Essex CHAMBERS

MENTAL CAPACITY REPORT: COMPENDIUM

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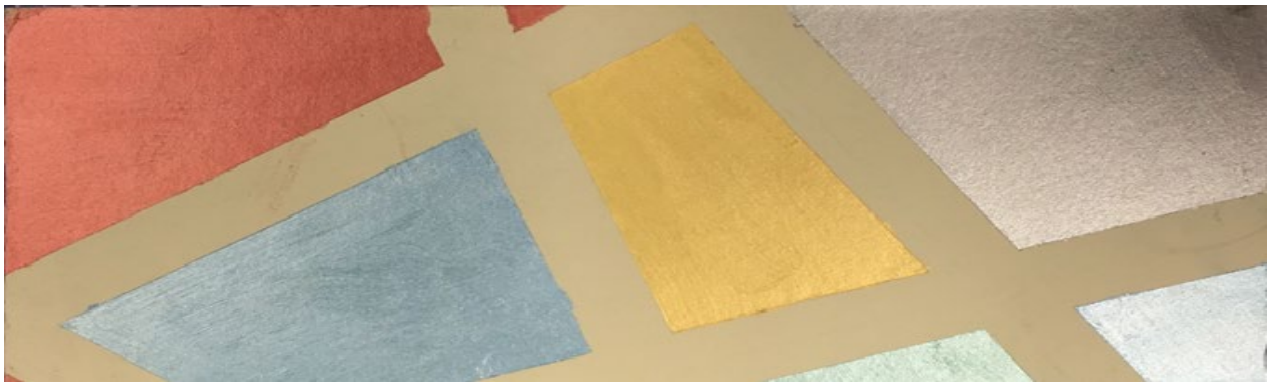

Welcome to the February 2022 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: religion and the burdens of treatment; vaccine case law update; and making the decisions the person would have made;

(2) In the Property and Affairs Report: the scope of the powers under an LPA, and updated safeguarding guidance from the OPG;

(3) In the Practice and Procedure Report: vulnerable parties and witnesses, and covert recordings;

(4) In the Wider Context Report: blood transfusions for teenage Jehovah's Witnesses, s.117 ordinary residence and a new capacity guidance website;

(5) In the Scotland Report: DNACPRs and the relationship between medical decision-making and guardians' decision, cross-border deprivations of liberty of children and guardians' remuneration.

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.

Contents

HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

New 39 Essex guidance note on deprivations of liberty for those under 18

The Children's Commissioner for England has identified a growing number of "locked up" children who do not appear in official statistics whilst an ongoing national shortage of appropriate secure accommodation and registered children's homes has resulted in some High Court judges refusing to authorise wholly inappropriate deprivations of liberty in hospitals. We have produced guidance to help practitioners navigate the complex waters relating to deprivation of liberty relating to those under 18,

complexity arising both from the substantive law (how does the concept of deprivation of liberty apply to those under 18?) and procedural law (how should deprivations of liberty be authorised?).

Capacity and fluctuating capacity guidance notes updated

To take account of the decision of the Supreme Court in *JB*, and of other case-law developments over the past few months, we have updated both our guidance note on assessing capacity and our guidance note on fluctuating capacity.

Liberty Protection Safeguards delayed to…

DHSC has confirmed that the Liberty Protection Safeguards (LPS) will not be implemented in April 2022. In a letter sent to LPS national steering group members, DHSC confirms that a 12-week consultation will be held on the draft regulations and Code of Practice for the Mental Capacity Act and the LPS. DHSC hopes to launch the consultation earlier this year. Plans to implement the LPS by April 2022 will thus not take place. The letter does not confirm a date either for the consultation to commence, or a new date for implementation of the LPS.

Religious belief and the burden of treatment

Cambridge University Hospitals NHS Foundation Trust v AH [2021] EWCOP 64 (Theis J)

Best interests - medical treatment

Theis J reconsidered the best interests of 56 year old Covid-19 patient AH for whom treating clinicians considered artificial ventilation was no longer in her best interests.

This was a rehearing of the case following a successful appeal. In a widely reported case in November last year [2021] EWCA Civ 1768, the Court of Appeal allowed the appeal against the order of Hayden J that it was no longer in AH's best interests to receive ventilator support and treatment owing in large part to Hayden J conducting a judicial visit after which he observed *"I got the clear impression she wanted some peace, she showed me that she did"*.

The Court of Appeal held [71-3] that this meeting and observation undermined the judge's reasoning on AH's best interests because a) he was not equipped to gain any insight into AH's wishes and feelings from his visit; and b) having conducted what became an evidence-gathering process, procedural fairness required that parties ought to have been given an opportunity to respond to his observations.

The case was subsequently remitted to the High Court for a hearing before Theis J. AH's treating clinicians continued to seek an order that it was no longer in her best interests to receive artificial ventilation; her four adult children and sister T vehemently opposed such an order.

Theis J summarized the background to the case [10]:

> *In January 2021 AH developed a systemic inflammatory response syndrome ('SIRS'), a recognised complication of Covid-19, with hyperpyrexia and multi organ failure. AH required renal dialysis, ventilation and sedation. This caused devastating damage. The episode was described by the clinicians as a 'cytokine/autoimmune storm' and resulted in a number of profound and permanent*

> *neurological and myopathic conditions, namely cerebral encephalopathy, brainstem encephalopathy, motor neuronopathy and necrotising myopathy. In lay terms, AH suffered extensive and devastating damage to her nerves, muscles and brain as a consequence she is paralysed from the neck down, is unable to speak, is tube fed, doubly incontinent and has been on mechanical ventilation since early January.*

By June 2021, AH's clinical team had noted a slight improvement which was also accompanied by a "visible and marked increase in her distress" [12] such that, following discussions with the Clinical Ethics Advisory Group, the balance of benefit was considered to swing against continued treatment.

While AH's family agreed that there would be no escalation of critical care support and no cardiopulmonary resuscitation, they did not agree to the total withdrawal of treatment, noting AH to demonstrate "occasional shafts of happiness" when seeing her family. The family's evidence was that, as a practising Muslim and devoted mother, AH would have wanted all treatment available to maintain her life.

Evidence from expert the consultant intensivist instructed on behalf of the Trust, Dr A , suggested to the court however that AH presented as "'obviously and almost continuously distressed' and that this is a 'ubiquitous feature of her clinical examination'" [17] His evidence was that AH was in 'MCS+,' 'a state of wakefulness with minimal awareness' albeit that Dr A considered that AH did not meet some of the definition of MCS+ which is where 'Patients show – some evidence of language processing/communication such as following simple commands, intelligible verbalisation or intentional communication, albeit still inconsistently' . The Prolonged Disorders of Consciousness Guidelines also refer to evidence of a feature of MCS+ as 'evidence of reasoning/problem solving (either verbal or non-verbal)'. Dr A stated in evidence that he had never seen this and considered it conceivable that AH's global neurology or neurological state was in fact less than had been believed and there is the risk that they may be erroneously attributing a higher level of function to her facial movements, which may simply be mimicry. He considered AH showed no ability to react spontaneously by smiling.

The evidence of Dr Danbury, the intensivist instructed by the Official Solicitor was that AH was in Terminal Decline of Consciousness and would inevitably remain ventilated for the rest of her life. He considered the process of her dying, if she remained in intensive care, "'will take months and will be progressively more distressing for her, her family and her carers'." [43] Theis J noted in her judgment:

> *46. In his sensitive oral evidence Dr Danbury said what is different now is that AH has spent more time on ICU, with the ability to assess her physical and cognitive function, which allows him to be more certain about the long term prognosis. He considers the chance of her emerging into a conscious state is 'very small indeed', later saying it was less than 1%. He did not consider his position was impeded by not having visited AH, as he considered all the records were internally consistent, whilst he was happy to see her he didn't believe his opinion would change. He had heard S's oral evidence. He considered AH is likely to respond to familiar voices and people as her long term memory is preserved, so he is 'not surprised' that she smiles more to family and they get the best out of her. The family are looking for signs of improvement, he recognised the horrible position the family are in but did not consider S's evidence was inconsistent with what is in the notes and his view.*

Dr Danbury gave evidence not only on the likelihood – or inevitability – of AH dying in the ICU but also of the burden of treatment. He gave evidence to the court that those patients he had been able to speak to after periods in intensive care likened treatment such as suctioning (which AH was having to experience every 2-3 hours) to being like a "red hot poker" [48].

AH's family gave evidence that her religious beliefs as a practising Muslim meant she would not want mechanical ventilation withdrawn. [60]

Having heard all the evidence from a number of clinicians and family members, Theis J ultimately determined it was no longer in AH's best interests to continue to receive treatment. She held:

> *93. Having considered the evidence as a whole and weighed the respective benefits and burdens of continuing treatment, including carefully weighing in the balance the strong presumption that it is in AH's best interest to stay alive, which would accord with her religious beliefs and is something her family strongly wish to happen, I have reached the conclusion that the very real burdens in the particular circumstances AH is in, with the prospect of no change and more probably a continued deterioration which may last many months of treatment, with the risk of an infection and dying away from her family, outweigh those very considerable benefits. If she is going to die her wishes are more likely to be that she would wish to do so with her family present.*

Comment

The medical evidence in this case was very clearly pointing in one direction – that continued ventilation was no longer in AH's best interests. Nonetheless, it is ultimately what Theis J considers AH would have considered important that is held up as a determining factor in the judicial decision-making: part of the continued trend of judicial emphasis (rightly, we think) on P's likely decision-making, a concerted effort to stand in P's shoes, rather than a top-down consideration of what is "best" for P.

Vaccination case update

Royal Borough of Greenwich v IOSK, NK and MOK [2021] EWCOP 65 (HHJ Hilder)

Best interests – medical treatment

IOSK was 17 years old at the time of the decision, turning 18 the following month, and subject to a care order.

As part of wider welfare proceedings, the local authority applied for a decision that it was in IOSK's best interests to be vaccinated against Covid-19. His parents both opposed the application and both believed that IOSK had an adverse reaction to the MMR vaccine as a child. IOSK's mother was also concerned that if he had a negative reaction this would not be identified timeously, due to her wider concerns about the standard of his care; IOSK's father advanced a number of arguments in his written evidence but submissions by counsel on his behalf focused on the risk of adverse reactions.

The relationship between the parents and the local authority had become 'to put it mildly, very strained'. (paragraph 6) Perhaps as a result of this, the local authority made an application for special measures to be applied for the questioning of their witness: if IOSK's father was unrepresented, he would put

questions in writing which would be put to the witness by the judge (he was ultimately represented by counsel).

HHJ Hilder held that vaccination was in IOSK's best interests. Although his parents' fears arising from their beliefs about the MMR vaccine were real, there is simply no scientific basis for such concerns. Given that IOSK was residing in a placement outside the parents' home, their concerns and the anxiety IOSK's being vaccinated would cause for them could have no effect on his welfare and accordingly could be accorded no weight (paragraph 34). The evidence did not support any view that IOSK was receiving inadequate care.

The evidence was that IOSK liked being outside and active, and enjoyed social contact on his own terms. The court was satisfied that vaccination was in IOSK's best interests and made an order approving a plan setting out how the vaccination was to occur, including IOSK having the opportunity to familiarize himself with the vaccination centre in advance.

The judgment also contains a helpful summary of the case law on vaccination in the context of the pandemic at [30]:

> *I have been referred to a number of recent decisions about covid-19 vaccination:*
>
> *a. Re H (A Child)(Parental Responsibility: vaccination) [2020] EWCA Civ 664 – in which the Court of Appeal set out (at paragraphs 43 – 54) the history and ultimately the refutation of any credible link between the MMR vaccine and autism, and concluded that "scientific evidence now clearly establishes that it is in the best interests of children to be vaccinated in accordance with Public Health England's guidance unless there is a specific contra-indication in an individual case" and "the matter is not to be determined by the strength of parental views unless the view has a real bearing on the child's welfare."*
>
> *b. E v. London Borough of Hammersmith & Fulham & W [2021] EWCOP 7: where it was concluded that vaccination was in the best interests of an 80 year old woman living in a care home, despite the objections of her son.*
>
> *c. SD v. Royal Borough of Kensington & Chelsea [2021] EWCOP 14: where it was stated (at paragraph 33) that there is no presumption in favour of vaccination but "it is P's voice that needs to be heard". On the facts of the matter, vaccination was in the best interests of P.*
>
> *d. NHS Tameside & Glossop v. CR & SR [2021] EWCOP 19 : the father of a 31 year old man, clinically vulnerable within JCVI terms, had concerns linked to fears around autism and the MMR vaccine, and P had had no vaccinations since. On the facts of the matter, vaccination was in the best interests of P, subject to the caveat that physical intervention to achieve vaccination was not authorised.*
>
> *e. SS v. London Borough of Richmond upon Thames & South West London CCG [2021] EWCOP 31: an 86 year old care home resident, had refused the vaccine in the context of increasing resistance to medical intervention of any kind. On the facts of the matter, vaccination was not in the best interests of P.*

f. A CCG v. AD & AC [2021] EWCOP 47: for a man in his 30s who had moderate learning disabilities, Downs Syndrome and autism, was clinically overweight, and lived in supported accommodation, vaccination was in his best interests. Mild sedative could be used in advance of the vaccination procedure, but not physical restraint.

A CCG v DC, MC and AC [2022] EWCOP 2 (HHJ Burrows)[1]

Best interests – medical treatment

Summary

This case concerned a 20-year-old man in residential care who lacked capacity to decide whether to have the Covid-19 vaccinations and boosters. He was at high risk of serious consequences because of his respiratory condition and profound learning disability. His parents did not consider the vaccinations to be in his best interests. Although the dispute had been clear since February 2021, no best interests meeting was held until September and no court application made until December 2021:

> *6. It seems to me this is unacceptable. If, as the CCG contends, DC is a highly vulnerable person for whom infection with COVID-19 could be extremely serious, then they have a duty to act speedily to protect him. Once it becomes clear there is a dispute between clinicians and the family on an urgent matter over important treatment of a mentally incapacitous adult, an application to the Court of Protection should be brought- and determined- with urgency." (emphasis added)*

Neither his parents nor his sister had been vaccinated against Covid. His father was concerned that the vaccines had not gone through the usual tests and may not be as safe and efficacious as the public had been led to believe. He was particularly worried about the risk of blood clots. But he was not an "antivaxxer"; rather, his reasons were explained and rationalised, unmotivated by conspiracy theories. As the court recognised, the usual trials had been truncated and licensing accelerated, albeit for very good reasons. His mother had been brought up in the Church of Scientology and was not opposed to vaccines *per se*. Instead, she was worried that this one might make her son ill and he would not recover; a view backed up by a rational analysis.

DC had never expressed any opinions or wishes from which the court could confidently predict what he would have decided. If he were a capacitous adult, there was every reason to believe that he would be as similarly independent in his thinking as his family:

> *56. I am quite sure that if DC were able to make decisions for himself, he would be influenced by the approach taken by his father and mother: he would challenge the figures, he would investigate them, and he would have conversations with his parents about the data. He would likely be influenced by his sister.*
>
> *57. That being said, a reasonable approach to such inquisitiveness would also take other factors into account. Firstly, that the vaccine is a response to an emergency, and therefore decisions have to be made before the level of understanding of risks/benefits is as full as might ideally be the case. A decision not to have the vaccine is as much a decision to expose oneself to risk as is the*

[1] Nicola having been involved in this case, she has not contributed to this note.

> *decision to have the vaccine. If one criticism can be made of MC, it is that his overthinking means that he is unable to act urgently, that he is perhaps somewhat paralysed by his own fixation on greater and greater information and drilling further and further down into an issue before he is able to make a decision. It could be argued that the coronavirus pandemic makes that a luxury he cannot afford. A decision has to be made if one is in a high risk category like DC.*
>
> *58. Furthermore, having the vaccine is designed to slow the progress of the virus and to relieve pressure on healthcare services. To that extent the decision to have the vaccine is altruistic as well as selfish. A reasonable person with high risk is likely to be inclined to receive the vaccine for altruistic reasons.*
>
> *59. Another important factor concerns DC's ability to leave his room and undertake activities. Risk assessments in respect of other people now include whether those having contact with them are or are not vaccinated. In other words, having the vaccine can open up the options available to engage with other people. It is clear from the evidence from the care home that DC is alone in being unvaccinated there. This has meant that he has been unable to attend outdoor events and has been required to isolate for up to 10 days after home visits.*

On balance, and though the court "hesitate[d] to go against DC's mother's instinct and his parents' analysis", HHJ Burrows held that it was in DC's best interests to be vaccinated and boosted:

> *62. I have to place DC at the centre of my decision-making. I am persuaded that without the vaccine he is at risk of COVID-19 causing him much greater harm than if he has it. He is at high risk. There are risks associated with the vaccine, and these are not yet fully understood. However, I am satisfied on the basis of the CCG's evidence that those risks do not outweigh the advantages. The main reason I will allow the application from the CCG is because I can see it having a positive effect on DC's enjoyment of life by allowing him to be more involved in the life of his care home and with his parents. If DC were able to make a decision for himself, I am satisfied that would be a magnetic factor for him.*

However, this was subject to the following caveats at paragraph 63:

(1) *The CCG will ensure that DC is reviewed after the vaccine is administered to identify any side effects. Any such side effects will be included in an ongoing risk/benefit analysis.*

(2) *MC's parents will be made aware of any findings and the state of the ongoing risk/benefit analysis.*

(3) *That analysis will be kept up to date and in line with NHS/JCVI advice.*

(4) *No physical intervention in the form of restraint is authorised.*

Comment

We note that different statutory bodies brought these disputes before the court, and there does not appear to be a consensus as to where responsibility for making an application of this nature falls.

In the latter case, the court endorsed for the MCA the approach adopted in children cases, namely that it was "*very difficult to foresee a case in which a vaccination approved for use in children, including vaccinations against the coronavirus that causes COVID-19, would not be endorsed by the Court as being*

in the child's best interests absent a credible development in medical science or peer reviewed research evidence indicating significant concern for the efficacy and/or safety of the vaccine or a well evidenced medical contraindication specific to the subject child (*M v H, and P & T [2020] EWFC 93).*" (paragraph 34) However, as is clear from the judgment, the subjective aim of trying to determine what P would have decided lies at the heart of this best interests decision.

Making the decision the person would have made

London Borough of X v MR, PD and AB [2022] EWCOP 1 (District Judge Eldergill)[2]

Best interests – residence - care

Summary

MR was an 86-year-old man with advanced dementia who, during the first Covid emergency in April 2020, was discharged from hospital to a secular nursing home where he remained with his wife. At that time, little or no consideration had been given to his wishes or to his religious and cultural needs. Some staff were not even told the couple were Jewish and had mistakenly fed them pork. Both challenged their respective DoLS authorisations, but his wife sadly passed away before the hearing.

He needed help with all activities of daily living, as well as a full body hoist to transfer, and his life expectancy was estimated to be between Spring 2022 and Spring 2024. The issue was whether it was in his best interests to remain or to move to a Jewish care home. With his life very much drawing to a close, "*this case is about not just where and how he lives but where and how he dies, where he would wish to live and die if he still had capacity, and what he wishes for himself now*" (paragraph 23). MR was settled, content, and had developed a rapport with staff who had taken some steps to try to accommodate his religious and cultural needs:

> *"81… Food is now specially prepared for him, to cater for his dietary requirements … Furthermore, it is recorded that … staff play Jewish movies and music for him on a daily basis. However, at the time of the hearing it was disturbing that no Rabbi had been involved or visited MR, more than 18 months after he arrived there. It is also disappointing that his support worker said that it would not normally be for the nursing home to arrange for a Rabbi to attend, and that it would be the responsibility of the family to make such arrangements … There appears to have been no attempt by anyone to try to arrange a visit to his synagogue, no one visiting from an organisation such as Jewish Visiting and, as far as I can tell, no organised attempt to celebrate or mark festival days with MR other than on one occasion … Article 9 [ECHR] surely requires more than this.*
>
> *82. On the balance of the evidence, I find that before the hearing on 1 December 2021 the local authority and the care home took insufficient steps to arrange and deliver a care plan which provided sufficiently for MR's religious and cultural needs. If MR were to remain at CC Nursing Home, it would be necessary to add a condition to the standard authorisation which requires the managing authority (care home) and supervisory body (local authority) to arrange visits by a Rabbi*

[2] Nicola having been involved this application, she has not contributed to this note.

> *and a weekly care plan that takes more account of his cultural and religious needs.*" (emphasis added)

The main factors in favour of staying put were his contentment, the high risk of adverse events of relocation (including a higher risk of mortality, although he could die soon even if he remained), and his loss of a sense of familiarity, environment and routine. But the secular nursing home could never be able to fulfil religious and cultural needs in the same way as a Jewish care home. The fundamental question, therefore, was

> *what are MR's religious and cultural needs, and how important is Jewish religious and community life to him? Furthermore, how important were these things to him when he had capacity and what he would be likely to want now if he still had capacity?* [84]

DJ Eldergill had uncontradicted evidence that Jewish law "*imposes obligations only upon those who enjoy full mental capacity*" which, owing to the stage of his illness, would no longer be expected of MR (paragraph 85). But such logic and compassion did not mean religious and cultural practices were irrelevant to him:

> *86 … Unless they now express contrary wishes, or there are other overriding considerations, where possible one must seek to enable them to live their remaining days in a way consistent with those wishes, beliefs and values. The Mental Capacity Act 2005 is an enabling Act designed to help, where practicable, those without capacity to live the life they wish or would wish to live if they still had capacity.*

Before her death, MR could no longer recognise his wife as they sat separately in the lounge, and he showed no interest when staff played Jewish movies and music for him every day. But in a heart-wrenching moment, he recalled and repeated information memorised long ago as he sang Jewish hymns with the Rabbi who visited. They had kindled something deep down (paragraph 97). He was a devoted and committed member of his synagogue who always sought connection with the Jewish community and felt the necessity to connect to his Jewish roots. On a fine balance, it was in his best interests to move as soon as practicable:

> *99. Having undertaken this balancing exercise as best I can, I have concluded that it is in MR's best interests to move to T Care Home as soon as practicable. Even if he were to remain at CC Nursing Home, he may have only months left to live. In my opinion, it is likely that he will benefit from the familiar religious and communal activities at T Care Home, although he would be unable to put into words why it pleases him. This gives him the best opportunity to enjoy or gain satisfaction from what life is left to him and the likely benefits outweigh the likely risks. I agree with AB and his sister that it is likely he will feel a comforting sense of familiarity and reassurance from seeing and hearing religious and cultural practices and traditions such as Friday night candles, making Kiddish, Friday night dinners, the singing of Jewish songs and a care home wide celebration of Jewish Sabbath, holy days and festivals (D82).*
>
> *100. A move to a Jewish care home is also in keeping with the fact that MR was a devoted and committed Jew, and the importance of his Jewish community to him. The evidence for this finding is set out above, in particular at paragraph 88. On the balance of the evidence, I believe that this is*

> *the decision he would make for himself if he still had capacity to decide. I find that when MR had capacity he and his wife envisaged spending their last days living and dying in a Jewish care facility, and that this wish was consistent with their beliefs and values. Sadly, Mrs R's wish was not carried into effect before she died.*
>
> *101. In summary, it is very unfortunate that MR was not discharged from hospital to a Jewish care home in April 2020. Before his illness advanced, he was a devoted and committed Jew who always sought connection with the Jewish community. I find that he intended to live in a Jewish care home should he no longer be able to live at home. His wishes, beliefs and values when he had capacity — who he was, how he chose to live his life, what he valued — align with a move to a Jewish care home. Because those wishes, beliefs and values were life-long, I find that it is likely that, notwithstanding the risks, he would now wish to move to a Jewish care home if he still had capacity, so as to live out what little time remains to him within such a community.* (emphasis added)

Comment

Reminiscent of his decision on behalf of *Manuela Sykes*, DJ Eldergill has once again illustrated the aim of best interests decision-making: to try to reach the decision that the person would have made for themselves if they still had capacity to make it. The depth of his factual analysis and thought reflects the scale of the challenge, particularly in the pursuit of MR's values and beliefs. Whilst past and present wishes and feelings are often more easily ascertained, identifying the values and beliefs of someone with advanced dementia is no mean feat. Particularly striking is that arguably MR's current preferences were to remain, but his will and past preferences would be to move. And that tension was amidst his rights under Articles 9, 8, 5, and 2 ECHR. The decision is therefore a good example of how respecting "*rights, will and preferences*" in Article 12 CRPD terms can involve a delicate balancing exercise when they do not all point in one direction.

The use of general anaesthesia in special care dentistry

The British Society for Disability and Oral Health has released a clinical guideline making recommendations for the team involved in providing dental general anaesthetic for adults within special care dental services. These medical guidelines may be of relevance to practitioners seeking to assist family members or carers in obtaining dental treatment for adults without capacity to consent to treatment who would not be able to tolerate standard dental interventions without being sedated. They provide detailed guidance on medical and other factors to be considered when referring a patient for dental treatment under general anaesthetic, and identify other medical procedures that could potentially be carried out at the same time, to the benefit of the patient, including eye examinations, gynaecological procedures, audiology examinations and even toenail cutting. The guidelines should be considered in any case before the Court of Protection concerning dental treatment, and may also be indirectly of interest in any case where a general anaesthetic is proposed to enable a medical procedure to be carried out that would ordinarily not require the patient to be sedated.

Template letter to statutory bodies to request special arrangements for vaccinations

We have produced a template letter (hosted by Rook Irwin Sweeney) to assist in requesting special arrangements for administering a vaccine for those who may need them. The letter highlights

obligations under the Equality Act to make reasonable adjustments for people with disabilities, and prompts decision-makers to consider plans to accommodate the person's needs.

PROPERTY AND AFFAIRS

Updated OPG Safeguarding Guidance

The OPG has updated its safeguarding policy, which sets out the steps it will take to safeguard people who have deputies or attorneys, or who have been the subject of one-off orders by the Court of Protection. The policy refers to such people as clients, and as 'children or adults at risk' rather than the previous terminology of 'vulnerable adults'. It defines categories of abuse – physical, domestic, sexual, psychological, financial or material, modern slavery, discrimination and harassment, organisational abuse, neglect, and self-neglect. There is a useful list of 'red flags' that might show financial abuse is taking place, and other factors which are known to increase the chance of abuse, including the client being aged over 75 and female. The policy explains when the OPG has no statutory role and cannot investigate suspected abuse, and how it will refer concerns to other agencies.

The scope of the power of attorneys and void or voidable actions

Chandler v Lombardi [2022] EWHC 22 (Ch) (Jason Beer QC (sitting as a Deputy High Court Judge))

Other proceedings – chancery

Summary

This case concerned a family dispute about the transfer of a property. Prior to her death, a property owned solely by Ms Chandler was transferred into the joint names of Ms Chandler and the defendant, Ms Lombardi (Ms Chandler's daughter) by Ms Lombardi acting in

her role as attorney for financial affairs. Ms Chandler's son and executor of her estate challenged the transfer. There had been a range of discussions between Ms Chandler and solicitors about appointing Ms Lombardi as her attorney under an LPA, amending her will to leave the property to Ms Lombardi rather than to all four of Ms Chandler's children, and transferring the property into the joint names of Ms Chandler and Ms Lombardi. LPAs for finances and health and welfare were registered, without Mr Chandler being consulted. Ms Chandler was subsequently diagnosed with dementia in addition to long-standing mental health problems.

Mr Chandler and Ms Lombardi were subsequently in dispute about Mrs Chandler's best interests and where she should reside and be cared for. The court held that Ms Lombardi had not had authority to transfer the property into joint names, as she had not sought permission from the Court of Protection to do so, despite it constituting a gift that fell outside s.12(2) MCA 2005. The next question therefore was whether the transfer was void, or voidable – a difference that mattered, since it affected whether the land register could be altered. The court held that the transfer was void and that the register should be rectified.

The court summarised the duties of an attorney in this situation and emphasised that a lack of knowledge of the need to seek the court's permission to make a gift of this nature was not an adequate defence:

The duties of an attorney under an LPA in respect of property and financial affairs are very clear. They are set out in the Mental Capacity Act 2005 and the Mental Capacity Act Code of Practice. They include the prohibition on gifts in s12 of the 2005 Act. When she signed the LPA in respect of property and financial affairs on 20th October 2016, Ms Lombardi signed an acknowledgement that stated inter alia "By signing this section I understand and confirm the following…I have a duty to act based on the principles of the Mental Capacity Act 2005 and have regard to the Mental Capacity Act Code of Practice". Whilst I accept that Ms Lombardi did not know about (and was not advised as to) the need to seek authorisation from the Court of Protection in respect of a gift such as this, that does not mean that she was acting with care. Indeed, quite the opposite: this was a gift very significantly in excess of that permitted by s12 of the 2005; it was made without consideration; if effective, it would have had the effect of substantially affecting the extent of Concetta's estate in the event of her death; and, in the light of the circumstances of the last two years of Concetta's life, it was a controversial and contentious step for Ms Lombardi to have taken (and, in my judgment, known by her to be such a step). For all of these reasons, Ms Lombardi should have taken steps to inform herself of the true position in law, whether by taking specific legal advice on the issue (which on the evidence she did not do), or otherwise. (paragraph 49)

PRACTICE AND PROCEDURE

Vulnerable parties and witnesses

S (Vulnerable Party: Fairness of Proceedings) [2022] EWCA Civ 8 (Court of Appeal (Baker LJ, Whipple LJ and Francis J)

Practice and Procedure – other

Summary

The Court of Appeal considered how to handle vulnerable witnesses in the Family Courts and the need to proactively identify vulnerable witnesses.

The case concerned care proceedings relating to a child, S. The main issue in proceedings related to injuries sustained by another child (J) while in the care of S's parents. The judge hearing the case at first instance concluded that J's injuries were partly accidental and partly inflicted by his own mother, A. A had assessed in separate proceedings relating to her own child, J. A had been able to give instructions, and due to the pandemic her legal team had not met her face to face until the appeal hearing.

A (who was an intervenor in the case) appealed.

Permission to appeal was allowed to be brought on a ground of procedural unfairness. She argued that the court had made findings against her which exceeded those sought in the schedule, without any reason for doing so. She argued that she 'has had significant findings made against her in proceedings not related to the welfare of her child and in which no relevant social worker evidence was produced.' (paragraph 20) A further argued that court had not taken account of her cognitive difficulties, and had not considered adjustments which might be required to ensure her participation (which may have been assisted by the use of an intermediary).

The Court of Appeal recorded that it was confident A had been treated fairly in the context of what had been known about her needs at the time. However, the later evidence made clear that she did have cognitive difficulties and there was a significant possibility that this would have affected the judge's view of the quality of her evidence.

The Court of Appeal set out the requirements of Part 3A of the Family Procedure Rules, which require the court to consider whether a party's participation in proceedings is likely to be diminished by reason of giving evidence, and if so to consider whether to make 'participation directions'. Participation directions are defined as being either 'a general case management direction for the purpose of assisting a witness or party to give evidence or participate in proceedings' or one of a range of measures set out in r3A.8. These include in particular providing for the witness or party to have the assistance of an intermediary.

The Court of Appeal set out at paragraph 39 the duties of the court, the parties and their representatives to identify vulnerable parties or witnesses in a case:

> *It is equally clear that the duty to identify any party or witness who is a vulnerable person, and to assist the court to ensure that each party or witness can participate in proceedings without the*

> *quality of their evidence being diminished, extends to all parties to the proceedings and their representatives. It will almost invariably be one of the parties or their representatives, rather than the court, who first identifies that a party or witness is or may be vulnerable. We consider that good practice requires the parties' representatives actively to address the question of whether a party is vulnerable at the outset of care proceedings. Indeed, as social workers will as a matter of course be looking for vulnerabilities in families as part of their practice, it is to be hoped that this issue will be identified before care proceedings are started. We recognise, however, that it is often not easy to identify vulnerabilities and that professionals dealing with urgent and difficult situations in families will have to contend with a large number of issues. For that reason, we consider that, to comply with the obligation under rule 3A.9, the judge conducting the case management hearing at the start of care proceedings should as a matter of course investigate whether there are, or may be, issues engaging Part 3A of the rules and that the parties' advocates should as far as practicable be in a position to respond. Furthermore, rule 3A.9 stipulates that the court's duty continues to the end of the proceedings. There will therefore be other points at which the court may have to address the issue – for example, where another party is joined to the proceedings.*

The Court of Appeal stressed [42] that a failure to comply with these provisions will not invariably lead to a successful appeal: the question in each question will be whether there has been a serious procedural irregularity, and if so, whether as a result the decision was unjust. On the facts however this was such a case.

Comment

The comments at [39] of the judgment on the steps which should be taken to identify any vulnerable witnesses, and what should happen once such identification is made, make interesting reading for COP practitioners. Parties other than P may well have their own vulnerabilities, and the observation of the Court of Appeal that good practice requires not only that parties' representatives actively address the question at the outset of proceedings but also that the judge conducting the case consider the matter is surely pertinent notwithstanding the lack of equivalent provision in the COP Rules.

Although the COP Rules do not provide for some of the measures identified in r3A.8 (the use of intermediaries, for one), a number of measures to assist vulnerable parties can be made in exercise of the court's general case management powers – see for an example the decision of HHJ Hilder in *Re IOSK*, a recent vaccination case reported elsewhere in this newsletter.

It should also be noted that the COP Rules provide that in any case not expressly provided for under the Rules, the court may apply either the Civil Procedure Rules or the Family Procedure Rules with any necessary modifications, in so far as necessary to achieve the overriding objective (COPR 2017 r2.5). In an appropriate case, the court may consider the provisions in both other sets of rules dealing with the participation of vulnerable individuals.

Covert recordings

Re Children (Private Law: Covert Recordings: Adjournment of Final Hearing) [2021] EWFC B82 (Recorder Briggs)

Practice and Procedure - other

Summary

The family court had to decide whether transcripts of covert recordings made by one party (the mother) of conversations between her and the father (also a party to the proceedings), could be relied on at a final hearing.

These transcripts had been filed and served by the mother some months before the hearing with no objection being raised by the father. They had also been placed into the trial bundle, again with no objection by the father. However in the father's position statement filed for the final hearing, he asserted that permission ought to have been sought by the mother to rely on the transcripts. He asked the Court not to admit the transcripts into evidence.

The argument in support of the application that the evidence should not be admitted, was that while there was no rule of court that requires a litigant to seek permission to adduce such evidence 'best practice' was that such applications be made.

During the hearing of the application, it became clear that the transcripts were taken from longer recordings, and that the mother had another hundred or so covert recordings that had not been filed or served. It was agreed that all recordings should be served on the father, and an adjournment was granted to allow the father to consider these. No decision was therefore made by the Court on the issues raised by the application.

The Judge with obvious displeasure noted that there was no court available to hear the adjourned trial for six months, going on to say at paragraph 17:

> *The production of audio and video material in family proceedings is now a frequent occurrence and there are obvious issues surrounding editing, quality of any transcription, production of original footage and wider context which must be case managed in advance of a trial. Even if that is not a matter of law (and I have yet to hear full argument on that issue), it is quite obvious from a practical perspective.*

Comment

In a case where such evidence is relied upon, practitioners would do well to raise this at the case management stage so that any issues that arise (such as whether there is an obligation to disclose further covert recordings which are not relied upon, or whether permission is required to rely on such evidence) can be thrashed out well in advance of a final hearing.

Equally, a party faced with such evidence should raise any objection at the time that it is served.

THE WIDER CONTEXT

New capacity guidance website launched

As part of the Mental Health & Justice project, a new website has been launched with guidelines for clinicians and social workers in England & Wales (but also of interest to others, such as lawyers) who are assessing capacity. A short walkthrough of the website is here.

Using the inherent jurisdiction to make medical treatment decisions for young people with capacity

E & F (Minors: Blood Transfusion) [2021] EWCA Civ 1888 (Sir Andrew McFarlane P, Davies LJ, Peter Jackson LJ)[3]

Summary

In *E & F (Minors: Blood Transfusions),* the Court of Appeal considered appeals brought by two young people, both Jehovah's Witnesses who conscientiously reject blood transfusions. They appealed orders in which it was declared that, although they were able to decide whether to consent to or refuse a blood transfusion, it would nevertheless be lawful for their doctors to administer blood in the course of an operation if that become necessary to prevent serious injury or death. Given that no crisis arose in either case, the declarations made at first instance never formally came into effect.

The key question for the court was how the State, acting through the court, should exercise its power to overrule the capacitous decision of a young person aged 16 or 17.

In the case of E, 16, she was diagnosed with acute appendicitis and needed urgent surgery, which would involve diagnostic laparoscopy (a low-risk examination procedure), followed by a laparoscopic appendectomy (removal of the appendix by keyhole surgery), but if that was not possible, by an appendectomy by open procedure. There was a risk, albeit very small, of severe surgical bleeding intraoperatively and there was therefore the possibility that a blood transfusion would be needed without which there was a *'very theoretical possibility"* of E bleeding to death. E provided her written consent to the surgery but wrote that she did not consent to blood transfusions.

The hospital trust filed an urgent application in the High Court, which was heard the same day by Theis J. The treating consultant anaesthetist (Dr A) provided a written statement. E and her father attended the hearing. Cafcass Legal also attended through a solicitor and Cafcass officer. After hearing evidence, Theis J gave a brief judgment in which she recognised E's wishes, expressed not only by herself but with the assistance of her parents and Guardian, as well as her age and level of understanding. She weighed against that the medical evidence that the procedure needed to be undertaken otherwise there was a risk of rupture with consequent risks of infection and sepsis, ultimately making an order authorising the use of blood products in certain circumstances.

In the second case, F, 17, had lost control of his motorcycle on a bend. He was admitted to hospital and diagnosed with a grade 3 laceration involving a quarter to a third of his spleen. With this kind of injury, there can be primary or secondary bleeding. Primary bleeding happens at or shortly after the time

[3] Tor and Arianna having been involved in the case, they have not contributed to this note.

of the injury; whilst secondary bleeding may occur later, as a result of a clot loosening that can then lead to catastrophic bleeding.

An application was filed at court for an order declaring that it was lawful and in his best interests for the doctors to provide blood and blood products in the event of an emergency arising from his injury. The trust initially sought an order for 100 days, but reduced it to 21. Judd J heard from two medical witnesses, as well as F and his parents. She determined that she needed to give very great weight to F's views, given his age (17 and a half), understanding and competence, but that they still form part of the best interest analysis. She decided to make the declaration sought by the Trust.

The central argument made in the appeals was that there is a strong presumption in favour of a young person's capacitous decision and that decision should only be rebutted where, on the balance of probabilities, the decision would cause serious harm or death. It was wrong for the courts to intervene in these cases, because the risks were remote and the young persons' decisions were *"reasonable and safe ones"* (paragraph 38(4)).

In his judgment for the Court, Sir Andrew McFarlane (President) observed that the inherent jurisdiction is available in all cases concerning persons under the age of 18 and *"that has always been so and any change must be a matter for Parliament."* (paragraph 44) The court wrote at paragraph 45:

> *When the court is being asked to exercise its inherent jurisdiction, there are in our view three stages. The first is to establish the facts. The second is to decide whether it is necessary to intervene. If it is, the final and decisive stage is the welfare assessment.*

In relation to the first stage, the court's central concern is to identify the risk in question. *"'[R]isk' can be used to mean the risk of an event occurring (its probability) or the risk from the event occurring (its consequences)*" (paragraph 46). That distinction must be kept *'in mind when making and interpreting statements about risk.'* (paragraph 46)

The next question is whether immediate action is necessary or whether the decision can be postponed. It ultimately depends on the facts and how realistic it is to expect a fair and timely decision if a crisis arises.

Finally, there is the welfare assessment. The authorities require that the assessment is undertaken from the individual's point of view and the court seeks to identify his or her best interests in the widest sense. That analysis does not, however, take place in a vacuum. The Court observed that (para 50):

> *The law reflects human nature in attaching the greatest value to the preservation of life, but the quality of life as experienced by the individual must also be taken into account. The views of the parents of a baby or young child are always matters of great importance. Likewise, our common experience leads us to pay increasing regard to the views of children and young people as they grow older and more mature.*

When undertaking such assessments in medical treatment cases for competent young people, it involves the *"balancing of two transcendent factors: the preservation of life and personal autonomy"* (para 53). The leading decision is *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64. There is no presumption in favour of the mature adolescent's decision, contrary to the appellants' submission; rather, welfare is the overriding principle. The court must act upon an objective

assessment of the young person's best interests, even if this conflicts with their sincere and considered views (para 73).

The court accordingly dismissed the appeals.

Comment

The judgment provides extremely helpful guidance as to how the court should approach these applications, and therefore how practitioners should draft them, in terms of (i) the three stages and (ii) the central task of weighing the two transcendent factors identified above. An undifferentiated list of factors does not help, particularly if that list is extracted from a case concerning a small baby with a brain injury rather than concerning a capacitous child approaching adulthood (para 71). A court should therefore focus on *Re W* and this decision (para 71).

Another important point is that, whilst recognising the pressure under which urgent orders are drafted, the court emphasised the importance of ensuring they accurately reflect the court's decision.

Finally, the Court noted that the first court order in F's case contained a recital to the effect that "*if a declaration was not made the clinicians would be able to treat him "using their emergency powers in the event of an emergency overnight*"". (paragraph 23) Whilst not expressing a concluded view, the Court made the following *obiter* comments (para 24):

> *Doctors undoubtedly have a power, and may have a duty, to act in an emergency to save life or prevent serious harm where a patient lacks capacity or cannot express a view, for example because of unconsciousness. However, we very much doubt that such a power exists in respect of treatment that has been foreseen and refused by a capacitous patient. It is doubtful whether such circumstances can properly be described as an emergency.*

Practitioners therefore need to be extremely cautious in to relying upon clinician's "emergency powers" in the absence of a court order.

S.117 MHA Ordinary Residence: the *Worcestershire* saga continues

R (On the Application Of) Worcestershire County Council v Secretary of State for Health and Social Care [2021] EWCA Civ 1957 (Court of Appeal (Coulson LJ, Carr LJ and William Davis LJ))

Summary

The Court of Appeal considered the appeal of Worcestershire County Council to the judgment of Linden J in [2021] EWHC 682 (Admin) (and summarised in our May 2021 Wider Context newsletter). JG was originally from Worcestershire and was detained under s.3 of the Mental Health Act 1983 with treatment resistant schizoaffective disorder. She was discharged and placed in residential care in Swindon, closer to her daughter. At that point, there was no dispute that Worcestershire was responsible for her MHA s.117 after-care services as she had been ordinarily resident there immediately before being first detained.

Almost a year later, she was re-detained under MHA s.2 and then s.3. Around two months into this hospital confinement, Worcestershire issued notice to terminate the residential care placement. Around

three months later she became a voluntary patient for another 15 months before finally being discharged from hospital.

The issue was whether Worcestershire or Swindon was subsequently responsible for her after-care. At first instance, Linden J held it was Swindon because that was where she had become ordinarily residing immediately before being re-detained.

But the Court of Appeal overturned that decision, holding that Worcestershire remained responsible. The main reason was because the after-care duty continues "*until such time as the clinical commissioning group or Local Health Board and the local social services authority are satisfied that the person concerned is no longer in need of such services*". No such decision had been made. In particular, the termination notice did not reflect such a decision. Moreover, the duty did not automatically end by operation of law when JG was re-detained. Such an approach would run counter to the continuity of care. As Coulson LJ observed:

> *55. There are other practical difficulties with the judge's solution. Indeed, the whole notion of an automatic change in the identity of the authority with the duty to provide after-care services, triggered by law rather than by a decision made by those actually involved in the care of the service user, seems to me to be unrealistic. It would be woefully uncertain. How would that change come about? How would it be effected? How would it be communicated? Who is responsible for identifying that it had happened? There were no answers to these questions.*
>
> *56. In addition, from a purely common sense perspective, the judge's conclusion seems to me to be a most unsatisfactory outcome. Someone like JG is particularly vulnerable. When/if she is detained, everyone must be trying to work to a plan which sees her release from detention as soon as possible. All through the period of her detention, there would be extensive planning by the responsible authority which, on the judge's findings in this case, was Worcestershire. It would be curious to find that, at the very moment those plans come to fruition, and JG is released, Worcestershire suddenly became irrelevant, and a new duty was owed by a new local authority. That would not make for continuity of care, and would be very unsatisfactory for the service user. Unless I was compelled to conclude that was the effect of s.117, I would be very reluctant to reach a decision on that basis.*
>
> *57. For the reasons that I have given, I do not need to reach such a decision. S.117 is clear. The duty subsists until it comes to an end by the communication of a decision by Worcestershire pursuant to s.117(2). There has been no such decision. The duty therefore continued throughout both the second period of detention and beyond."*

The Court of Appeal also confirmed that, unlike the Care Act 2014, there are no deeming provisions in the MHA 1983 (see paragraphs 74-75), except where the accommodation itself provided to meet an after-care need under s.117.

Comment

DHSC has confirmed that Worcestershire County Council has lodged an application for leave to appeal in the Supreme Court. In the meantime, the Secretary of State has confirmed that after-care disputes will continued to be stayed until we have the final word.

This is a significant decision which impacts upon local authority funding arrangements for after-care services. The first instance decision reflected the conventional legal view (and the Secretary of State's guidance) that, where a person receiving after-care services became ordinarily resident in another local authority area, it was that local authority that would take over s.117 responsibility if the person was re-detained under MHA s.3. Such an approach ensured that those responsible for meeting a person's after-care needs remained local to where they were residing immediately before their hospital admission.

The Court of Appeal's decision changes that approach. It means that the first local authority will continue to remain responsible unless and until a joint decision is made by that local authority and the responsible CCG/LHB that the person is no longer in need of any after-care services. Although re-detention does not automatically terminate the s.117 duty, it seems clear from the judgment that, had a joint decision been taken that JG was no longer in need once she had been re-detention under MHA s.3, the outcome would have been different. As a result, the focus is now likely to move to the circumstances in which after-care bodies can lawfully decide that a person no longer has after-care needs when they are now receiving inpatient hospital care.

There are likely to be a significant number of after-care funding arrangements which will be affected by this judgment. The Swindons of this after-care world that had been paying for s.117 will now want to seek recoupment from the Worcestershires. Many civil debt claims are no doubt being prepared by eager local authority lawyers.

Where is the CCG dispute, you might wonder? Well, by virtue of s.14Z7 of the NHS Act 2006, NHS England has set out rules on payment responsibility which are binding on CCGs. As detailed in section 18 of the 2020 Who Pays? Guidance, such rules very much mirror the Court of Appeal's approach, namely that the "originating CCG" that was first responsible for s.117 retains responsibility until such time as the person is discharged from s.117 after-care. This is the case regardless of where they are treated or placed, and regardless of where they live or which GP practice they are registered with. Further guidance and helpful scenarios are provided therein for those wishing to find out more. In the meanwhile, the cardinal principle is that patients must not be disadvantaged by funding disputes.

Book review: *The Assisted Decision-Making (Capacity) Act 2015: Personal and Professional Reflections*

This month we highlight a recent (free) book on the Irish Assisted Decision-Making (Capacity) Act 2015 ('the 2015 Act') produced by the Irish National Office for Human Rights and Equality Policy with the School of Law at the University of Cork and the Decision Support Service. The book contains a series of essays entitled *The Assisted Decision-Making (Capacity) Act 2015: Personal and Professional Reflections.*

The 2015 Act was enacted in the Republic of Ireland to replace 19th century legislation relating to mental capacity. It intends to provide a framework for the lawful deprivation of liberty for the

purposes of providing care and treatment for those who require assistance in exercising their decision-making capacity.
The book covers the main reforms introduced under the 2015 Act, which are summarised in the foreword to the book as including the following:

- *a statutory definition of capacity based on a functional, time-specific and issue-specific assessment;*
- *a regulated three-tier framework for decision-making;*
- *detailed guiding principles, including a statutory presumption of capacity and the replacement of a 'best interests' standard with the requirement to give effect to a person's will and preferences;*
- *enhanced tools for advance planning by way of enduring powers of attorney and advance healthcare directives;*
- *the establishment of the Decision Support Service within the Mental Health Commission, with numerous functions to promote and regulate the new framework.*

One of the much-discussed themes of the book is the adoption of lessons from other jurisdictions within the 2015 Act, following a 150-year period without reform of the system. This is best reflected in the Act's emphasis on enabling persons, so far as is possible, to exercise their decision-making *autonomy* rather than focusing on *capacity*. The book contains much discussion of this 'paradigm shift' from the recognition of all persons as rights-holders, who are entitled to be at the centre of decisions that affect them; with much reference made to the role of the United Nations Convention on the Rights of Persons with Disabilities (CRPD). The book also identifies limitations with the act: its complexity, dense wording, and that it is incomplete – a 2021 amending bill is still in progress.

A video of the launch event, including Ms Aine Flynn, Director of the Decision Support Service, Professor Mary Donnelly, School of Law, UCC, Ms Caoimhe Gleeson, Programme Manager, National Office for Human Rights and Equality Policy is available here.

SCOTLAND

DNACPRs, and the relationship between medical decision-making and guardians' decisions: Is Scotland moving further away from human rights compliance?

In the December 2021 Scotland newsletter, we reported the outcome of the first of two actions brought by PKM's Guardians ("the Guardians") against Greater Glasgow Health Board ("the Board"). At the end of that article, we mentioned the possibility of early consideration by the Inner House of a second action between the same parties. Events moved quickly. An interim order in the second action was appealed direct to the Inner House and the appeal was decided there on 16th December 2021.

In both actions, the Guardians sought orders under section 70 of the Adults with Incapacity (Scotland) Act 2000. In the first action, the sheriff at first instance refused the two orders sought in that action. Upon appeal to the Sheriff Appeal Court, the terms of an amended order were agreed and the order granted; agreed, that is to say, between the Guardians and the Board, neither the adult, PKM, nor the Safeguarder appointed by the court having participated in the proceedings before SAC. The order required PKM "*to comply with the joint guardians' decision to consent to medical treatment by behaving in a manner that allows kidney dialysis treatment to occur and to attend whenever is required for that purpose*".

In the second action the Guardians seek an order requiring the Board to revoke and remove from PKM's health records (to include computer records) any Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) "directions". At first instance, the sheriff initially refused to grant an interim order in those terms, then at a subsequent hearing granted the interim order. The Board appealed that decision to SAC, which in turn acceded to a request to remit the matter to the Court of Session. The Inner House refused the appeal and confirmed the grant of the interim order. PKM again did not participate in the appeal proceedings. The Safeguarder is narrated as having been present, but no contribution by the Safeguarder to the proceedings is narrated.

The second action remains live. It is understood that Mental Welfare Commission has entered, or is about to enter, the process.

A central feature of both actions is that PKM refused, and continued to refuse, to consent to, or cooperate with the administration of, dialysis treatment; and he had stated that should he suffer cardiac arrest he would not wish to be resuscitated. The treating doctors assessed him as having capably made both decisions, and had taken the view that in consequence they were bound to respect them. It appears that in none of the proceedings to date in either action has there been any assertion by any party that the relevant decisions of PKM were other than capably made. Nevertheless, in the first action his decision was overruled, and as matters stand in the second action that decision by PKM has also been overruled *ad interim*.

The decision of the Inner House in the second action took the form of a Statement of Reasons dated 16th December 2021 ("the Statement"). Unusually, the Statement has not been published on the scotcourts website. After a delay of more than a month, I was advised that it was not going to be so published as no orders had been made regarding the anonymity of the parties and of the adult. It was considered that the Statement was better than risking identification of the adult. I was permitted to use the Statement subject to considering sufficient protection of the identity of the parties and of the

adult. In fact, the Statement contains no more identification of them than did the published decision of SAC in the first action. The Statement may accordingly be accessed here.

This decision by the Second Division of the Inner House is not easy to reconcile with the decision of the First Division in *MH v Mental Health Tribunal for Scotland* [2019] CSIH 14; 2019 SLT 411, on which we commented in the May 2019 Report, in which the Inner House stressed the importance of the principle of open justice, but having initially refused to anonymise, the First Division then agreed to do so upon submission of a medical report which justified anonymising the appellant's name in those proceedings (which we reported in the June 2019 Report). Nowhere is it narrated that any evidence was produced in the second action warranting disapplication of the principle of open justice.

The Statement raises fundamental questions about the rights and status of people with mental and intellectual disabilities. Supplementarily to those fundamental issues, it raises issues of importance arising upon the facts and decision-making processes in both actions. Views have already been expressed that each of those fundamental issues is of such importance, in conjunction with those supplementary issues, that it would be in the public interest if each and all of them were to be referred to, and determined by, the Supreme Court; with resort thereafter, if need be, to the European Court of Human Rights.

However, those fundamental questions were not introduced to any substantial extent by the parties appearing before the Inner House. In a "postscript" to the Statement (paragraph [18]) the Inner House noted that parties had proceeded on the basis that "transaction" in section 67 of the 2000 Act included decisions about healthcare. The Inner House alluded to the possibility of a different interpretation. It is clear from the remainder of the Statement that the litigation, and in particular the proceedings before the Inner House, has been conducted as a bilateral dispute between doctors and guardians, with the adult himself a passive non-participant, rather than as primarily the prime party whose rights to self-determination, capably exercised according to the only available evidence, should or should not be respected, whether by doctors or by guardians. The Inner House determined the appeal on the basis of the submissions by the parties, and did not address the more fundamental issues raised by the litigation. The postscript perhaps indicates unease that the proceedings were so limited. The more fundamental issues cannot escape comment, but first it is appropriate to consider some of the implications of the Statement itself, which – so far as they go – are valuable.

There has been a history of unresolved tensions between decisions by guardians, and also attorneys, on the one hand, and medical practice generally, including in particular practice under Part 5 of the 2000 Act and practice under the Mental Health (Care and Treatment) (Scotland) Act 2003 ("the 2003 Act"). The 2003 Act in particular does not take adequate account of the role of guardians and attorneys, and the status of their decisions. Remedying that will be a matter for the Scott Review. Beyond that, however, ever since the passing of the 2000 Act there have been failures to recognise that Part 5 is one element of the integrated scheme of the Act as a whole, and cannot be read in isolation as if it were the starting-point for all medical decision-making. This difficulty can be traced back to the Bill for the 2000 Act having been allocated to the Justice Committee, and having been dealt with by the Justice Department of Scottish Government, but with input from the Health Department on Part 5 only. Lack of coordination can be seen from the outset in the preparation of codes of practice and other guidance, dealt with by the Justice Department with the exception of Part 5, which was dealt with by the Health Department. See for example the section "Error in Code of Practice" at paragraph 14-16 of "Adult Incapacity" (Ward, W Green, 2003). The Statement helpfully redresses the balance by in effect emphasising the status of guardians and their decisions, and by reasonable extension (though not

mentioned) of attorneys. It is narrated that the Board's appeal proceeded solely by reference to provisions of Part 5 of the Act: the Board's "*argument was supported by reference to sections 47 – 50 of the Act, both of which appear in Part 5 of the Act, rather than Part 6 where the guardianship provisions appear*". This is an appropriate correction to much that occurs in practice, and should be respected by all concerned.

Secondly and importantly, the Inner House pointed towards the need for a better understanding of the function of a DNACPR form, and the position generally of medical practitioners as such in paragraph [13]: "*… a guardian cannot force a doctor to resuscitate someone or provide treatment which he does not think it appropriate to give. In the present case, whether to attempt resuscitation will be a clinical decision to be made at the time that such an assessment is called for*."

The Inner House rejected an argument that "*an interpretation which gave a degree of priority to the guardianship order created risk to an adult who had, or had recovered, de facto capacity*". The court summarised the potential remedies available to an adult or a person interested in the adult's welfare, and referred with approval to the decision of SAC in *K v Argyll and Bute Council*, 2021 SLT (Sh Ct) 293 as regards decisions whether to grant orders under section 70, quoting from that decision the passage that includes: "*The adult has the opportunity to participate in this process (section 70(3))*". (paragraph 14) However, the Statement does not narrate how the adult was given that opportunity in reality, rather than in theory, in the present case.

The Inner House gave short shrift to an argument that the sheriff had erred in granting interim orders on 1st December 2021, having refused to do so on 24th November 2021. It is narrated that on the second occasion the sheriff had before him additional evidence in the form of affidavits from the guardians and oral evidence from a care home manager. The court commented at paragraph 17 that:

> *The powers of the sheriff under section 3 are properly drawn in the widest terms, to enable the sheriff to do what is most appropriate in the circumstances of the case. It cannot be said that the respondents did not have a prima facie case, or that the sheriff was not entitled to conclude that the balance of convenience favoured the making of an interim order*.

One could say that this endorsement of how the sheriff proceeded, and impliedly of the guardians' actions in returning to the sheriff with relevant evidence not previously before the sheriff, could be seen as important practice guidance where – as often in this jurisdiction – an interim order may frequently be granted in an urgent and rapidly developing situation, with more evidence becoming available. One might venture to say that not only is it proper in such circumstances to go back to the sheriff a second time; it might sometimes be the duty of the applicant's agent to do so. Moreover, just as the sheriff considered the matter *de novo* on the basis of what was before him a week after the initial refusal, likewise he will require to do so for final disposal, which is why this litigation remains of considerable interest and significance.

An oddity of the Statement is that instead of quoting the terms of section 1 of the Act it quotes a version which for some reason lists those provisions as "Table 1" and inserts headings above each of sections 1(2) – (5). Those headings represent a rather narrow view of the relevant provisions, as well as not appearing in the Act. They are unlikely to have influenced the limited scope of the decision reflected in the Statement, though such limitations would require to be discarded when, as is hoped, the litigation proceeds to address those issues prior to final determination.

In an action that is still *sub judice*, the issues that might be identified include the following (1 – 6 being of wide-ranging and fundamental importance; 7 – 9 being more focused upon the particular facts of both actions):

1. *Did the decisions in each action properly take account of the exceptional status of all interventions under the 2000 Act; of the difference between incapacity and incapacitation; and of the position in Scots law of physical interventions, and in particular medical interventions?*

   Tellingly, the court, in the last paragraph of the Statement, recorded that it had not been addressed on the question that was central in the SAC appeal of whether the provisions of section 67 of the Adults with Incapacity (Scotland) Act 2000 ("the 2000 Act") apply to decisions in matters of personal health and welfare, as opposed to matters of entering transactions in terms of the words of that section. It therefore appears that this and subsequent questions were not addressed by the Inner House. Interventions under the 2000 Act are predicated upon the incapability of the adult, and provide a mechanism for the adult's legal capacity to be exercised for the adult when the adult cannot do so. The 2000 Act equates "incapacity" with "incapability", a completely different concept from "incapacitation" which has been rejected by all human rights-orientated jurisdictions, remaining only in a few jurisdictions with which one would not imagine that Scotland would wish to be aligned. Scots law is particularly strong on recognising the right of any patient, if acting capably, to refuse consent to physical interventions, and particularly medical interventions, which if inflicted without consent – whether benignly or not – and without some other express justification in law, are potentially assaults in both civil and criminal law. Section 82 of the 2000 Act limits the liabilities of those exercising powers under Parts 2, 3, 4 and 6 of that Act, but not medical practitioners acting under Part 5.

2. *Were the interventions sought in each action competently granted in terms of the 2000 Act?*

   Prima facie the 2000 Act in terms of its long title is concerned with matters of which an adult is incapable, and it is arguable that the Act and its procedures simply do not apply where an adult has, or has regained, capability.

3. *If competent, were the decisions of SAC in the first action and the Inner House in the second action "interventions" requiring to comply with section 1; and if so did they comply?*

   One would suggest that both decisions were clearly "interventions", but at least in the Statement it is not narrated whether the Inner House considered that point, and whether it in fact satisfied itself that it was complying with the section 1 principles.

4. *To what extent, if at all, does the 2000 Act permit incapacitation, and in particular does it do so in any personal welfare matters?*

   It is clear from the Scottish Law Commission 1995 Report that led to the 2000 Act, if indeed not from the Act itself, that the purpose of section 67 is to ensure commercial certainty by giving effect to transactions entered into by guardians within their powers. The section does potentially limit the rights of the adult, and for that reason, as well as securing compliance with international obligations,

requires to be strictly construed. It is difficult to see any basis on which, instead, the provisions could be extended, from the validation of transactions entered, into the personal health and welfare field. Consenting to a proposed medical intervention is not "entering a transaction". Going further than that, there is nothing in the 2000 Act authorising the overriding of a capable decision by the adult.

5. *Can a question whether, and if so how, to intervene in a matter in which the adult has clearly expressed current views ever properly be determined by a court unless the adult is represented and/or personally interviewed by the judge, or one of the judges, asked to determine the matter?*

   There would appear to be an argument that representation or such interview is required both to comply with section 1(4)(a) of the 2000 Act, and also to comply with Article 6 of the European Convention on Human Rights, and in particular the requirement for "equality of arms".

6. *What is the nature, status and effect of a DNACPR form?*

   The case does not appear to have explored the nature of DNACPR forms. The official guidance with which the forms are published stresses that the form is not legally binding. It is evidence that an advance clinical assessment and decision have been made and recorded to guide immediate clinical decision-making in certain future events. It stresses that healthcare staff cannot be obliged to carry out interventions that they judge are contra-indicated or possibly harmful. The guidance in England & Wales is even more explicit that a DNACPR form is not legally binding, and that if a patient wishes to make a DNACPR decision legally binding, the patient should execute an advance decision to refuse treatment.

7. *Were the powers conferred by the Guardianship Order properly and competently so conferred?*

   The relevant power is in the following terms: "*… to make decisions regarding his healthcare, to consent to any healthcare that is in his best interests, to refuse consent to any proposed healthcare that is not in his best interests or does not accord with his known wishes and feelings …*". A "best interests" test is incompetent, having been rejected for the purposes of the 2000 Act in favour of the section 1 principles. The "benefit" principle in section 1 is the gateway which if closed does not allow an intervention to proceed any further. I am not aware of any disagreement with my suggestion, originally in the Current Law Statutes Annotations to the 2000 Act and subsequently repeated, including in "Adults with Incapacity Legislation" (Ward, W Green, 2008), that: "*With due caution, 'benefit' can reasonably be interpreted as encompassing overcoming the limitations created by incapacity, so as to permit something which the adult could reasonably be expected to have chosen to do if capable, even though of a gratuitous or unselfish nature*". Section 1(2) closes the door to any proposed intervention under the Act "*unless the person responsible for authorising or effecting the intervention is satisfied that the intervention will benefit the adult and that such benefit cannot reasonably be achieved without the intervention*". The decisions addressed of PKM addressed in both actions were competently made and were decisions to which medical practitioners were willing to accede. The matters were determined by the adult's competent decisions. Whether or

not anyone else agreed with them, that was the end of the matter and there was no need to substitute anyone else's decision, because no further benefit to the adult could thus be conferred.

8. *Esto those powers were properly and competently conferred, were the decisions of the Guardians within the scope of those powers?*

   Even if the above comment at 7 were incorrect, it is difficult to see that by overriding a competent decision of the adult in a healthcare matter the guardians were complying with the section 1 principles. The section 70 order sought in the second action can only be granted if within the powers held by the guardian – see the decision of SAC in *JK v Argyll and Bute Council*, 2021 SLT (Sh Ct) 293. Moreover, a section 70 order may only be granted in respect of a decision that the adult, and/or another person to whom it is addressed, "might reasonably be expected to comply with". Neither legally nor ethically can doctors "reasonably be expected" to enforce treatment in the face of a capable refusal by the adult.

9. *What are the effects of the Safeguarder not having actively participated in the proceedings before the Inner House, so far as is narrated in the Statement?*

   The provisions regarding safeguarding before the sheriff, and in the Court of Session, are the same. Safeguarding includes "*conveying [the adult's] views so far as they are ascertainable to the court*". There is no narration in the Statement of the participation of the safeguarder. That, like other unanswered questions, may emerge from further procedure.

Adrian D Ward

Deprivation of liberty of children in cross-border situations

In the December 2021 Scotland section, we reported the case of *Lambeth Borough and Medway Councils, Petitioners*, [2021] CSIH 59; 2021 SLT 1481, in which the Inner House of the Court of Session issued a Note providing guidance to practitioners as to the appropriate procedure to follow, pending remedial legislation, in petitions to the *nobile officium* seeking orders to render lawful in Scotland the deprivation of liberty of vulnerable children from England & Wales who are placed in Scotland, in accordance with orders of the High Court of England & Wales.

There have been two further developments. Scottish Government has launched a paper entitled "Cross-border placements of children and young people into residential care in Scotland: policy position paper" ("the SG paper"). In the meantime, an application by City of Wolverhampton Council for exercise of the *nobile officium,* in similar circumstances to those of the petitions by Lambeth Borough and Medway Councils, was determined by the Inner House on 23rd December 2021 ("the Wolverhampton petition").

The SG paper has not been launched as a formal consultation, but comments were invited on it by 28th January. Rather disappointingly, the paper does not acknowledge that the difficulty that has arisen arises from the long-standing failure of Scottish Government to implement its obligation under Article 5 of the European Convention on Human Rights to make appropriate provision to regulate situations of deprivation of liberty in Scotland. Recommendations and draft legislation were issued by Scottish Law Commission as long ago as 2014. The High Court in England & Wales operates under statutory

provisions which came into force in England & Wales in 2009, with a revised scheme of provision due to come into force this year. We have frequently highlighted in this Report the serious and discriminatory violations of the rights of elderly and disabled people in Scotland which can reasonably be attributed to (a) the lack of an appropriate regime to govern deprivations of liberty in Scotland and (b) the related widespread failure to recognise deprivations of liberty when they are proposed or occur, and the need for them to be lawful. Disappointingly, the most that Scottish Government has done so far is to adopt an apparent policy, likely to be an inefficient use of resources in the long term quite apart from the harm done, of looking for "sticking plaster" for particular consequences of the lack of provision which hit the headlines (for example, the widespread unlawful discharge of patients from hospital into care homes, or retention of them in hospital also in situations of unlawful deprivation of liberty), or which result in something close to a clear demand by the courts that a particular consequence be remedied (as in the matter of cross-border placement of children). In the latter case, it is clear from the SG paper that Scottish Government propose a two-step approach, firstly – explicitly as an interim step – by making regulations under section 190(1) of the Children's Hearings (Scotland) Act 2011. For the envisaged content of the regulations, see the SG paper. At the same time, Scottish Government is exploring "how non-statutory administrative agreements could be used alongside the regulations to set out procedures around the cross-border DOLS placing process".

As further steps, Scottish Government will continue to urge the UK Government to take prompt and effective action to resolve the issues of lack of capacity of provision in England & Wales; and also to continue to review the legal framework applying to children and young people in secure and residential care in Scotland. Disappointingly, there is no undertaking to take action so long overdue, and so urgently required, to remedy the underlying problem of lack of a deprivation of liberty regime in Scotland. The curious outcome of the proposals is that children and young people in Scotland, and in particular those transferred into Scotland from England & Wales, will benefit from safeguards not available to Scottish adults.

The Wolverhampton petition is *City of Wolverhampton Council v The Lord Advocate*, 2021 CSIH 69; 2022 SLT 1. While it must be stressed that everything in this article focuses on children and young persons, and the relevance to adult capacity law is by way of comparison only, Scottish practitioners might be interested to note the terms of the decision, including the role accorded to the Cross-border Judicial Protocol Group, established in terms of the Judicial Protocol Regulating Direct Judicial Communications between Scotland and England & Wales in Children's Cases, and the limitation of the order issued by the court to a period of three months.

Adrian D Ward

Guardians' remuneration

In the November 2021 Scotland section we were able to report that the immediate reduction in remuneration of professional guardians obliged to charge VAT, intimated in the October 2021 Journal of the Law Society of Scotland and resulting in a predictable furore, was "off the table". A further intimation in that matter was posted on the OPG website, under "News", on 10th January 2022. The item is headed "Attention all professional financial guardians". That item narrates that there have been discussions via the Law Society's Mental Health and Disability Sub-Committee, and that OPG have agreed to retract that original decision. Professional financial guardians can continue to claim VAT in addition to the sum of remuneration awarded, and that will be approved by OPG. The note acknowledges that the role of a professional financial guardian is "slightly different" from that of lay guardians such as relatives, and acknowledges the valuable work done by professional guardians "for

incapable adults across Scotland, who have no family members able to step into this important role". OPG plans to work with professional guardians to review their "uplifts" process this year. The leading case on the subject of guardians' remuneration, *X's Guardian, Applicant*, referred to in our November article, was in fact concerned with uplift payments claimed by that particular guardian. It is perhaps an under-used process to ensure fair and reasonable remuneration in particular cases. The note concludes with an apology for any confusion or inconvenience caused, whilst the matter was investigated further.

Puzzlingly, the note of 10th January includes the statement that: "We will seek a remedy to this lacuna around VAT and professional appointments, when the legislation is reformed". To date, that reference has not been clarified. The fees chargeable by OPG are fixed by regulation (see sections 7(2), 86 and 87(1) of the Adults with Incapacity (Scotland) Act 2000). However, the only provision in relation to the fixing of guardians' remuneration is section 68(6) of that Act, providing that any remuneration or outlays for guardians "shall be fixed by the Public Guardian", who is required to "take into account the value of the estate". That is not subject to any power to Scottish Ministers to make regulations: discretion rests entirely with the Public Guardian, who must if necessary (of course) be able to demonstrate that it has been properly exercised. However, under section 68 the Public Guardian has power already simply to fix the remuneration payable, which can be different for different guardians and allows the Public Guardian to take account of the VAT situation as she judges appropriate, provided that she does "take into account the value of the estate". The value of the estate is thus one of the factors to be taken into account, not the sole or determining factor.

A practical issue brought to light by discussion among professional guardians, following upon the original attempt to reduce their remuneration, is a concern that people who are often those who most need the services of a professional guardian are at risk of not receiving those services because there is insufficient money in the estate to allow them to be remunerated anywhere near adequately. Typically, these are cases where the local authority looks for a solicitor to act as financial guardian; where the work of the financial guardian is likely to involve very considerable support and interaction with the adult and/or family; but funds are meagre. It is not uncommon for professional guardians (like other professionals) to do a reasonable amount of work pro bono, but it appears that the number of such guardianships for which local authorities seek guardians is tending to exceed what professional guardians may reasonably be expected to do on a pro bono basis, and it is reported that a number of them are beginning to decline to accept such appointments. Obviously, resolution of that matter is not within the competence of OPG, beyond the possible relevance of the function under section 6(2)(f) of that Act to consult the Mental Welfare Commission and local authorities on matters relating to the exercise of functions under the Act "in which there is, or appears to be, a common interest". The issue is one of funding specialist professional services necessary to ensure that particularly vulnerable adults (whose vulnerabilities include financial vulnerabilities) are not seriously and discriminatorily disadvantaged.

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Conferences

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

Advertising conferences and training events

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

Our next edition will be out in March. 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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