management of the lives of capacitous individuals.

The (limited) role of the Inherent Jurisdiction: Part 2

London Borough of Islington v EF [2022] EWHC 803 (Fam) (18 March 2022) (Alex Verdan QC, sitting as a Deputy High Court Judge)

Inherent jurisdiction

Mental Capacity – Contact

Safeguarding

COP jurisdiction and powers – Interface with inherent jurisdiction

Summary

In 2017 EF was a looked after child who, at the age of 14, met GH in an online chat room who was 11 years older than her. She initially pretended to be an adult and they began an online relationship. After revealing the following year that she was in fact 15, he posted an engagement ring from Brazil and said he would come to England when she was 16 to marry her. She briefly ended the relationship the following year but then it resumed.

From 2018-20 she experienced acute psychosis which led to self-injury and suicidal ideation and three hospital inpatient admissions. In 2019, GH came to England to meet her, until he was arrested for possession of child pornography and returned to Brazil, but contact continued.

EF now lived in semi-independent accommodation, receiving medication and psychiatric support for schizo-affective disorder, and attended college where she was studying an Art diploma. Her mental state was stable, and she was doing well. When she was 17, the local authority made a without notice application and interim orders were granted to prevent her leaving the country and her passport was withheld. An expert consultant forensic psychiatrist was instructed to assess her capacity and vulnerability.

There was insufficient evidence to show that EF had been groomed but '*there is in my judgment a real possibility that he will exploit her by taking advantage of her*.' [83] This was due to '*EF's age when the relationship started, GH continuing the relationship despite her age, his addiction to porn, him downloading child pornography, her mental ill health and vulnerability and him being willing for her to move to Brazil despite the risks to her health.*' [83] GH's downloading of child pornography was '*extremely concerning and indicates a sexual interest in children as it was linked to his porn addiction*.' [84] The judge found that GH had probably sought to isolate EF from her family and the dynamic of GH's relationship with EF was one of undue influence.

Capacity

The expert was instructed to assess EF's capacity to litigate, to decide where to live, to decide as to the care and support she receives, to manage her finances, to have contact with GH, to marry, to relocate abroad and to engage in sexual relations. The evidence was '*clear*' that '*for the purposes of the MCA*' EF was able to make these decisions. [61] Specifically in relation to contact, however, the expert's view was that her '*limited understanding of the nature of the relationship impacts on her ability to weigh up the necessary information about her contact with GH*' and this is '*a consequence of her trauma history and subsequent vulnerability*.' [65] The expert's view was that EF '*could not understand the nature of her relationship with GH, the risks to her from the relationship nor weigh up all the competing factors*.' [70]

The judge agreed that EF's understanding of the risks posed from GH was '*superficial/minimal*.' [79] EF too would be concerned were a young female friend of hers to have a similar plan, but she '*could not see the very same risks for herself*.' [80] Indeed, she '*does not appreciate the risks to*

her physical safety nor the risks to her mental health.' [81] What were those risks?

> *91. My conclusion based on Dr D's evidence is that if EF travels to Brazil there is firstly a significant risk that she would suffer a deterioration in mental state, and secondly that if that happened there is a real risk that deterioration could become severe and thirdly that in that event she would probably be unable to access the care and support she needs, and so would be at risk of exploitation by others and would be at serious risk of suicide. Although I have expressed each of the above separate stages as a likelihood I cannot say whether the serious risk of suicide is in itself a likelihood as there are a number of stages that need to occur although I do accept it is a real possibility. Nor can I say that the risk of suicide is an immediate one as the timing of it depends on a wide range of factors.*

Despite this evidence, the court concluded that '*it is clear from Dr D's evidence and the parties agree that EF has capacity*' [92] to make the relevant decisions and so the MCA was not applicable.

Inherent jurisdiction

The judge concluded that despite GH's undue influence, '*I do not find that EF is deprived or disabled from being able to make decisions but rather that the relevant decisions she is making are unwise ones*.'[90] The orders sought would be against EF and dictatorial in nature and should not therefore be made. The judge continued:

> *98. If I am wrong about that and there is a jurisdiction to make such orders against victims it only exists in truly exceptional circumstances. I am not satisfied that those exist in this case. The scale of interference is significant and not in reality time limited to 6 months as it is by no means certain that in 6 months' time the court will be in a different position as there is every chance that despite the work that EF will carry out with the LA her views will not have changed. The justification for the inference is the risk to EF's health and wellbeing and in the worst case her life. I have already dealt with my assessment of that risk [in paragraph 91 above].*
>
> *99. Moreover, EF is an adult with capacity and wants to be in a relationship with GH. She has known him for 3 years and separated from him once. She has received advice from professionals not to go and is intelligent enough to understand that advice and act on it if she so wishes. She plans to visit Brazil at least once before moving there permanently. She has saved up a reasonable sum so that she will have a degree of independence once over there. She plans to take a second mobile phone with her as another level of security. She has researched the medical and health facilities in Brazil and is aware of its shortcomings. She has agreed not to travel to Brazil until her course is completed. She has agreed to continue to work with the LA before she leaves. These are sensible decisions which show a degree of independence and critical thinking.*

In the absence of exceptional circumstances, the travel ban could not be justified. EF had undertaken not to travel before the end of her college course in four months' time, before which she will attend social work sessions proposed by the local authority dealing with a range of subjects including healthy relationships, support, life in the UK and life in Brazil, the object of which is to '*at least give her greater understanding of the risks*'. [55] The judgment ended with a judicial plea which bears full citation:

108. I end this judgment with a plea to EF. I have accepted that the LA and Dr D are right to be very worried about her because I have found that there are real risks to EF's wellbeing from moving to Brazil and living with GH.

109. I have concluded that the professionals in this case have EF's best interest at heart and want to protect her and keep her safe.

110. The court's view is that EF would be making a very unwise decision to move to Brazil.

111. I urge her to work with them between now and July when her course finishes.

112. I urge EF to attend all the sessions that the LA arrange for her.

113. I ask EF to listen carefully to the advice given and think more deeply about the issues in this case.

114. EF told me she would be worried if a friend of hers was about to embark on a similar trip. She needs to think about her own case as if she were that friend.

Comment

Given the evidence, the position of the parties and the court that EF was able to make all of the relevant decisions is certainly not without interest. Reminiscent of *PC and NC v City of York Council*, one cannot help but wonder in this complex case whether perhaps EF was unable to comprehend the risks posed by GH but that the causative nexus had not been proven for MCA purposes. Neither was the nexus between GH's undue influence and EF's decision-making ability established for inherent jurisdiction purposes, for his influence did not deprive or disable her from making the decisions.

The crux of the case appears to be that despite the court's assessment of risk at paragraph 91, a travel ban would not have been a necessary and proportionate interference with EF's Article 8 ECHR rights in the context of this 3-year relationship. Moreover, the order would have been directed at EF, presumably by way of an injunction, which poses a challenge of logic. The basis for seeking an injunction was that EF was not acting of her own free will. So how could she be held accountable for breaching the injunction? She either is or is not able to exercise her own will.

Best interests and transplants

Manchester University NHS Foundation Trust v WV [2022] EWCOP 9 (08 March 2022) (Arbuthnot J)

Best interests - Medical treatment

Judgment has been handed down in the case of William Verden, which readers may recognise from appeals in the national press by William's family to find a kidney donor. William, now 17, started showing signs of kidney failure in 2019. Treatment with steroids did not help, and he was diagnoses with Steroid Resistant Nephrotic Syndrome (SRNS). He currently receives haemodialysis four times a week, and without a transplant his life expectancy would be around 12 months.

The case initially came to court because the Trust was seeking a decision that it was not in William's best interests to receive a transplant, and instead to continue with haemodialysis.

However, the position of the clinicians giving oral evidence differed from the Trust's initial stance; ultimately, no clinician giving evidence took the view that that a transplant was contrary to William's best interests. At the close of the hearing, the Trust's position was formally neutral on William's best interests and submitted that it

was a matter for the court. Arbuthnot J recorded in her judgment that she had no doubt the Trust's initial position was reached after careful multi-disciplinary discussions, but the evidence of the Trust's witnesses *'had become more nuanced as they were able to reflect on and consider the oral evidence.'* [30]

The court heard evidence from a large number of witnesses. Dealing first with the nephrologists, the judgment records that the consultant paediatric nephrologist put forward by the Trust (Dr A) and the independent expert (Professor Saleem) had different experiences in relation to the likelihood of recurrence but both agreed that plasma exchange would be the normal way to treat this. The independent expert was clear that but for the complications presented by William's ADHD, autism and learning difficulties, a transplant would be offered.

The intensivists the court heard from (Dr B for the Trust, Dr Danbury as independent expert) dealt with the risks to William of post-operative treatment in paediatric intensive care if the transplant went ahead. Dr Danbury had considered that the risks were such that it might outweigh the benefits, on the basis that the Trust was initially suggesting 6 weeks sedation and ventilation would be required. Having heard the nephrologists give evidence, and in light of the fact that two weeks was by then the period proposed, he considered that this would be in William's best interests.

The court also heard from a consultant child and adolescent psychiatrist for the Trust (Dr C) and an independent child psychologist (Dr Carnaby) on the challenges which a transplant and the post-operative care required might pose for William. The court also heard from William's mother, and carried out a judicial visit to William himself.

Although the transplant carried with it significant complexities (in particular in relation to how William could be supported to tolerate the post-operative period and the sedation and ventilation required) this was ultimately a case in which the question before the court was stark. If the court decided a kidney transplant was not in William's best interests, he would die, and within only a year or so. William and his family wanted the transplant. Notwithstanding the undoubted complexities and the risks of the transplant, it had the commensurate benefit of giving William a chance of long-term survival. The judge accordingly decided that a transplant was in William's best interests and approved sedation and ventilation for 14 days in the event of disease recurrence.[2]

Analysis

The Trust's own evidence at the hearing supported the conclusion that it was in William's best interests to receive a kidney transplant, even taking into account the short-term hardship he would experience. It is not clear why the Trust did not seek to rely on the evidence on which it had based its initial application, opposing transplantation; alternatively, it is not clear why, having apparently abandoned the evidence on which it initially relied, the Trust did not reconsider its position prior to the final hearing. On the face of the judgment, it is not clear why mediation was not more seriously pursued in this case to either seek to resolve the care planning issues that appeared to become the focus of the hearing, or to at least significantly narrow the issues in dispute before the court.

Fluctuating capacity in practice

CA v A Local Authority & Anor [2021] EW Misc 26 (CC) (08 November 2021) (HHJ Davies)

Mental capacity – Assessing capacity

[2] Tor having appeared in this case, she has not contributed to the summary or analysis above.

Summary

In *CA v A Local Authority & Anor* [2021] EW Misc 26 (CC), HHJ Davies had to consider whether CA had capacity to make decisions in relation to her residence in the context of medical evidence concluding the CA had fluctuating capacity. The assessor had, however, determined that at the time of his assessment that she had capacity to make the relevant decision.

CA is 46 years old. She has been diagnosed with schizophrenia and a mild learning disability. She is deaf, registered blind, and has cerebral palsy on her left-hand side. She had been living in a British deaf home since September 2019 and had been asking to leave it.

The local authority's position was the issue should be adjourned for a further assessment by the clinician, given that the assessment had taken place in January and the hearing was in November. CA (supported by her litigation friend) invited the court to find that lacks capacity because of her current mental state – her mother supported that view.

HHJ Davies considered the decision of Sir Mark Hedley in *Cheshire West v PWK* [2019] [2019] EWCOP 57 and observed that Hedley recommended a *"longitudinal approach"*, noting at [10] of the *CA* judgment:

> *By that I mean I am not looking at a snapshot decision, but I am looking at an overall view, if I can put it like that. In that case he said: "It is important to recognise in this case that there is likely to be a particular focus on understanding relevant information, retaining it and using or weighing it. There will be many occasions when PWK is hampered by anxiety when those grounds are clearly made out. However, that will not always be the case. It may fluctuate. The question is how the law deals with that".*

HHJ Davies noted that a distinction is made between, on the one hand, *"the general concept of managing affairs [as] an ongoing act"* and a specific act of making a will, on the other.[12] The former is a continuous state of affairs, the demands of which may be unpredictable and sometimes urgent.

On the evidence, HHJ Davies accepted that CA exhibited signs of being very unhappy and possibly depressed (but she did not have any medical evidence in respect of diagnosis). CA's mental health had suffered during lockdown; and the decision in respect of her residence was extremely stressful and very emotive. HHJ Davies referred to an example of CA being offered a specific placement but she was unable to give her view on it. HHJ Davies determined that CA lacks capacity to decide where to live; and that an '*ongoing act deciding about where she should live, her care and support*'. [15]

Covid vaccine round-up

North Yorkshire Clinical Commissioning Group v E (Covid Vaccination) [2022] EWCOP 15 (Poole J)

NHS Liverpool CCG v X and Y [2022] EWCOP 17

GA, Re (vaccination) [2021] EWCOP 66 (Sir Jonathan Cohen)

Best interests – medical treatment

There have been three further judgments published, both approving the vaccine as being in P's best interests: *Re GA (vaccination)* [2021] EWCOP 66; *NHS Liverpool CCG v X and Y* [2022] EWCOP 17; and *North Yorkshire Clinical Commissioning Group v E (Covid Vaccination)* [2022] EWCOP 15. In the latter case, Poole J observed that:

> 38….*Earlier in the pandemic it could more reasonably be said that Covid-19 vaccines*

> *were "new" and that, if not "untested", the evidence for effectiveness and complications was not the same as it would have been for more established vaccination programmes. Now, millions of doses have been given and the evidence base is much larger albeit the vaccines have not been in use for long enough for longer term studies to be performed.*

Poole J went on to give general guidance at [53], including that:

> *i) The best interests assessment is not confined to evidence of the health benefits and risks of vaccination but involves a wide review encompassing all the relevant circumstances including those set out at s.4(6) and (7) of the MCA 2005;*
>
> *ii) In relation to the benefits and risks to the health of P from vaccination, it is not the function of the Court of Protection to "arbitrate medical controversy or to provide a forum for ventilating speculative theories." The Court of Protection will "evaluate P's situation in the light of the authorised, peer-reviewed research and public health guidelines." It will not carry out an independent review of the merits of those guidelines.*
>
> *iii) There may be exceptional cases where P's condition, history or other characteristics mean that vaccination would be medically contra-indicated in their case but in the great majority of cases it will be in the medical or health interests of P to be vaccinated in accordance with public health guidelines.*
>
> *iv) Hence, disagreements amongst family members about P being vaccinated which are at their root disagreements about the rights and wrongs of a national vaccination programme are not suitable for determination by the court. It will be in P's best interests to avoid delay and for differences to be resolved without recourse to court proceedings.*

Comment

Poole J's indication that where objections to the vaccine are rooted in a dispute about the national vaccine programme, not P's particular circumstance, they should be resolved without court proceedings, is welcome. Practitioners should feel confident making decisions in reliance on s.5 MCA (and, where light touch restraint is required to administer the vaccine, s.6 MCA) without feeling there is an obligation to issue court proceedings in respect of either first doses, or subsequent ones.

Restraint and Positive Behaviour Support Plans for people with Learning Disabilities

Tor and Dr Theresa Joyce have prepared *Restraint and care plans in the Court of Protection: Positive Behaviour Support plans for people with learning disabilities*.

The document is aimed at lawyers in the Court of Protection to help them interrogate Positive Behaviour Support (PBS) plans that are presented to the court for approval for people with learning disabilities. A few notable recommendations include:

- Monthly reviews of PBS plans may be needed if any physical restraint is being used. If there are reviews only every 6 to 12 months, then they are unlikely to be delivering appropriately detailed monitoring and adjustment of the plan.
- If there is no change in the rate of occurrence of behaviours and consequent restraint/seclusion, then consideration should be given to whether the staff team are trained and supported in delivering individually-based support to the person.

- If there are not improvements, it the environment may not be appropriate for the person's needs, in which case it may be necessary to find a placement for the person where these environmental issues can be considered as part of the commissioning process.

The authors consider that the use of restrictive physical interventions for people with learning disabilities and/or autism should be eliminated and, in many circumstances, can be eliminated even within the constraints within which the Court of Protection is invited to operate.

Covid-19 Vaccination in those with mental health difficulties

The recent article *COVID-19 Vaccination in those with mental health difficulties: A guide to assist decision-making in England, Scotland, and Wales* considers the legal frameworks in both England and Wales and Scotland for making decisions about vaccinations for those who lack capacity to take the decision for themselves. The article is written for medical practitioners and focuses on psychiatric inpatients (whether voluntary patients or detained patients). It considers the question of vaccinating people under the Mental Health Act, concluding that it *'is difficult to interpret vaccination as treatment for the symptoms of mental disorder'*, though airs some arguments to the contrary. It also considers the application of relevant advance decisions, and the position when proxy decision-makers disagree. It is a concise and helpful article for those charged with the welfare of psychiatric inpatients who lack capacity to take decisions regarding COVID-19 vaccination.

A review of deprivation of liberty applications relating to children

Alice Roe, Mary Ryan and Andrew Powell of the Nuffield Family Justice Observatory have recently published Deprivation of Liberty: A Review of Published Judgments. The authors considered the 31 reported judgments on this issue between 2014 and 2021, looking to judgments either authorising a deprivation of liberty under s.25 Children Act 1989 in secure accommodation, or under the inherent jurisdiction. The authors note that this is a small fraction of the total number of applications of this type, and that in 2020/21, 392 applications were made in England and Wales for secure accommodation orders, and 579 applications were made in the inherent jurisdiction.

Notable themes identified include:

- Shortages of appropriate placements: there is a severe shortage of available placements in secure children's homes. The authors recognised a cohort of children whose needs cannot be met by secure children's homes, who are also not considered detainable under the Mental Health Act 1983 (noting children who display *'very severe self-harming or aggressive behaviours'*). The authors found themes that these children *'require specialist, intensive therapeutic provision, often in single occupancy restrictive placements. There is a severe lack of availability of this type of placement.'* These children had often been known to social services for years, and there appeared to be limited evidence of early intervention and support for the children's families.
- Shortages of secure mental health inpatient beds for children
- Judicial concerns about the increasing use of the inherent jurisdiction to deprive children of their liberty, often in 'emergency placements' which end up lasting for significant periods of time, which lack appropriate therapeutic or educational provision. In some recent cases (as above), courts have refused to authorise deprivations of liberty in these settings.

- Placements repeatedly breaking down and children being subjected to multiple moves.
- Children being moved far from their homes, including out of the jurisdiction into Scottish placements.
- The placement of children in unregistered or unregulated settings.
- Use of the High Court for injunctions against adults to protect children (with the authors noting these cases all took place between 2014 and 2016).

PROPERTY AND AFFAIRS

Important guidance from the Court of Appeal on testamentary capacity and assessments

Hughes v Pritchard, Hughes and Hughes [2022] EWCA Civ 386 (24 March 2022)(Moylan LJ, Asplin LJ, Elisabeth Laing LJ)

Mental capacity – Testamentary capacity

In *Hughes v Pritchard and Ors* [2022] EWCA Civ 386, the Court of Appeal allowed the appeal of the Claimant in a probate action, whose claim to prove the Will of his late father had been dismissed on the grounds that the testator lacked mental capacity at the date he made the Will. The appeal was from the decision of His Honour Judge Jarman QC, sitting as a judge of the Chancery Division [2021] EWHC 1580 (Ch), which case was noted in the September 2021 issue of *The Mental Capacity Report*.

The Claimant was one of the Testator's three children and one of two who survived him. The First Defendant was his sister, the Second Defendant was the Deceased's son's widow and the Third Defendant was one of their children. The Testator had been a director and shareholder in a building company, but a few years before his death the company had ceased trading by virtue of want of business and, shortly before he died and at the time he made the contested Will, the company was in the process of being dissolved.

In addition, the Testator had been a farmer, owning and renting various plots of land. At the time of his death, he owned the bungalow where he lived, 79 acres of farmland known as "*Buchanan*", another 58 acres of farmland three miles from that, "*Yr Efail*", a cottage and livestock, and had a bank balance of about £290,000. The dispute, in effect, turned on the disposition of the land known as *Yr Efail*.

The Testator made a Will in 2005, after his divorce from his second wife, and whilst all his children were alive. At that time, the son who later died was working the land and the provisions of the 2005 Will were that the shares in the building company were left between the Claimant and the First Defendant equally, and the farmland went to the son (who subsequently died) who worked it. The bungalow and personal effects were left to the Second Defendant daughter and the residuary estate divided equally between the three children.

The son who had worked the land, and was the beneficiary of the 2005 Will in relation thereto, died by suicide in September 2015. By that time, the building company had ceased to trade and, therefore, had little value. By that time also, the Testator was beginning to suffer from memory problems. He granted a Lasting Power of Attorney in March 2015 and, in December 2015, he had been assessed as scoring 47 out of 100 on the Addenbrooke's Test, indicating a moderately severe degree of mental impairment.

Nevertheless, the Testator determined that he needed to change his Will in the light of the circumstances which had occurred since 2005. The solicitor who he instructed had not met him before and did not have a copy of the 2005 Will. She took instructions for the new Will. The main difference was that *Yr Efail* was to be left to the Claimant, with the remainder of the farmland held on Trust for the Second Defendant for life and then to her three sons equally. The First Defendant, as well as receiving a gift of the bungalow, received a gift of the cottage and all other property was in residue and divided equally amongst the Testator's grandchildren.

The solicitor made a detailed attendance note of the meeting on 11 March 2016, and produced an initial draft Will on 22 March 2016. She then met the Testator again, with the attendance note showing that the Testator had made enquiries about title deeds of various properties, realising the importance of correctly describing the properties in his Will. There was also discussion about the company shares.

At that meeting, the solicitor suggested that it would be prudent to obtain a medical certificate for the Testator to avoid issues in respect of

contesting the Will. In that respect, the solicitor contacted the Testator's GP, asking him to carry out an assessment with full instructions. The GP visited the Testator on 14 June 2016, taking a draft of the Will with him. The GP went through the Will and clearly established that the Testator had a full understanding of the nature of the Will, understood the process, had a full understanding of the extent of his property and that changes to the Will were due to circumstances within the family, and stated his conclusion that he had no issues regarding the Testator's capacity and would be happy to witness the Will at a convenient time.

That was on 7 July 2016 and the GP duly attended to witness the Will. The Will was read over clause-by-clause to the Testator, who confirmed that he agreed with it. The attendance note of the meeting recorded the fact that it took 55 minutes and was detailed and lengthy.

The Testator died on 7 March 2017. The Claimant sought to prove the Will and it was contested on various grounds, including want of knowledge and approval, and undue influence. The Judge dismissed those defences and there was no appeal from those decisions.

At the trial, the court heard from a significant number of witnesses, including a joint medical expert, a consultant old age psychiatrist. His conclusion was that it was more likely than not that the Testator had testamentary capacity when he gave instructions for and then executed the 2016 Will.

Notwithstanding that, the first instance judge found against the Will on the grounds of want of mental capacity. At paragraph 86 in the Court of Appeal, Asplin LJ, with whom the other judges agreed, summarised the issue as follows:

> "*It seems to me, therefore, that the real question in this appeal, is not whether the judge should have merely accepted Ms Roberts'* [the solicitor] *evidence together with that of Dr Pritchard* [the GP] *as if it were a 'touchstone' as to the validity of the 2016 Will, as some of the grounds of appeal might suggest. The relevant questions are whether: the judge was right to place less reliance on Ms Roberts' evidence because of her reliance upon Dr Pritchard and because she did not ask the Deceased about the change in the bequest of* Yr Efail*; the fact that she had no medical qualifications and was not told about his medical background; whether he was right to conclude that Dr Pritchard's failure to ask the Deceased about the changes in his testamentary intentions at* Yr Efail *and his reason for the change impacted significantly upon the weight to be given to Dr Pritchard's evidence; and ultimately, when evaluating the evidence as a whole he was right to place greater weight on evidence, other than that of Ms Roberts and Dr Pritchard, relating to the Deceased's conduct in conversations before and after the 2016 Will was executed.*"

At paragraph 87, Asplin LJ reminded herself that the question was whether no reasonable jury could have reached the conclusion the judge did, or that, giving appropriate weight to the evidence of Ms Roberts and Dr Pritchard, was the judge entitled to find as he did on the basis of the evidence as a whole?

The court, of course, reminded itself of the basis upon which courts approach testamentary capacity, namely the test set out in *Banks v Goodfellow* [1869-70] LR 5 QB 549 as follows:

> "*It is essential… that a testator shall understand the nature of the act and its effects; shall understand the extent of the property of which he is disposing; shall be able to comprehend and appreciate the claims to which he ought to give effect; and, with a view to the latter object, that no disorder of the mind shall poison his affections, pervert his senses of right, or prevent the exercise of his natural faculties, that no insane delusion shall influence his will in disposing of his property and bring about a disposal of it which, if the mind had been sound, would not have been made.*"

The Claimant/Appellant also relied on the proposition that a Will that had been drafted by an experienced independent lawyer should only be set aside on the clearest evidence of lack of mental capacity, see *Halles v Burgess* [2013] EWCA Civ 74.

The court also reminded itself of the "*Golden Rule*" (which had been followed in this case), which is to the effect that, as a matter of practice, where a solicitor is instructed in relation to a Will of an aged testator or a testator who has suffered a serious illness, it should be witnessed and approved by a medical practitioner who satisfies himself of the capacity and understanding of the testator, and records and preserves his findings, see *Kenward v Adams*, Times Law Reports, 29 November 1975.

The principal attack on the judge's findings related to the way in which the fact that neither the solicitor nor the GP had asked the Testator about why he was changing his Will undermined (fatally, as it turned out) their assessment of his capacity. At paragraph 94, Asplin LJ said this:

> "*It seems to me, however, that they* [the solicitor and GP] *should not have been downgraded for those reasons in this case. Although it may be prudent for a solicitor and, for that matter, for a medical practitioner whose attention has been drawn to significant changes in testamentary intentions, to ask the testator about these changes, there is no rule to that effect. It seems to me that all Templeman J meant in Re Simpson was that reference to the terms of a previous Will may be a helpful safeguard when seeking to confirm that the testator is aware of those who have a call upon his or her bounty. … In any event, it seems to me that it is no more than that. It is a helpful tool when seeking to confirm that the Banks v Goodfellow test and its third limb, in particular, is satisfied. Reference to changes from provisions of a previous Will, although a prudent step, should not be elevated into a requirement either for the drafting solicitor or the medical practitioner before their evidence in relation to capacity can be accepted.*"

At paragraph 98, Asplin LJ reaffirmed the point made by Lewison LJ in *Simon v Byford* [2014] EWCA Civ 280, that the question of capacity is concerned with the potential to understand. It is not a test of memory or a requirement for actual recollection. At paragraph 99, she went on to state that testamentary capacity does not require a testator to recall the terms of a past Will they have made, or the reasons why it provided as it did, as long as they are capable of accessing the information if needed and of understanding it once reminded of it.

At paragraph 102, Asplin LJ then held that, applying that test, the mere fact that the 2005 Will and the change in the disposition of *Yr Efail* was not discussed did not undermine the evidence of the GP, the solicitor or the Joint Expert.

Further elucidation of that was given in paragraph 106 and 107 of her judgment, where she criticised the first instance judge for, in effect, giving no weight to the solicitor's and the GP's evidence at all, and considered that the focus of the judge's conclusions was too much in relation to *Yr Efail* and fairness, which strayed from a proper application of the *Banks v Goodfellow* test (see paragraphs 108 and 109).

On that basis, the Court of Appeal allowed the appeal and upheld the 2016 Will. That, however, was not the end of the matter because in the same judgment the first instance judge had held that a proprietary estoppel had arisen in favour of the Testator's son in relation to *Yr Efail* and, therefore, in effect, it lay outside the estate. There was a cross-appeal in relation to that which was allowed only to the extent that the judge had not properly determined detriment and remedy. With considerable reluctance, the Court of Appeal directed the remission of the matter to the High Court for consideration of detriment and remedy.

Invitation to the pilot for digital submission of property and affairs applications

HMCTS continues to extend an invitation to the pilot for the digital submission of Property and Affairs cases, which was introduced in Autumn 2021 to a small number of professional users. It has now been further developed to test a new upfront notification process for the applications coming through the London office at First Avenue House. There are 69 professional court users currently onboard.

HMCTS encourages court users to sign up to join the pilot to further expand its testing and use. A reserve list may be created if necessary to onboard in waves with an aim to add everyone who requests participation as soon as possible.

To join the Pilot for upfront notification, please send your name and preferred email details to: COP_EAPPS@justice.gov.uk.

PRACTICE AND PROCEDURE

Reporting Restrictions

LF v A NHS Trust, G and M CCG [2022] EWCOP 8 (Hayden J)

Media – Anonymity

Summary

In December 2021, Hayden J delivered a judgment about the best interests of a 27-year-old woman who had spent the bulk of her life in hospital. The court decided it was in her best interests to be discharged to a residential placement, in the hope that she might in due course be able to live at home with her parents. G's parents did not accept the court's judgment, but permission to appeal was refused.

G's parents then attempted to launch a media campaign to raise funds to care for G at home (even though the court's decision was not based on financial considerations). They sought the lifting of reporting restrictions which had been in place since August 2017 to facilitate this campaign.

Hayden J refused their application, finding that removing the order requiring G to anonymised in connection with the Court of Protection proceedings would jeopardise the success of the residential placement. G's father was attempting to *"pursue, in the public domain, an outcome which has been assessed as contrary to his daughter's interests"*.[25] While it was possible that in the future *"a crowd funding initiative, based on wider awareness of the facts, might become an entirely justifiable objective in circumstances where there was a genuine funding issue"* [27] that was not the case at present.

Comment

This case is a useful illustration of the court's approach to attempts to remove reporting restrictions in order to further a campaign or crowd-funding exercise which is not based on an accurate report of legal proceedings or available options.

The MCA/MHA interface: what role should the COP have in discharge planning for those detained under s.3 MHA 1983?

PH v A Clinical Commissioning Group & Anor (Dismissal of proceedings) [2022] EWCOP 12 (14 March 2022): (HHJ Burrows)

Practice and Procedure (Court of Protection) – MCA Tools

Mental Health Act 1983 – Interface with the MCA

Summary

HHJ Burrows refused to allow proceedings to continue where P was detained under the MHA and his discharge was *"not imminent, even on his own case"* [23].

The application in this case was made by PH's mother. It is one of a growing number of cases brought regarding patients with ASD and learning disabilities detained under s.3 Mental Health Act 1983 concerning an individual who all parties agree is not placed in "the right place" to meet their needs – see for example *PH & RH v Brighton and Hove City Council* [2021] EWCOP 63.

HHJ Burrows acknowledged the role played by Court of Protection proceedings and that the use of the MCA and the COP becomes more relevant as a detained patient moves towards a discharge where there will be a need for orders from that Court to enable discharge to take effect. [20] He noted:

> *18. The interaction between the Mental Capacity Act (MCA)/ Court of Protection and the MHA is a difficult area of law. The MHA is mainly concerned with the*

detention and treatment of mentally disordered patients in hospital. In respect of those patients, the MCA largely defers to the MHA. This is explicitly so in s.28 of the MCA and Schedule 1A. Indeed, once a patient is detained under the MHA, decisions about medical treatment for mental disorder including the manifestations of the mental disorder are, for all intents and purposes outside the reach of the MCA/COP.

19. The position is different once a MHA patient who lacks the relevant capacity is discharged into the community and made subject to one of the community orders under that Act: a community treatment order (CTO)(s. 17A MHA), guardianship (s. 7 MHA) or (in the case of a restricted patient) by way of a conditional discharge. Then the two regimes may have to work together. This is particularly so where the patient is subject to restrictions that amount to a deprivation of his liberty- something the MHA cannot authorise, save in the Court of Protection approved Judgment: No permission is granted to copy or use in court PH v A CCG & A City Council Page 7 very limited circumstances of a condition attached to leave of absence (s. 17(3) MHA).

In PH's case, however, plans were in progress to construct an appropriate placement within the hospital where he was detained and s.117 Mental Health Act 1983. Aftercare planning was progressing with a view to moving PH into the community at some point in the future. This future remained distant at the time of the application, however:

20. The use of the MCA and COP becomes relevant where the detained patient is moving towards a discharge where there will be a need for orders from that Court to enable discharge to take effect. There is a rich and complex jurisprudence in this area. There are COP decisions dealing with conditionally discharged patients living in the community under MCA Orders: see for instance Birmingham City Council v SR, Lancashire County Council v JTA [2019] EWCOP 28 (Lieven, J.). Then there is the relationship between standard authorisations and guardianship: see C (by his litigation friend, the OS) v A Borough Council [2012] COPLR 350 (Peter Jackson, J.). Finally, the Birmingham case confirms the decision of the Upper Tribunal in DN v Northumberland, Tyne and Wear NHS Foundation Trust [2011] UKUT 327 (UTJ Jacobs) and in AM v South London & Maudsley NHS Foundation Trust [2013] COPLR 510 (Charles, J.) namely that there is nothing wrong in principle for the COP to make best interests declarations, and to authorise deprivation of liberty where P is detained under the MHA, but where the COP order will take effect only at the point of his discharge- that order indeed enabling the discharge to take effect.

21. Consequently, and as agreed by all counsel, in this case: a) There is no jurisdictional bar to this Court making orders of the type sought for Peter. b) It is, however, a matter of case management.

22. There is no doubt that in many cases the involvement of the COP is essential where a patient under the MHA is approaching discharge, as I have suggested above. The previous Vice President, who was also the President of the Upper Tribunal dealing with appeals from the First-tier Tribunal, Mr Justice Charles grappled with these procedural issues in a number of cases, most notably in Secretary of State for Justice v KC & C Partnership NHS Foundation Trust [2015] UKUT 376 (AAC).
23. However, Peter is still detained in a hospital under the MHA. His discharge from that regime is not imminent, even on his own case. The role of the Court in this case would be as some form of observer,

> *with a view to becoming actively involved in the future. But that future is not as close as was envisaged by Charles, J in the KC case. The COP's involvement is someway down the line, and it will depend on the speed with which the CCG and the LA are able to discharge their s.117 duties.*

In such circumstances, the ongoing involvement of the Court of Protection was not in keeping with the overriding objective:

> *24. I am unable to see how this Court has any useful and proper function in this process at this stage. Overseeing the statutory bodies in the discharge of their duties by the periodic ordering of statements, assessments and reports is a very costly and inefficient way of proceeding. That is from the viewpoint of those statutory bodies. However, it is equally so from the Court's point of view. I must look at this from the perspective of the overriding objective in COPR 2017 r.1.1. The proceedings at this stage will be expensive and lengthy. They will not be considering decisions that Peter would be making if he had the capacity to do so until there is a discharge plan readily available to be chosen and approved. In those circumstances, allotting any of the Court's time to the application at the moment is inappropriate.*

Comment

While it is unquestionably correct that the COP's role in discharge-planning must be limited where patients remain under the auspices of the MHA, the glacial pace with which discharge planning often proceeds is a well-known source of frustration for patients and practitioners alike. This case serves to illustrate that the scope of the Court of Protection's power must be carefully considered in applications where the person remains detained under the MHA – and specifically, what practical purpose a COP application actually serves to a person with no foreseeable prospect of leaving hospital.

Costly decisions

A Local Authority v ST (Costs application) [2022] EWCOP 11 (14 March 2022): (HHJ Burrows)

Costs

Summary

A Local Authority v ST [2022] EWCOP 11 acts as a helpful reminder to local authorities and public bodies of the importance of complying with directions and making appropriate concessions in good time.

The case concerned 'Sarah', an 18 year old with autism/ADHD who reached a crisis point just before Christmas 2021, precipitating an urgent application to court from the local authority. The Official Solicitor accepted the invitation to act as her litigation friend.

As matters progressed, the local authority raised concerns about Sarah's use of social media, fearing that she might make contact with people who wished her harm. The local authority proposed significant restrictions. The OS raised two concerns: there was no evidence in relation to Sarah's capacity to use social media, and the restrictions proposed were in any event unnecessary and disproportionate.

Directions were made for the filing of capacity evidence, and evidence in relation to ST's current use of the internet. The capacity assessment found that ST was able to understand and retain relevant information, and could *'weigh some of the pro's and con's [sic] but she cannot weigh the risks to the extent that would keep her safe'*. [16] Her social worker's statement (filed slightly late) recorded that she was currently using the internet but there were no inappropriate posts.

The court found that by the time this evidence was filed, it should therefore have been clear that neither the capacity nor best interests evidence was compelling.

The evidence was filed on a Friday, with the local authority's position statement due by close of business on the Monday and the Official Solicitor's on the Tuesday, for a hearing on the Thursday. The local authority not having filed a position statement (or bundle) in accordance with the timetable, the Official Solicitor filed one raising the issue of costs. The local authority then instructed counsel and filed a position statement conceding the issue the day before the hearing. The hearing was therefore not effective.

The court was at pains to emphasise that the original application was properly brought, and there was no question of bad faith on the part of the local authority. However, given that the hearing was specifically to deal with the social media issue, and the Official Solicitor had made her position clear from the start, it was incumbent on the local authority to ensure it complied with the court's directions and kept the strength of its case under proper review.

It should have been clear from the time the evidence was filed that it was highly unlikely the court would find Sarah lacked capacity to make decisions regarding the use social media, or even if it had, to have approved the proposed restrictions. Had the local authority complied with the timetable, this would have been identified and raised in good enough time to avoid the hearing.

The local authority was therefore ordered to pay 85% of the Official Solicitor's costs of the ineffective hearing.

Litigation capacity in non-P parties

Re GA [2021] EWCOP 67 (01 July 2021): (Sir Jonathan Cohen)

Mental capacity – litigation

Summary

An interesting illustration of a situation which many practitioners will be familiar with – what is the correct approach for the court to take when a party who is not P appears themselves to lack capacity to conduct the litigation?

In *A Local Authority v GA & others* [2021] EWCOP 67, the situation arose in an unusual fashion. P's son, TA, had previously represented himself. He went on to instruct solicitors, and those solicitors wrote to the court outlining their concerns about whether their client lacked capacity to litigate. This was strongly disputed by TA and due to legal privilege the exact basis for the solicitors concerns could not be put before the court.

Sir Jonathan Cohen noted, however, that some concerns had been identified by the independent social worker previously instructed, and that TA had expressed strongly held and somewhat unusual views. Recognising that it was quite possible the outcome would be that TA held such views but had and always had had capacity to conduct the litigation, the judge nonetheless ordered a capacity assessment to be conducted by a psychiatrist. This included directions for TA's medical records to be made available (which TA had resisted) and apportioned the cost of such a report to TA's legal aid certificate.

Conferences: The Judging Values and Participation in Mental Capacity Law Conference (20 June 2022)

The Judging Values in Participation and Mental Capacity Law Project conference will be held at the British Academy (10-11 Carlton House Terrace, London SW1Y 5AH), on Monday 20th June 2022 between 9.00am-5.30pm.

Is there something unique about being a lawyer or judge in the Court of Protection (CoP)? Could this uniqueness have something to do with the values that CoP professionals have? This conference will look at these questions, as well as key practical challenges for lawyers, participants, and decision-makers who are

charged with applying the Mental Capacity Act 2005 in England and Wales. Drawing on the academic research conducted through the Judging Values and Participation in Mental Capacity Law project (including close to 60 in-depth interviews with CoP practitioners and retired judges), issues to be explored include:

- How values orient legal professionals in practising and judging in the CoP;
- The law and reality of considering P's values in best interests decision-making;
- The challenges of effective participation in the CoP and why "P-centricity" is so hard to achieve in practice;
- How academic research and legal practice in the CoP can mutually and productively inform one another;
- Potential areas for training for CoP legal professionals;
- What might be learned from other international mental capacity regimes.

The conference fee is £25 and a buffet lunch and refreshments will be provided. The conference will be followed by a drinks reception.

As well as presentations by the Judging Values project team, distinguished panel speakers include: Former President of the Supreme Court Baroness Brenda Hale of Richmond, Former High Court Judge Sir Mark Hedley, Former Senior Judge of the Court of Protection Denzil Lush, Former District Judge of the Court of Protection Margaret Glentworth, Victoria Butler-Cole QC (39 Essex Chambers), and Alex Ruck Keene (39 Essex Chambers, King's College London).

The day will feature plenary sessions as well as break-out thematic discussions that will both inform and facilitate the reflections of conference participants. The event is well suited to contribute to ongoing CPD requirements for both solicitors and barristers, and will be of interest to academics of mental capacity law.

If you would like to attend, please register on the events page here by 1 June 2022. If you have any queries please contact the Project Lead, Dr Camillia Kong: camillia.kong@bbk.ac.uk

Conferences: 7th World Congress on Adult Capacity 7-9 June 2022

Against the odds, preparations and involvements from across the world are moving strongly forward to assure the success of the 7th World Congress on Adult Capacity in Edinburgh International Conference Centre on 7th–9th June 2022. Speakers from 29 countries across five continents (at latest count) have committed to attend personally (subject to any remaining controls affecting their individual journeys) to contribute to plenary and parallel sessions of the Congress. For Scotland and the UK, it will combine major involvement of Scotland's law reform process, led by the Scott Review Team, and eminent contributions from across the UK, with a once-in-a-lifetime worldwide perspective, with both contributions and interactions from far and wide. The event has by now been allocated to every inhabited continent except Africa, but this will be only the second time in Europe. The event is a must for everyone with an interest in mental capacity/incapacity and related topics, from a wide range of angles and backgrounds, including people with mental and intellectual disabilities themselves, and their families and carers; professionals, legislators, administrators, providers of care, support and advocacy services, and others. The event will provide:

- a focus for developments of human rights-driven provision for people with mental and intellectual disabilities,
- a powerful springboard for future research, reform and practical delivery,

- an opportunity to share and discuss worldwide practical experience and initiatives across the huge range and variety of relevant disabilities, in many cultural settings,
- as the first Congress since the start of the pandemic (the 2020 event having been postponed until 2024), a unique opportunity to consider the impact of the pandemic on human rights across the world,
- for professionals and workers in all relevant disciplines and services, an essential understanding of the rapidly evolving practicalities, possibilities and expectations that now set the standards of best practice, and
- in particular for practising lawyers and other professionals, an enhanced understanding of current law, its proper interpretation, and forthcoming developments.

Certificates for CPD purposes will be provided to all who request them.

Amid the difficulties and threats of the pandemic and now war, but with excellent support and best advice, the organising committee opted for a live, in-person event, to a huge welcome from intending participants weary of life by online communications and platforms – helpful though they have all been in the absence of alternatives. Despite the difficulties, the organising committee has also been able to ensure financial viability through any uncertainties that may remain, with hugely valued support from both Scottish and UK Governments, and others, led by the Law Society of Scotland, and including supporters such as the National Guardianship Association of the United States, and with more promised in the pipeline, all to be duly acknowledged in the near future. Further such support continues to be welcome, from any who still wish to commit to contributing to the success of the event.

In terms of the programme, well over 100 abstract submissions (several of them multiple submissions by teams) from across the globe, each to be presented personally at the Congress, and all of a high standard, have been rigorously reviewed and accepted. The line-ups for the plenary sessions now appear to be largely settled, though with some potential contributors still to be confirmed. At time of going to press, the confirmed elements in the plenary sessions are as follows:

PLENARY 1: CONGRESS OPENING, ADULT CAPACITY – THE PRESENT AND FUTURE

CONGRESS OPENING AND WELCOME – Adrian Ward, President, WCAC 2022

SESSION CHAIR – Lord Jim Wallace of Tankerness, Member of House of Lords (attending in A Private Capacity)

SPEAKERS
Kevin Stewart MSP
Her Honour Judge Carolyn Hilder, Senior Judge of the Court of Protection
Prof Dr Makoto Arai, Chuo University, and founder of the World Congress series, President of WCAG 2010
Prof Jonas Ruskus, Vice Chair of the CRPD Committee

PLENARY 2: LAW REFORM – BALANCING PROTECTIONS AND FREEDOMS

SESSION CHAIR – Adrian Ward, President, WCAC 2022

SPEAKERS
John Scott QC, Chair, Scottish Mental Health Law Review
Prof Volker Lipp, Full Professor of Law, University of Göttingen, and President of WCAG 2016
Prof Gerard Quinn, UN Special Rapporteur on the Rights of Persons with Disabilities
Ray Fallan, Network Growth and Development Officer, tide

PLENARY 3: SUPPORTED DECISION-MAKING

SESSION CHAIR – Prof Jill Stavert, Chair, WCAC 2022 Academic Programme Committee

SPEAKERS
Aine Flynn, Director of the Decision Support Service
Prof Israel Doron, Dean – Faculty of Social Welfare and Health Sciences, University of Haifa
Dr Michael Bach, Director, Canadian Centre for Diversity and Inclusion

PLENARY 4: WCAC 2022 AND BEYOND

SESSION CHAIR – John Scott QC, Chair, Scottish Mental Health Law Review

SPEAKERS
Prof Wayne Martin, Director, The Autonomy Project, University of Essex
Mary-Frances Morris, Alzheimer
Adrian Ward, President of WCAC 2022
Prof Dr Isolina Dabove, Main Researcher and Professor, National Scientific and Technical Research Council – Argentina and President of WCAC 2024

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THE WIDER CONTEXT

Acquired brain injury call for evidence

DHSC has opened a call for evidence to help develop the government's acquired brain injury strategy. The consultation is specifically seeking *'the views of people living with acquired brain injury or other neurological conditions and their families, as well as professionals working in this space.'* The exercise is structured as a call for evidence rather than a formal consultation on specific proposals, and is *'a request for ideas on which [the government] can build.'*

The call for evidence is open until 6 June 2022, and an easy read version of the call for evidence is available.

Call for Carers

Neil and fellow researchers at the University of Manchester are seeking to understand the experiences of people supporting a family member to live at home with dementia during the pandemic. The study is taking place across the UK, and you do not have to live with the family member to complete the survey. If you are in this position, they would love to hear from you, or if you are in a position to help to find respondents, that would be enormously helpful.

The survey is available online or in paper format – the online link is here: https://www.qualtrics.manchester.ac.uk/jfe/form/SV_3Rcu3T71wOz05eu , and they would be very grateful if you could circulate to relevant individuals and networks or post to your social media. If you have a group where paper copies would be better, please contact Jayne Astbury on jayne.astbury@manchester.ac.uk or telephone 07385 463 137 for delivery of a stack of surveys.

The survey is expected to take about 30-45 minutes to complete and will remain open until 30 June 2022.

New chair of the National Mental Capacity Forum announced

Dr Margaret Flynn has been appointed as the new chair of the Mental Capacity Forum, for a term of three years. *'Since 2019, Dr Flynn has been a Trustee of Anheddau Cyf, a not-for-profit charity supporting adults with learning disabilities, autism and mental health challenges across North Wales. Dr Flynn was also appointed as a Director of All Wales People First in 2018. She has been a Director of Flynn and Eley Associates Ltd since 2009 and has held various editorial roles for the Journal of Adult Protection since 1999.'*

Inequitable access to transplants

In a slightly odd coincidence of timing, given the recent decision in the case of William Verden, an article that Alex has co-written about adults with impaired decision-making capacity and inequitable access to transplants has just appeared in Transplant International. It is open access (i.e. free) and we hope that the article will prompt debate about strategies for non-discrimination, the developments of policies, as well as further research in this area.

Impact on psychiatrists in intellectual disability of Court of Protection orders for section 49 (Mental Capacity Act) reports

A recent article has set out the results of an online survey of 104 learning disability psychiatrists, of whom approximately 2/3 of whom had been asked to complete s.49 MCA reports in Court of Protection proceedings. It sets out a number of concerning findings and suggests further consideration is required of the use of such orders.

The study's findings include (in relation to those asked to prepare a s.49 report):

- Approximately half were asked to provide an opinion outside their subjective expertise;

- 61.8% were asked to prepare a report for an individual not on their case-load;
- 30.8% of the reports were estimated to take 10-20 hours to complete, and 21.8% required more than 20 hours to complete. Only 15% took less than 5 hours to complete;
- Extensions were requested in 78.2% of the reports described;
- Only 25% of the respondents were somewhat or fully confident in writing reports, and 69.1% stated that they had 'no support' in preparing the report;
- 85% experienced stress as a result of being asked to prepare a report, with some experiencing stress of such a degree that they took sick leave;

The article also found that there were impacts on other patients, and the psychiatrists were not allocated sufficient time in their working day to complete the reports:

> *Over three-quarters of those who had been ordered to produce a section 49 report said there had been an impact on their work with patients, including cancellation of clinics, home visits and attendance at clinical meetings. Other essential activities also had to be postponed, such as preparation for appraisal. Many noted that they had to work on the report in their own time.*

While the study considered psychiatrists working in intellectual disability, the authors considered it was likely that older adult psychiatrists would be experiencing more significant impacts.

Article 2 and 3 damages claims: who can bring the claim on behalf of the person?

Milner v Barchester Healthcare Homes Ltd [2022] EWHC 593 (QB) (22 March 2022) (Master Davison)

Article 2 – Article 3 – damages claims

Ms Milner was a close friend of Elsie Casey, who died aged 94 in a care home where she was subject to a standard authorisation. Ms Milner had issued a claim for damages for breaches of Mrs Casey's Article 2 and Article 8 rights prior to her death, alleging serious neglect at the care home.

The Defendant care home company sought to strike out her claim. The court held that the claim based on Article 2 should not proceed as there was no real prospect of the Claimant showing that there had been a real and immediate risk to Mrs Casey's life. She had been assessed as being at risk from choking, but that was a relatively benign, chronic issue, as for many elderly people. There was no evidence that aspiration pneumonia had caused her death.

The claim under Article 3 was allowed to proceed. The court noted that the allegations in respect of Article 3 included that Mrs Casey was ill-treated for 4.5 years, including being unwashed and left in soiled clothing and bedding, becoming dehydrated, falling, and being subject to inappropriate restraint. The care home in question had been subject to criticism at the time by outside agencies. It was possible that the complaints made would be found to violate Article 3.

Although there was not a close link between conduct complained of and Mrs Casey's death, Ms Milner might be able to establish that she had a strong moral interest or other compelling interest in bringing the claim, give the obvious public interest in ensuring that care homes refrain from breaches of human rights, and that any breaches should be properly investigated.

'Monitoring the Mental Health Act'

The CQC report 'Monitoring the Mental Health Act 2020/2021' has been published and can be found here.

The CQC has a duty under the MHA to monitor how services exercise their powers and discharge their duties when patients are detained in hospital or are subject to community treatment orders or guardianship. The report makes depressing reading, the key messages being that:

(i) the workforce is under extreme pressure – the pandemic having placed additional stresses on staff. The report states that *'staff are now exhausted, with high levels of anxiety, stress and burnout, and the workforce is experiencing high levels of vacancies. The negative impact of working under this sustained pressure poses a challenge to the safe, effective and caring management of inpatient services and to the delivery of care in a way that maintains people's human rights.'*

(ii) During the pandemic there has been an increase in children and young people being cared for in inappropriate settings while they wait for a bed, as well as people being admitted to hospital for prolonged periods and

(iii) urgent action is required to address longstanding inequalities in mental health care, and in particular the CQC remains concerned that Black or Black British people are more likely to be detained under the MHA, spend longer in hospital and have more subsequent readmissions than White people.

Of particular significance to mental capacity practitioners are the following:

- That there remains confusion, even in mental health settings, about people's legal rights under the MHA, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The CQC would welcome clearer guidance about which legislation to use with the introduction of the Liberty Protection Safeguards.
- The fall out from the Supreme Court (SC) decision of *SSJ v MM* [2018] UKSC 60 in 2018, in which the Supreme Court held that restricted patients cannot, under the MHA, be conditionally discharged from hospital to continued deprivation of liberty (for example in a residential social care placement. This has led to
  - (i) a practice of recalling such patients (albeit not actually requiring their physical return to hospital) whilst granting them extended leave of absence from hospital; and
  - (ii) in the case of *Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust & Anor v EG* [2021] EWHC 2990 (Fam), to the High Court invoking section 3 of the Human Rights Act to declare that where it is necessary to do so in order to avoid a breach of a patient's Convention rights, s.72 of the MHA can be construed so as not to require discharge from detention even where the link to the hospital is tenuous. Accordingly, the CQC calls for the proposals to create an explicit 'supervised discharge' power to be implemented, to apply to people who would not be able to leave hospital without such a measure being in place.

Compulsion is no defence: the limits of an insanity plea

R v Keal [2022] EWCA Crim 341 (18 March 2022) (Burnett LJ, Thirlwall LJ, Morris J)

Other proceedings – criminal

On the very edges of capacity law, in R v Keal [2022] EWCA Crim 341, the Court of Appeal refused to expand the *M'Naghten* rules to include those circumstances in which defendants are aware that what they are doing is wrong but have no power no resist the compulsion under which they are acting.

R v Keal concerned the attempted murder by the Appellant of his mother, father and grandmother in 2018. At the time the Appellant, aged 33, was suffering from significant mental ill health: he had attempted suicide the previous day and had been battling mental health problems and drug addiction for a number of years.

The evidence at his trial, and on which he was convicted of three counts of attempted murder, was that the Appellant had carried out violent, sustained attacks against his family members but that, in the course of the attack on his father he had said *"I'm sorry I don't want to, I'm sorry I'm sorry dad" and to his mother, "I'm sorry, this isn't me it's the devil"* [3-4].

The judge at the original criminal trial had directed the jury on the so-called *M'Naghten* Questions and had directed them [21] that

> *8. The defendant has raised the defence of insanity; insanity being a legal term used to describe the effect of a medical condition on the functioning of the mind. Insanity does not have to be permanent or incurable: it may be temporary and curable.*
>
> *9. In law, a person is presumed to be sane and reasonable enough to be responsible for their actions. But if a person proves that it is more likely than not that, when they did a particular act, because they were suffering from a disease of the mind either they did not know what they were doing or they did not know that what they were doing was wrong, by the standards of reasonable ordinary people, the defendant is to be found "not guilty by reason of insanity". "Wrong" in this context means wrong in law i.e. against the law.*
>
> *10. There are two elements to the defence of insanity. First, the defence must establish, on the balance of probabilities, that Mr Keal was suffering from a disease of the mind that led to a defect of reasoning. Second, they must show either that he did not know the nature and quality of his actions or that he did not know that what he was doing was wrong.*

While all four expert psychiatrists who had examined Mr Keal agreed he was suffering from a disease of the mind that led to a defect of reasoning, they all also agreed that he knew the nature and quality of his actions: the question for the jury was therefore whether he *"knew what he was doing was wrong"* [11], specifically whether he knew that *"it was against the law"* [12].

The Appellant appealed to quash his conviction and have his guilty verdicts replaced by not guilty by reason of insanity on the basis that the jury had been misdirected; that *"where a defendant's delusion operates so as to deny him agency, his culpability is the same, whether or not he is conscious that his act is wrong"*. [26] The Appellant submitted that the insanity defence should extend to those who are aware that what they are doing is wrong, but feel compelled by their delusion to do it anyway.

The relevant elements of the M'Naghten Rules were identified by the Court at [11] as Rules 2, 3 and 4, namely:

> *2nd. What are the proper questions to be submitted to the jury, when a person alleged to be afflicted with insane delusion respecting one or more particular subjects or persons, is charged with the commission of a crime (murder, for example), and insanity is set up as a defence?*
>
> *3rd. In what terms ought the question to be left to the jury, as to the prisoner's state of mind at the time when the act was committed?*
>
> *4th. If a person under an insane delusion as to existing facts, commits an offence in consequence thereof, is he thereby excused?*

The conclusions reached by Tindal LCJ in *M'Naghten,* as set out in *Keal* at [12], are, broadly, that jurors should be told:

> *[t]hat every man is to be presumed sane and to possess a sufficient degree of reason to be responsible for his crimes, until the contrary be proved to their satisfaction;…*
>
> *[t]o establish a defence on the ground of insanity it must be clearly proved that at the time of committing the act, the accused had to be labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong…*
>
> *the law is administered upon the principle that every one must be taken conclusively to know it, without proof that he does know it…*
>
> *If the accused was conscious that the act was one which he ought not to do, and if that act was at the same time contrary to the law of the land, he is punishable; and the usual course therefore has been to leave the question to the jury, whether the party accused had a sufficient degree of reason to know that he was doing an act that was wrong.*

Tindal LCJ, in answer to the fourth *M'Naghten* question (if a person under an insane delusion as to existing facts, commits an offence in consequence thereof, is he thereby excused) held:

> [12] … *the answer must of course depend on the nature of the delusion: but, making the same assumption as we did before, namely that he labours under such partial delusion only, and is not in other respects insane, we think he must be considered in the same situation as to responsibility as if the facts with respect to which the delusion exists were real. For example, if under the influence of his delusion he supposes another man to be in the act of attempting to take away his life, and he kills that man, as he supposes, in self-defence, he would be exempt from punishment. If his delusion was that the deceased had inflicted a serious injury to his character and fortune, and he killed him in revenge for such supposed injury, he would be liable to punishment." (emphasis added)*

Dismissing the appeal in *Keal*, Lord Burnett who delivered the sole judgment of the Court of Appeal first set out the meaning of "wrong".

> *37. The meaning of "wrong", and the leading cases on that question, Windle and Johnson were relied upon by the trial judge and have featured in the arguments before us.*
>
> *38. In Windle the appellant killed his wife. There was evidence that he was suffering from a defect of reason from a disease of the mind. The medical evidence was that*

he knew that he was doing an act which the law forbade, but it was possible that when he did so he believed that he was putting her "out of her sufferings". It was argued that the word "wrong" meant "morally wrong". The defence could be established where the defendant thought he was doing a beneficial act, even though he knew it was wrong in law. Lord Goddard LCJ rejected that argument: he held that the word "wrong" in the M'Naghten Rules means "contrary to law".

39. In Johnson, the Court of Appeal revisited the position where the defendant knows that what he did was wrong as a matter of law but did not consider that what he had done was wrong in the moral sense. As in Windle, it was common ground that the appellant knew what he was doing was against the law, but one of the doctors took the view that the appellant did not consider that what he had done was wrong in the moral sense. At §§17 to 20 Latham LJ cited the views expressed in the then current editions of Archbold, Blackstone's Criminal Practice and in Smith and Hogan on Criminal Law. He concluded, at §23, that the strict position remained as stated in Windle and in the passages of those three textbooks to which they had referred. Finally, at §24, Latham LJ observed that there is room for reconsideration of rules which have their genesis in the middle years of the 19th century but "it does not seem to us that that debate is a debate which can properly take place before us at this level in this case". The Court of Appeal certified a question of public importance for consideration by the House of Lords. The House of Lords refused to grant leave to appeal.

40. The passage in Blackstone's Criminal Practice expressly approved by Latham LJ is now found (in substantially the same terms) in the 2022 edition at paragraph A3.33. Addressing the issue of not knowing that the act was "wrong", the authors state:

> *"This is an alternative to not knowing the nature and quality of the act and is the only sense in which an insane person is given a defence when none would be available to the sane (knowledge of moral or legal wrongness as opposed to knowledge of the facts which render it wrong, being generally irrelevant to criminal responsibility). The major question debated here is whether 'wrong' means legally wrong or morally wrong. It is suggested that the key to a proper understanding of this question is to recognise that the question is a negative one. If D* **does** *know* **either** *that his act is* **morally** *wrong (according to the ordinary standard adopted by reasonable men, per Lord Reading in Codere (1916) 12 Cr App R 21)* **or** *that it is* **legally** *wrong then it cannot be said that 'he does* **not** *know he was doing what was wrong'. In two leading decisions on the matter (Codere and Windle [1952] 2QB 826), it was only necessary to hold that it was correct to tell the jury that D could not rely on the defence if D knew that his act was legally wrong. Both were murder cases and it was not seriously suggested in either that D did not know his act was legally wrong and yet knew that it was*

> *morally wrong. (On the contrary, Windle thought he was morally right to kill his suicidal wife and yet knew it was legally wrong since he said, 'I suppose they will hang me for this'.) The ruling in Windle that '"wrong' means contrary to law' has now also been applied in Johnson… to a case where there was some evidence that D did not know that his act was morally wrong; it was held that this could not avail him as it was agreed that he knew that it was legally wrong. A converse case would be that of a D who does not appreciate that his act is legally wrong but who does realise that it is morally wrong, where arguably the defence would again not be made out." (original emphasis)*

41. We endorse this analysis of the authorities. In order to establish the defence of insanity within the M'Naghten Rules on the ground of not knowing the act was "wrong", the defendant must establish both that (a) he did not know that his act was unlawful (i.e. contrary to law) and (b) he did not know that his act was "morally" wrong (also expressed as wrong "by the standards of ordinary people"). In our judgment, "wrong" means both against the law and wrong by the standards of ordinary reasonable people. Strictly a jury must be satisfied that the defendant did not know that what he was doing was against the law nor wrong by the standards of reasonable ordinary people. In practice how the jury is directed on this issue will depend on the facts and issues in the particular case.

42. The focus in Windle (and Johnson) on "wrong" meaning "contrary to law" flowed from the nature of each case. On the facts of both, each defendant knew what he was doing was "contrary to law", but there was evidence that he did not consider that the act was "morally wrong". The defence failed because the defendant could not establish (a) above. Equally, in the reverse, and likely rare, case, where the defendant did not know what he was doing was "contrary to law", but did know it was "morally wrong", the defence is not available; and indeed that is situation which Tindal LCJ had in mind when distinguishing between "knowledge of the law of the land" and knowing what "he ought not to do" in his answer to the second and third questions (set out in paragraph 12 above).

As to whether the M'Naghten Rules include an element of "lack of choice", ie extend to include those circumstances where an accused is aware that something is "wrong" but feels compelled to do it anyway, the Court of Appeal held that they did not. Further, it pointed it out that it was bound by Court of Appeal authority in the form of *R v Kopsch* (1927) 19 Cr App Rep 50 which dismissed what Lord Hewart described as the *"fantastic theory of uncontrollable impulse"*. [45] It further noted that the Law Commission had specifically recognised that the law as it stands does not include an element reflecting lack of capacity to control one's actions – ie a defence of irresistible impulse.

The *Keal* judgment is very clear that *"the defence of insanity is not available to a defendant who, although he knew what he was doing was wrong, he believed that he had no choice but to commit the act in question"* [48]. Furthermore, it notes that, having considered the matter at some length previously, any extension of the law of insanity is matter that should properly be left to Parliament.

Having a deputy and Article 14 ECHR 'status'

MOC v Secretary of State for Work and Pensions [2022] EWCA Civ 1 (11 January 2022) (Peter Jackson, LJ, Singh LJ, Andrews LJ)

Other proceedings – Administrative

In *MOC v SSWP* [2022] EWCA Civ 1, the Court of Appeal considered whether having a property and affairs deputy was a protected 'status' for the purposes of Article 14 ECHR. The case related to the Disability Living Allowance (DLA) 'Hospitalisation Rule', which operates to suspend the payment of DLA where a person has been in hospital after 28 days. MOC argued that this policy unlawfully discriminated against him.

There is a difference in the application of Hospitalisation Rule for children and adults following a successful challenge to the rule in respect of children in *Mathieson v Secretary of State for Work and Pensions* [2015] UKSC 47. Since 2016, the regulations allow anyone under the age of 18 to continue to receive DLA or PIP while in hospital; however, adults do not continue to receive DLA after 28 days in hospital. Adults living in residential care settings are also barred from receiving the care component.

MOC was 60 years old and had complex medical conditions and disabilities. He had qualified for the highest rates of both the mobility and care component DLA since 1993 (and has presumably since been migrated to the Personal Independence Payment). MOC's sister, MG, had been appointed his property and affairs deputy by the Court of Protection.

In June 2016, MOC was admitted to an acute hospital and re-admitted in July 2016. He remained there until September 2016, at which time he was admitted to a specialist neurorehabilitation unit. In July 2017, he was admitted to a nursing home within a local hospital, and he has not been able to return to living in the community.

MOC's DLA was fully suspended from August 2016 (28 days after his July 2016 admission) due to the effect of the Hospitalisation Rule. His DLA mobility component was restored on his transfer to the nursing home in August 2017. His care component was not payable under the relevant regulations while he was in nursing care.

Through MG, MOC argued (first to the First-Tier Tribunal (FTT) and then to the Upper Tribunal (UT)) that the 'Hospitalisation Rule' unlawfully discriminated against him under Article 14 read together with Article 1 Protocol 1 ECHR ('A1P1'). At the FTT, MG argued on behalf of MOC that MOC had been discriminated against *'on the grounds of age and status as an "uncapacitous [sic] person in hospital."'* [27] The FTT declined to read *Mathieson* across to find that the Hospitalisation Rule was unlawful in respect of adults.

In the UT, the parties were agreed that MOC was *'a severely disabled adult in need of lengthy in-patient hospital treatment.'* [32] The court did not agree that MOC had a relevant 'status' for the purposes of Article 14 as being either an:

> *(1) "incapacitous severely disabled adult in need of lengthy in-patient hospital treatment", or*
>
> *(2) "a severely disabled adult who lacks capacity to make decisions about care and medical treatment in need of lengthy in-patient treatment".*

The principal reason for rejecting this submission was that capacity was unsuitable as a key element in identifying a "status" for Article 14 and too "potentially evanescent" (para. 10). The Judge also observed that, if lack of

> *capacity was a trigger for a finding that there had been a breach of a claimant's human rights, there was a risk of people moving in and out of being the subject of a breach on a "virtually daily basis" (para. 7).* [32]

The UT considered that in any event, any difference in treatment was justified. While it may be relevant for the purposes of the Regulations whether the person required an informal carer, the evidence in the case did not support a conclusion that the deputy had a *'hands-on caring role.'* [34]

The Court of Appeal agreed with the UT that the proposed status (argued before it as *'that of "a severely disabled adult who lacks capacity to make decisions about care and medical treatment in need of lengthy in-patient hospital treatment"'*) was not one on which an Article 14 discrimination claim could be properly founded in this case. The Court of Appeal found that the UT:

> *65...was right to observe that the question of capacity as such is not a status. First, the scheme of the 2005 Act was designed to move away from a status-based approach to a functional approach, in other words to focus on particular decisions at a particular time. Secondly, there needs to be reasonable certainty: a person's capacity may change from time to time and may do so quickly. That is not a sound foundation for the "status" required by Article 14.*
>
> *66. I should also observe that I can see no logical connection between the purpose of DLA and the role of a deputy appointed under the 2005 Act. There were times at the hearing when it appeared to be suggested that what this case is really about is whether a deputy is entitled to claim expenses for performing her tasks as a deputy. Whether or not that would be a good idea as a matter of social and economic policy, in my view it has nothing to do with whether the rule under challenge is discriminatory.*

Book Review: The Spaces of Mental Capacity Law: Moving Beyond Binaries (Beverley Clough)

The Spaces of Mental Capacity Law Moving Beyond Binaries (Beverley Clough, Routledge, 2021, Hardback £120/ebook £33.29)
[*A version of this book review will be forthcoming in due course in the International Journal of Mental Health and Capacity Law, so this serves as a sneak preview – the most recent issue of the journal can be found here*]
Dr Beverley Clough, Associate Professor in Law and Social Justice at the University of Leeds, has established herself in a relatively short space of time as one of those whose works go straight onto the reading list for students (in all senses) of matters capacity related. Her latest work, the fruits of a ISRF Early Career Fellowship, is "The Spaces of Mental Capacity Law: Moving Beyond Binaries," and should equally find its way onto the reading list. It is a stimulating, and very challenging, exploration of both the conceptual spaces and the contexts which mental capacity laws exist, focusing primarily upon England & Wales.

After two largely conceptual chapters, drawing out, in particular, a model with which to interrogate the space occupied by the Mental Capacity Act 2005, the central spine of the book is a dissection of five 'binaries' that Clough identifies as pervading mental capacity laws in jurisdiction such as England & Wales: (1) capacity/incapacity; (2) care/disability; (3) state/individual; (4) freedom/deprivation of liberty; and (5) the distinction between public law and private law. In each of the chapters, Clough identifies ways in which the binary in question is perhaps not as fixed as is assumed, either by current law, or by those who apply it. She is particularly interested in, and critical of, the ways in those binaries are embedded in the broader logics of liberalism, and one of the signal

services of the book is to bring those links into the light.

Refreshingly, at least to this reader, whilst Clough is clear that her goal is to open up new ways of thinking about mental capacity law, the book adopts a subtle and nuanced approach to some of the ways in which current legal frameworks relating to capacity have been challenged by those dissatisfied with the ways in which they serve (or do not serve) those with impairments of different kinds. She has, for instance, some acute, and interestingly sceptical observations about the debates relating to relational autonomy and vulnerability. She also asks some particularly pertinent questions about the potential for the UN Convention on the Rights of Persons with Disabilities to allow an escape from the binaries that she identifies, noting the extent to which (perhaps ironically) that the "residue of liberal legal ideals is present across the Articles of the Convention in terms of the language used and a focus on autonomy" (page 191).

I noted at the outset that the book is challenging, a word that I chose carefully for its multiple meanings. The more conceptual chapters, in particular, are definitely not an easy read, and those new to the field might find themselves at times having to wrap the wet towel around their heads whilst they trace the development of the arguments through. The wet towel would be well-used, though, because the chapters which follow amply bring the theoretical into close and detailed contact with 'real life.' As both an academic and a practitioner before the Court of Protection, I must also confess to giving the odd hollow laugh at the sustained analysis of judgments[1] which I am well aware reflect as much the vagaries and contingencies of fate than they do of the workings out of any very considered philosophy. That having been said, of course: (a) the judgments reflect the written record, and are therefore fair game for dissection; and (b) Clough's analysis of what is not said, or what is assumed, in those judgments is always stimulating.

The major reason for saying that I find the book challenging in what could be taken as a negative fashion is perhaps a little unfair, but it is only a function of it being so stimulating in what it covers. What the book left me wanting was a second volume in which Clough grapples with the ways in which the binaries that she so interestingly challenges play out in two key areas.

The first is where questions of disability are simply not in play (or not in play in the same way) in relation to capacity than in the ways she carefully analyses in chapter 3. For instance, what is a doctor to do in relation to a patient who is unable to consent to a life-saving procedure not because of any underlying cognitive challenges, but because they are unconscious having been brought in after a car-crash? It would certainly be possible to find other ways of directing and/or limiting the doctor's approach[2] but it does seem very difficult not to find a route which does not, at some level, engage questions of capacity.

The second is where there is no direct state involvement. Each of the binaries that she describes arises in situations where the state is in some way involved in the life of the individual(s) concerned, and Clough makes a powerful case for revisiting the very foundations of that involvement. It is, however, not so obvious that the state is intervening in a situation where someone seeks to enter into a contract, to make a gift, or to make arrangements to dispose of their property after death. All of those are situations where the capacity/incapacity binary arises (although largely unmediated by the Mental Capacity Act 2005[3]). I hope that Clough can be persuaded to offer some thoughts in her future work as to whether (and if so) how the binary needs to be revisited in such contexts. For my part, and accepting that I may be incapable of escaping the coils of liberal legal ideals, I might still require some persuasion that – for all its flaws – there is any other model that commands greater legitimacy for all the

purposes for which it is which it is required than that of mental capacity.
I reiterate, though: that I make these observations is primarily a function of how stimulating the work itself is, and I recommend it highly to all those interested in thinking more broadly about mental capacity law than is sometimes possible in the thickets of the MCA 2005 itself.

[Full disclosure, I was provided with an inspection copy of this book by the publishers. I am always happy to review books in the field of mental capacity and mental health law (broadly defined).]

[1] Some of which relate to cases I have been in.
[2] There are some civil law jurisdictions, for instance, there is general health legislation providing for treatment to be provided in an emergency absent consent.
[3] The test for capacity to contract, to make a gift, and to make a will are all governed by the common law, save that the Mental Capacity Act 2005 governs the situation if the Court of Protection is being asked to act on behalf of the person.
Alex Ruck Keene

Shedinar: Deprivation of Liberty in the Shadows of the Institution (Dr Lucy Series)

Deprivation of Liberty in the Shadows of the Institution (Dr Lucy Series, Bristol University Press, 2022, Hardback £24.99/ebook free)

In this conversation, Alex asks Dr Lucy Series about her book Deprivation of Liberty in the Shadows of the Institution (available here, for free, thanks to the Wellcome Trust) looking at the tangled history of deprivation of liberty, social care detention, *Cheshire West* and its legacies, and the concept of the empowerment entrepreneur.

SCOTLAND

The Guardians' remuneration

We have reported on this topic in recent Scotland sections, including last month when we explained that an "Uplifts Working Group" has now been established. We are grateful to the Public Guardian and to the four members of the Working Group for confirming that we may now publish the names and contact details of the members of the Working Group. They have agreed to be contacted by solicitors who wish to offer feedback or suggestions, as is Fiona Brown herself. Fiona Brown accordingly appears at the head of the list, which is as follows:

Fiona Brown, Public Guardian: fbrown2@scotcourts.gov.uk
Fiona Thomson of Ledingham Chalmers: Fiona.thomson@ledinghamchalmers.com
Lorna Brown of Caritas Legal: lornabrown@caritaslegal.co.uk
Paul Neilly of Mitchells Roberton: Paul@mitchells-roberton.co.uk
Toni McNicol of Blackadders: Toni.mcnicoll@blackadders.co.uk

We were pleased to hear that the Working Group had its first meeting on 23rd March, which is reported to have gone well.

Adrian D Ward

Open justice or anonymisation; written decisions; and Article 8

From time to time we comment on child law cases because of elements of relevance to adult incapacity practice. In the petition of *X & Y v The Principal Reporter and KB*, [2022] CSOH 32, X & Y, foster carers and prospective adopters of a child IB, aged five, appealed unsuccessfully to the Court of Session against aspects of a decision by a children's hearing in respect of IB. See the full Opinion of Lady Wise for an account of all matters addressed before her, the arguments of the parties, and her decisions. Three aspects are of potential interest to adult incapacity practitioners, namely whether X & Y were entitled to non-disclosure to IB's mother of their names and addresses; whether it was fatal that written reasons for the decision of the children's hearing were not provided; and some comments on Article 8 of the European Convention on Human Rights, including the distinction between private life and family life and whether engagement of a person's Article 8 rights in proceedings conferred right to attend and participate.

The leading case on anonymisation of parties remains *MH v Mental Health Tribunal for Scotland*, 2019, SC 432, upon which we reported in the May 2019 Report, further referred to in the June 2019 Report. The key principle stated by Lord President Carloway in that case is that there will always be a presumption in favour of open justice, unless the particular rules or circumstances necessitate anonymity. Subsequently to the decision in that case, the court received and accepted evidence justifying anonymity, and granted it. In the February 2022 Report we referred to a Statement of Reasons in the litigation between PKM's Guardians and Greater Glasgow Health Board, where the importance of anonymity led the Second Division not to report its Statement of Reasons in the usual way at all. We commented that this decision of the Second Division was not easy to reconcile with the decision of the First Division in MH. In X & Y, Lady Wise referred to MH but not to PKM. KB, the mother of IB, had apparently accepted that IB should be adopted. She wanted to know where IB would be, and the identity of her prospective adoptive parents. Access arrangements were in place and there was no evidence that she had used previous knowledge of IB's whereabouts inappropriately. The children's hearing had ruled in favour of disclosure to KB, overruling a request by IB's social worker for non-disclosure, and Lady Wise agreed. Before the children's hearing there had been some discussion about the appropriate test to be met before non-disclosure could be ordered. In her decision, Lady Wise narrated that: "*No suggestion was made to the hearing that the*

petitioners wished non-disclosure for their own benefit and so the discussion centred only on whether it would be harmful to IB were the names and address to be disclosed." Lady Wise emphasised that: *"there is no barrier to those such as the petitioners requesting anonymity in the children's hearing procedure, but it cannot be automatic because the statutory scheme applies to a wide spectrum of cases*." In cases involving the children's hearing: *"any request for anonymity is necessarily considered on a case by case basis*". Looking at the topic more broadly: "*There is simply no basis for an assertion that the rules applicable to one tribunal ought to be the same as those applicable in separate court proceedings*". On this point she concluded by re-emphasising the presumption in favour of open justice enunciated in MH.

Secondly, the petitioners criticised the failure of the hearing to provide written reasons for its decision on the non-disclosure measure. Lady Wise described this as a "procedural regularity" but held that: "*The critical issue, however is whether the procedural irregularity has been 'damaging to the justice of the proceedings' – C v Miller, 2003 SLT 1379 at 1395*." She held that she had received sufficient explanation from the account of the proceedings before the hearing in the evidence before her, and that on this occasion the "procedural irregularity" was not damaging to the interests of justice. This does however resonate with the long-standing concerns about the paucity of decisions by sheriffs in the adults with incapacity jurisdiction, particularly when most such decisions affect or at least address fundamental rights of the adult involved. The lack of clear lines of authority that would be available in written decisions seems to be an element in the often uncoordinated diversity of decision-making by different courts and individual sheriffs across the country. The difference with the volume of reported cases in England & Wales exceeds anything proportional to respective populations, and reflects the considerable benefits of having their jurisdiction limited to a specialist court.

Finally, it is of interest to note that Lady Wise held that the X & Y case engaged the right to private life, but not the right to family life, in terms of Article 8 of ECHR. She held that mere engagement of Article 8 rights in proceedings before a children's hearing did not necessarily confer any right to attend or to participate.

Adrian D Ward

World Congress and Scott Review consultation

Beyond the constant demands of current workload, dominant themes for Scottish practitioners in all aspects of adult incapacity work, and all related areas including in particular mental health law and adult support and protection law, are the 7th World Congress on Adult Capacity, 7–9 June 2022 in Edinburgh, and the consultation period upon the consultation document issued by the Scottish Mental Health Law Review ("the Scott Review") on 17th March 2022, with an unprecedently short consultation period concluding on 27th May 2022.

Generally on the World Congress, see our description in the March Mental Capacity Report, which included details of the plenary sessions. Most of the detailed information for the plenary sessions can now be viewed on the Congress website www.wcac2022.org: click on "Congress programme" and then in the first line on the link at "here" to the full programme. This shows the great wealth of contributions to be heard at the Congress, much of it of interest to Scottish practitioners, particularly those seeking to develop best practice, and present arguments in favour of best practice, drawn comparatively from a worldwide context, particularly in view of the dearth of reported decisions in Scotland, and the apparent uncoordinated diversity of decisions both reported and unreported, mentioned in the preceding item. Registrations to attend continue to flow in from across the world, and those who have not yet registered should do so at the "Registration" link on the

website without delay, to avoid risk of disappointment.

The Scott Review consultation document, together with separate Summary (and also an easy-read version), are all available on the SMHLR website at Homepage | Scottish Mental Health Law Review. We do not attempt to summarise here the content of the 189-page consultation document when a Summary is also available, and all those with an interest will wish to concentrate on reading the primary material and commenting on it, particularly the specific consultation questions listed at the end of each chapter. Value would not be added by seeking to provide in addition a "summary of the Summary"! Moreover, formulation of responses will require careful consideration of the consultation document as a whole, rather than rapid reactions to individual points in isolation. We have however already referred to the seriously inadequate consultation period from 17th March to 27th May 2022, somewhat less than the minimum for routine consultations of relatively narrow scope of three months, and the norm for consultations of this magnitude of six months.

Consultees will wish to concentrate on doing the best that they can within the available period, contributing the best value that they can achieve towards the overall review process. The 170 or so from a great variety of backgrounds who attended a seminar on the review hosted by Edinburgh Napier University on 23rd March will certainly have benefitted towards making their contributions by an impressive and well co-ordinated presentation by the review team, led by John Scott. John will participate substantially in the World Congress, including leading the review team in a dedicated session just a fortnight after conclusion of the consultation period.

Adrian D Ward

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Victoria regularly appears in the Court of Protection, instructed by the Official Solicitor, family members, and statutory bodies, in welfare, financial and medical cases. Together with Alex, she co-edits the Court of Protection Law Reports for Jordans. She is a contributor to 'Assessment of Mental Capacity' (Law Society/BMA), and a contributor to Heywood and Massey Court of Protection Practice (Sweet and Maxwell). To view full CV click here.

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Neil has particular interests in ECHR/CRPD human rights, mental health and incapacity law and mainly practises in the Court of Protection and Upper Tribunal. Also a Senior Lecturer at Manchester University and Clinical Lead of its Legal Advice Centre, he teaches students in these fields, and trains health, social care and legal professionals. When time permits, Neil publishes in academic books and journals and created the website www.lpslaw.co.uk. To view full CV click here.

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Nicola appears regularly in the Court of Protection in health and welfare matters. She is frequently instructed by the Official Solicitor as well as by local authorities, CCGs and care homes. She is a contributor to the 5th edition of the *Assessment of Mental Capacity: A Practical Guide for Doctors and Lawyers* (BMA/Law Society 2019). To view full CV click here.

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Katie advises and represents clients in all things health related, from personal injury and clinical negligence, to community care, mental health and healthcare regulation. The main focus of her practice however is in the Court of Protection where she has a particular interest in the health and welfare of incapacitated adults. She is also a qualified mediator, mediating legal and community disputes. To view full CV click here.

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Steph regularly appears in the Court of Protection in health and welfare matters. She has acted for individual family members, the Official Solicitor, Clinical Commissioning Groups and local authorities. She has a broad practice in public and private law, with a particular interest in health and human rights issues. She appeared in the Supreme Court in *PJ v Welsh Ministers* [2019] 2 WLR 82 as to whether the power to impose conditions on a CTO can include a deprivation of liberty. To view full CV click here.

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Arianna has a specialist practice in mental capacity, community care, mental health law and inquests. Arianna acts in a range of Court of Protection matters including welfare, property and affairs, serious medical treatment and in matters relating to the inherent jurisdiction of the High Court. Arianna works extensively in the field of community care. To view a full CV, click here.

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

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Adrian is a recognised national and international expert in adult incapacity law. He has been continuously involved in law reform processes. His books include the current standard Scottish texts on the subject. His awards include an MBE for services to the mentally handicapped in Scotland; honorary membership of the Law Society of Scotland; national awards for legal journalism, legal charitable work and legal scholarship; and the lifetime achievement award at the 2014 Scottish Legal Awards.

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Conferences

7th World Congress on Adult Capacity, Edinburgh International Conference Centre [EICC], 7-9 June 2022 The world is coming to Edinburgh – for this live, in-person, event. A must for everyone throughout the British Isles with an interest in mental capacity/incapacity and related topics, from a wide range of angles; with live contributions from leading experts from 29 countries across five continents, including many UK leaders in the field. For details as they develop, go to www.wcac2022.org. Of particular interest is likely to be the section on "Programme": including scrolling down from "Programme" to click on "Plenary Sessions" to see all of those who so far have committed to speak at those sessions. To avoid disappointment, register now at "Registration". An early bird price is available until 11th April 2022.

The Judging Values and Participation in Mental Capacity Law Conference

The *Judging Values in Participation and Mental Capacity Law* Project conference will be held at the British Academy (10-11 Carlton House Terrace, London SW1Y 5AH), on **Monday 20th June 2022 between 9.00am-5.30pm**. It will feature panel speakers including Former President of the Supreme Court Baroness Brenda Hale of Richmond, Former High Court Judge Sir Mark Hedley, Former Senior Judge of the Court of Protection Denzil Lush, Former District Judge of the Court of Protection Margaret Glentworth, Victoria Butler-Cole QC (39 Essex Chambers), and Alex Ruck Keene (39 Essex Chambers, King's College London). The conference fee is £25 (including lunch and a reception). If you would like to attend please register on our events page here by 1 June 2022. If you have any queries please contact the Project Lead, Dr Camillia Kong.

Forthcoming Training Courses

Neil Allen will be running the following series of training courses:

22 April 2022	DoLS refresher for mental health assessors (half-day)
28 April 2022	The Mental Health and Capacity Act Interface (full-day)
6 May 2022	Necessity and Proportionality training (half-day)
13 May 2022	BIA/DoLS legal update (full-day)
16 May 2022	AMHP legal update (full-day)
17 June 2022	DoLS refresher for mental health assessors (half-day)
14 July 2022	BIA/DoLS legal update (full-day)
16 September 2022	BIA/DoLS legal update (full-day)

To book for an organisation or individual, further details are available here or you can email Neil.

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.

Conferences (continued)

Pregnancy, Childbirth and the Mental Capacity Act: 4 May 2022

Ian Brownhill will be offering a course through Edge Training to assist delegates to navigate the challenging landscape of mental capacity law in the field of obstetrics. Delegates will cover the basics of the Mental Capacity Act and how the law should be applied in relation to specific decisions such as caesarean sections and birth plans. Related areas will also be covered such as contraception and termination of pregnancies. There will be particular consideration of those detained under the Mental Health Act and guidance on when to apply to the Court of Protection. To register, click here.

Essex Autonomy Project Summer School 2022

Early Registration for the 2022 Autonomy Summer School (*Social Care and Human Rights*), to be held between 27 and 29 July 2022, closes on 20 April. To register, visit the Summer School page on the Autonomy Project website and follow the registration link.

Programme Update:

The programme for the Summer School is now beginning to come together. As well as three distinguished keynote speakers (Michael BACH, Peter BERESFORD and Victoria JOFFE), Wayne Martin and his team will be be joined by a number of friends of the Autonomy Project who are directly involved in developing and delivering policy to advance human rights in care settings. These include (affiliations for identification purposes only):

> Arun CHOPRA, Medical Director, Mental Welfare Commission for Scotland

> Karen CHUMBLEY, Clinical Lead for End-of-Life Care, Suffolk and North-East Essex NHS Integrated Care System

> Caoimhe GLEESON, Programme Manager, National Office for Human Rights and Equality Policy, Health Service Executive, Republic of Ireland

> Patricia RICKARD-CLARKE, Chair of Safeguarding Ireland, Deputy Chair of Sage Advocacy

Planned Summer School Sessions Include:

> Speech and Language Therapy as a Human Rights Mechanism

> Complex Communication: Barriers, Facilitators and Ethical Considerations in Autism, Stroke and TBI

> Respect for Human Rights in End-of-Life Care Planning

> Enabling the Dignity of Risk in Everyday Practice

> Care, Consent and the Limits of Co-Production in Involuntary Settings

The 2022 Summer School will be held once again in person only, on the grounds of the Wivenhoe House Hotel and Conference Centre. The programme is designed to allow ample time for discussion and debate, and for the kind of interdisciplinary collaboration that has been the hallmark of past Autonomy Summer Schools. Questions should be addressed to: autonomy@essex.ac.uk.

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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