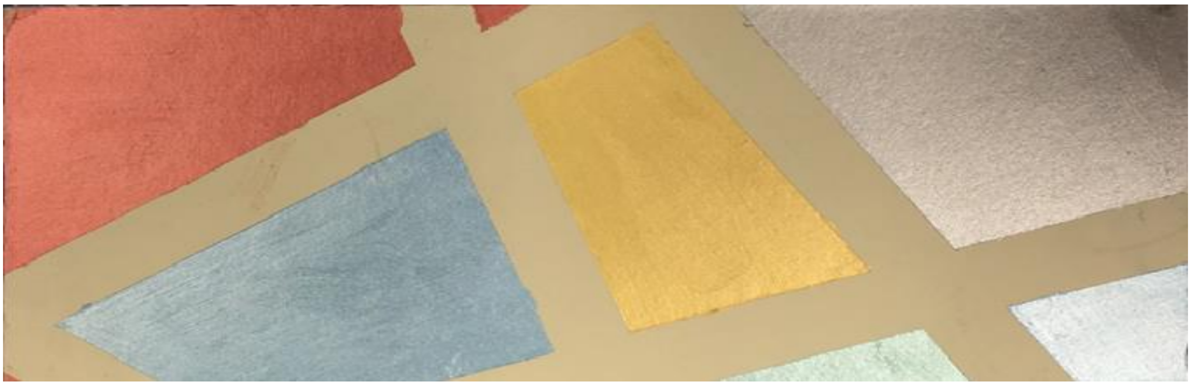
39 Essex
CHAMBERS

MENTAL CAPACITY REPORT: COMPENDIUM

July 2019 | Issue 96



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

(1) In the Health, Welfare and Deprivation of Liberty Report: when to appoint welfare deputies, termination and best interests, capacity in the context of sexual relations and birth arrangements, and the interaction between the MHA and the MCA in the community;

(2) In the Property and Affairs Report, fraud and vulnerability; news from the OPG, and deputyship and legal incapacitation;

(3) In the Practice and Procedure Report: Court of Protection fees changes; contingency planning, costs and s.21A applications; mediation in the Court of Protection;

(4) In the Wider Context Report: the Chair of the National Mental Capacity Act Forum reports, a new tool to assist those with mental health/capacity issues to know their rights, older people and the CPS/police; and books for the summer;

(5) In the Scotland Report: establishing undue influence and an update on the Scott review.

You can find all our past issues, our case summaries, and more on our dedicated sub-site here. If you want more information on the Convention on the Rights of Persons with Disabilities, which we frequently refer to in this Report, we suggest you go to the Small Places website run by Lucy Series of Cardiff University.

Editors
Alex Ruck Keene
Victoria Butler-Cole QC
Neil Allen
Annabel Lee
Nicola Kohn
Katie Scott
Katherine Barnes
Simon Edwards (P&A)

Scottish Contributors
Adrian Ward
Jill Stavert

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

Personal welfare deputies – to appoint or not?

Re Lawson, Mottram and Hopton (appointment of personal welfare deputies) [2019] EWCOP 22 (Hayden J)

Deputies – welfare matters

Summary[1]

The Vice-President of the Court of Protection, Hayden J, has outlined a set of principles to govern the appointment of personal welfare deputies. In *Re Lawson, Mottram and Hopton (appointment of personal welfare deputies)* [2019] EWCOP 22, a preliminary issue was listed in three applications for permission to apply for the appointment of a personal welfare deputy, namely "what is the correct approach to determining whether a welfare deputy should be appointed"? In particular, the question was whether

---

[1] Tor having been involved in the case, she has not contributed to this summary.

such appointments should only be made – as the Code of Practice suggests (at paragraph 8.38) in "*the most difficult cases*."

To answer this question, Hayden J looked in some detail at the case-law, the Code, the structure of the MCA and the appointment of deputies in practice, including a rehearsal of evidence provided by the Office of the Public Guardian as to the numbers of personal welfare deputy appointees (currently averaging about 375 per year, compared to an average of around 15,000 property and affairs deputies) and the role of the OPG in supervising them.

Hayden J considered that the case law showed the Court of Protection:

> *51* […] *is gradually and increasingly understanding its responsibility to draw back from a risk averse instinct to protect P and to keep sight of the fundamental responsibility to empower P and to promote his or her autonomy.*

Having concluded his review, he held at paragraph 53 that a number of "*clear principles*" emerge:

> *a) The starting point in evaluating any application for appointment of a PWD is by reference to the clear wording of the MCA 2005. Part 1 of the Act identifies a hierarchy of decision making in which the twin obligations both to protect P and promote his or her personal autonomy remain central throughout;*
>
> *b) Whilst there is no special alchemy that confers adulthood on a child on his or her 18th birthday, it nevertheless marks a transition to an altered legal status, which carries both rights and responsibilities. It is predicated on respect for autonomy. The young person who may lack capacity in key areas of decision making remains every bit as entitled to this respect as his capacitous coeval. These are fundamental rights which infuse the MCA 2005 and are intrinsic to its philosophy. The extension of parental responsibility beyond the age of eighteen, under the aegis of a PWD,*[2] *may be driven by a natural and indeed healthy parental instinct but it requires vigilantly to be guarded against. The imposition of a legal framework which is overly protective risks inhibiting personal development and may fail properly to nurture individual potential. The data which I have analysed (paragraph 26 above) may, I suspect, reflect the stress and anxiety experienced in consequence of the transition from child to adult services. As a judge of the Family Division and as a judge of the Court of Protection I have seen from both perspectives the acute distress caused by inadequate transition planning. The remedy for this lies in promoting good professional practice. It is not achieved by avoidably eroding the autonomy of the young incapacitous adult;*
>
> *c) The structure of the Act and, in particular, the factors which fall to be considered pursuant to Section 4 may well mean that the most likely conclusion in the majority of cases will be that it is not in the best interests of P for the Court to appoint a PWD;*

---

[2] Note, the judgment uses the acronym 'PWD,' which may produce inadvertent cognitive dissonance in some as in other contexts it refers to "persons with disabilities."

d) The above is not in any way to be interpreted as a statutory bias or presumption against appointment. It is the likely consequence of the application of the relevant factors to the individual circumstances of the case. It requires to be emphasised, unambiguously, that this is not a presumption, nor should it even be regarded as the starting point. There is a parallel here with the analysis of Baroness Hale in ***Re W*** [2010] UKSC 12*. In that case and in a different jurisdiction of law, the Supreme Court was considering the perception that had emerged, in the Family Court, of a presumption against a child giving oral evidence. The reasoning there has analogous application here:*

> *22."However tempting it may be to leave the issue until it has received the expert scrutiny of a multi-disciplinary committee, we are satisfied that we cannot do so. The existing law erects a presumption against a child giving evidence which requires to be rebutted by anyone seeking to put questions to the child. That cannot be reconciled with the approach of the European Court of Human Rights, which always aims to strike a fair balance between competing Convention rights. Article 6 requires that the proceedings overall be fair and this normally entails an opportunity to challenge the evidence presented by the other side. But even in criminal proceedings account must be taken of the article 8 rights of the perceived victim: see SN v Sweden, App no 34209/96, 2 July 2002. Striking that balance in care proceedings may well mean that the child should not be called to give evidence in the great majority of cases, but that is a result and not a presumption or even a starting point."*

e) To construct an artificial impediment, in practice, to the appointment of a PWD would be to fail to have proper regard to the 'unvarnished words' of the ***MCA 2005*** *(****PBA v SBC [2011] EWHC 2580) (Fam****). It would compromise a fair balancing of the* ***Article 6 and Article 8 Convention Rights*** *which are undoubtedly engaged;*

f) The Code of Practice is not a statute, it is an interpretive aid to the statutory framework, no more and no less. It is guidance which, whilst it will require important consideration, will never be determinative. The power remains in the statutory provision;

g) The prevailing ethos of the MCA is to weigh and balance the many competing factors that will illuminate decision making. It is that same rationale that will be applied to the decision to appoint a PWD;

h) There is only one presumption in the MCA, namely that set out at Section 1 (2) i.e. 'a person must be assumed to have capacity unless it is established that he lacks capacity'. This recognition of the importance of human autonomy is the defining principle of the Act. It casts light in to every corner of this legislation and it illuminates the approach to appointment of PWDs;

*i) P's wishes and feelings and those other factors contemplated by Section 4 (6) MCA will, where they can be reasonably ascertained, require to be considered. None is determinative and the weight to be applied will vary from case to case in determining where P's best interests lie (****PW V Chelsea and Westminster Hospital NHS Foundation Trust and Others*** *[2018] EWCA Civ 1067);*

j) It is a distortion of the framework of Sections 4 and 5 MCA 2005 to regard the appointment of a PWD as in any way a less restrictive option than the collaborative and informal decision taking prescribed by Section 5;

> *k) The wording of the Code of Practice at 8.38 (see para 20 above) is reflective of likely outcome and should not be regarded as the starting point. This paragraph of the Code, in particular, requires to be revisited.*

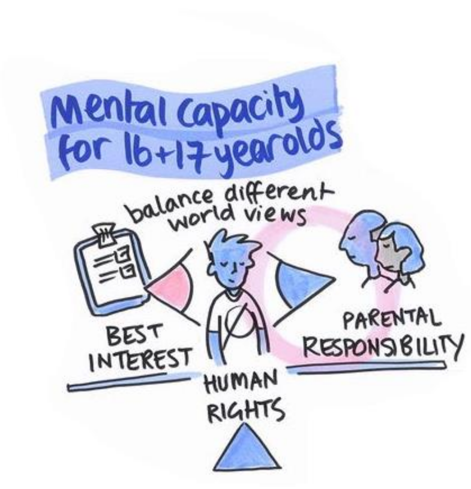
Hayden J neither granted nor refused permission to the three applicants before the court, so their applications for permission to apply (and, if that is granted, to be appointed as personal welfare deputies) will have to be considered in light of these principles.

Comment

The principles set out above are quite densely expressed. However, they can be summarised as:

1. The Code of Practice is wrong insofar as it suggests that the starting point is that personal welfare deputies should only be appointed in the most difficult cases;
2. Each case falls to be decided on its merits, and by reference to whether an appointment is in the best interests of P;
3. P's wishes and feelings will form an aspect of that decision (for instance if it is clear that P would wish a family member to be appointed to be their personal welfare deputy);
4. The proper operation of s.4 and s.5 means that, in practice, personal welfare deputies will not often be appointed, in particular because the appointment should not be seen, in and of itself, as less restrictive of P's rights and freedoms.

In reaching his conclusions, Hayden J very clearly took a side in a debate that has been simmering for some time (and is an extension of that which is troubling the Supreme Court in *Re D* at the moment), namely the extent to which the rights of parents to have a specific role in decisions relating to their children should be extended where those children will always have impaired decision-making capacity. This graphic by Cara Holland at Graphicchange (@graphichange) summarises that debate in visual form:



The dilemma encapsulated here extends beyond 18 where the end of legal parental responsibility does not lead to the end of their emotional and moral responsibility. Hayden J's judgment makes clear that majority does, in fact, mean majority, and a deviation from the 'ordinary' decision-making structure set up under s.5 MCA 2005 will have to be justified.

Some reading the judgment might feel that it does not face head on the practical realities of decision-making in relation to those with impaired capacity. Despite cases such as Winspear emphasising that a failure properly to consult those interested in P's welfare has legal consequences, it is clear that many family members feel excluded from decision-making. Sometimes, this is because others involved are seeking to develop P's autonomy and enable them to secure their own life choices; sometimes this is for rather less noble reasons.

Others reading the judgment may feel relieved that Hayden J 'held the line' in terms of the decision-making structure under s.5 MCA 2005, which deliberately seeks to limit interference with legal capacity to specific issues and specific decisions, rather than handing extended surrogate decision-making power to one person and thereby, for benign reasons, depriving P of legal capacity. Although the CRPD made an entry in the case in support of the proposition that the court should be more willing to appoint personal welfare deputies where that choice represented the wishes and feelings of P, it could also have been deployed in support of the argument that a broader presumption in favour of appointment of such deputies would represent a move away from compliance with Article 12 CRPD by rendering more widespread the legal 'incapacitation' of individuals with impaired capacity.

In practical terms, one very clear implication of this judgment is that it will be necessary to explain in any application for appointment as a personal welfare deputy why the 'collaborative and informal' decision-making structure that the MCA has put in place has not been serving P's interests.

Termination and best interests

Re AB (Termination) [2019] EWCA Civ 1215 (Court of Appeal) (McCombe, King and Peter Jackson LLJ)

Best interests – childbirth – medical treatment

Summary[3]

The question arose for determination whether it was in the best interests of a young woman with moderate learning disabilities to undergo a termination. Matters proceeded at speed in the case, Lieven J giving her judgment on the Friday, and the application for permission (by AB's mother) being made on the Monday morning, the hearing of the appeal being that afternoon, and the decision being announced at the conclusion of the hearing. Several weeks later, the Court of Appeal set out its reasons for – unusually – reversing an evaluative judgment of a first instance judge as to best interests.

Background

AB was a 24-year-old woman with moderate learning disabilities. She exhibited challenging behaviour and (in the words of the Court of Appeal) functioned at a level of between 6 and 9 years old. At the turn of 2019, AB was staying with her family in Nigeria and, in circumstances which were unclear, became pregnant; a fact that was discovered by her adoptive mother (CD) upon AB's return to this country in April 2019.

---

[3] Tor having been involved in the case in the Court of Appeal, she has not contributed to this summary.

Capacity assessments were undertaken early in May which concluded that AB lacked the capacity to decide whether to continue with the pregnancy. CD was wholly opposed to abortion both from a religious and cultural point of view; she was a devout Roman Catholic and in Nigeria, she said, terminating a pregnancy was 'simply unheard of'. On 16 May 2019, by which time AB was about 16 weeks pregnant, CD arrived at the hospital with AB, together with all of AB's possessions packed into three suitcases and two rucksacks. CD told the hospital that she was 'handing over' the care of AB. Since that time, AB had lived in a residential unit. In her statement, CD said that she did not do this for fear of being ostracised by her community if AB had a termination, but because she felt she could not support AB in having a termination.

The NHS Foundation Trust responsible for the antenatal care of AB concluded that it would be in her best interests for the pregnancy to be terminated on the basis. CD was implacably opposed to the proposal and, accordingly, the Trust made an application to the High Court. By the time that the matter came before Lieven J, AB was 22, going on 23 weeks pregnant, which meant that there was considerable urgency to the decision as the latest possible date under the Abortion Act 1967 (in a case such as AB's) for termination is 24 weeks' gestation. Before Lieven J, CD maintained, contrary to her initial position, that she would then wish to have AB back to live with her even if she had a termination. As King LJ noted:

> *The rights and wrong of all of this were not matters with which the judge needed to concern herself and, for my part, the relevance is only in that it highlights that AB's home circumstances are complicated and that it would be naive to presume that an easy solution to the conundrum presented to the court would be for AB to have her baby and move back home where she and her baby would live with, and be cared for, by CD.*

The task of the court

Helpfully, the Court of Appeal outlined what the task of the court was in a case such as this:

> *Given that the doctors were united in their view that the test in s1(1)(a) Abortion Act 1967 was met* [ie that continuing the pregnancy involved a greater risk to the mental health of AB than if the pregnancy were terminated],*the role of the court* [is] *to consider, by way of an evaluation of all the material factors, whether it would be in the best interests of AB to provide the consent necessary in order for the proposed termination to take place. It follows that, whilst the court's task in identifying the best interests of AB may overlap with the task of the doctors in applying the Abortion Act, they are not one and the same: Re X (A Child) [2014] EWHC 1871 per Munby J (as he then was) at [6-7].*

On behalf of CD, it was submitted, in reliance on *Re X*, that:

> *terminating a pregnancy without the consent of the woman carrying the child represents such a profound invasion of her Article 8 rights that it should only ever be contemplated where section 1(1)(b) of the Act is satisfied, that is to say "the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman".*

Eleanor King LJ, on behalf of the Court of Appeal, did not go this far, but emphasised that:

> *However one looks at it, carrying out a termination absent a woman's consent is a most profound invasion of her Article 8 rights, albeit that the interference will be legitimate and proportionate if the procedure is in her best interests. Any court carrying out an assessment of best interests in such circumstances will approach the exercise conscious of the seriousness of the decision and will address the statutory factors found in the Mental Capacity Act 2005 (MCA) which have been designed to assist them in their task.*

Having rehearsed the approach to best interests by reference to Aintree, and, in particular, paragraph 24 at which Lady Hale emphasised that it is a test containing a strong element of substituted judgment, King LJ noted that:

> *It is well established that the court does not take into account the interests of the foetus but only those of the mother: Vo v France (2005) 10 EHRR 12 at [81-82]; Paton v British Pregnancy Advisory Service [1979] QB 276; Paton v United Kingdom (1980) 3 EHRR 408. That does not mean that the court should not be cognisant of the fact that the order sought will permit irreversible, invasive medical intervention, leading to the termination of an otherwise viable pregnancy. Accordingly, such an order should be made only upon clear evidence and, as Peter Jackson LJ articulated it in argument, a "fine balance of uncertainties is not enough".*

The decision of Lieven J

Lieven J held that:

> *62. Focusing on AB and her own facts, the risks of allowing her to give birth are in no particular order; increased psychotic illness; trauma from the C section; trauma and upset of the baby being removed and the risk of the baby being placed with CD and AB losing her home as well as the baby. The benefits are that of her having a child born alive and the possibility of some, albeit future contact. She may take joy from this, it is not possible to know.*
>
> *63. In my view the balance in terms of AB's best interests lies in her having the termination. I should make clear that I do not underestimate the harm from this course, but I think that it is clearly outweighed by the harm from continuing the pregnancy.*

The appeal decision

The first ground of appeal was that Lieven J had erred in finding that, if AB's pregnancy continued to term, her baby would be removed by way of protective order on the part of the local authority and/or placed too much weight on this factor in the best interests analysis.

On the facts, Eleanor King LJ considered that:

> *The judge was entitled to take into account the expert evidence available which stated categorically that AB would be unable to care for a baby. The judge, far from improperly anticipating future events, was simply expressing the sad reality of the situation, namely that AB is incapable of caring for herself, let alone a baby. Based on the totality of the evidence from both the lay and medical witnesses, it cannot be said, or even argued, that for the judge to have concluded that AB will be unable to care for her baby, was premature, inappropriate or discriminatory.*

However, Eleanor King LJ found that Lieven J had erred in:

> *extrapolating from that finding a real risk that the baby would be placed with CD and that, as a consequence, AB would lose her home as well as her baby, a finding that erroneously impacted on the best interests analysis.*

The second ground of appeal was that Lieven J had erred in failing to carry out a detailed and careful balancing exercise in respect of whether termination or planned caesarean section were in AB's best interests, having regard to the need for powerful evidence of risk to the mother's life or grave risk to the mother's long-term health of continued pregnancy.

Eleanor King LJ identified that:

> *The unenviable task facing the judge was, amongst all the other factors, to weigh up the psychiatric/psychological risks to AB of each of the two alternatives as presented to her by the doctors:*
>
> *i) Termination would be at a stage requiring invasive intervention to bring the pregnancy to an end at a time when AB has an increasing awareness (but very limited understanding) of her pregnancy. AB knows she has a "baby in her tummy" and that it will be born. There is an acceptance by all the parties that AB was, and is, at the very least, 'engaged' with the pregnancy and has indicated on occasions that she likes the idea of having the baby;*
>
> *Or alternatively,*
>
> *ii) The continuation of the pregnancy to term when the baby would be born by caesarean section and would be taken away from her, if not immediately, then very soon thereafter.*

Eleanor King LJ did not express a view as to whether this ground of appeal was, itself, made out, but noted, "[w]*hilst ultimately the three experts were in agreement, it can be seen that they were faced with a most challenging task in trying to determine which of the two outcomes would be the worst for AB and ultimately the view was one expressed to be 'on balance'*."

The third ground of appeal was that the judge erred in failing to have full regard to AB's wishes and feelings and/or her Article 8 right to motherhood.

Eleanor King LJ found that:

> *Whilst it is clear that the judge did not apply any "automatic discount" to AB's view* [to use the phrase from Peter Jackson J's judgment in Wye Valley], *in my judgement she failed to take sufficient account of AB's wishes and feelings in the ultimate balancing exercise. The fact that they might in the end be outweighed by other factors does not alter the fact that this was a significant omission.*

Interestingly, Eleanor King LJ also then went on to consider separately AB's beliefs and values, noting that

> *57. No reference is made in the judgment to the beliefs and values that would be likely to influence AB had she capacity, nor were any submissions made in relation to "beliefs and values" to this court.*
>
> *58. It is undoubtedly the case that AB has been brought up in a community whose religious and cultural beliefs and values are strongly opposed to abortion. This cultural background and these religious beliefs could, in the right circumstances, have a profound impact upon the best interests assessment. AB, however, has never had capacity and there can therefore be no direct evidence as to her actual beliefs and values; who can say if she might not have lost her faith or rebelled against the tenets of her community by the time she reached her twenties. It may be that, had she capacity, she would have been heavily influenced by the beliefs governing her community, but there is no evidential basis for concluding that to be the case, and to import those views into the best interests analysis would be mere speculation.*
>
> *59. It follows that the fact that the judge did not refer specifically to s4(6)(b) does not represent a shortcoming in her best interests evaluation; in other cases it might be different.*

Turning to consultation, Eleanor King LJ considered that Lieven J had erred in failing to place in the balance as to what outcome was in AB's best interests either the views of her mother or her social worker, noting that:

> *CD and Ms T each know AB better than the assessing psychiatrists could possibly do notwithstanding the lengthy, caring and careful assessments they had carried out. The judge had the expert evidence of the psychiatrists on the one hand and the views of those who know AB best on the other, but she did not weigh them up, the one against the other.*

Conclusion

Eleanor King LJ's conclusions should be set out in full:

> *71. Part of the underlying ethos of the Mental Capacity Act 2005 is that those making decisions for people who may be lacking capacity must respect and maximise that person's individuality and autonomy to the greatest possible extent. In order to achieve this aim, a person's wishes and feelings not only require consideration, but can be determinative, even if they lack capacity. Similarly, it is in order to safeguard autonomy that s1(4) provides that "a person is not to be treated as unable to make a decision merely because he makes an unwise decision".*

72. It may be that, on any objective view, it would be regarded as being an unwise choice for AB to have her baby, a baby which she will never be able to look after herself and who will be taken away from her. However, inasmuch as she understands the situation, AB wants her baby. Those who know her best, namely CD and her social worker, believe it to be in AB's best interests to proceed with the pregnancy as does the Official Solicitor who represents her in these proceedings.

73. The judge's conclusion as to what was in AB's best interests was substantially anchored in the medical evidence. In my judgement, that medical evidence, without more, did not in itself convincingly demonstrate the need for such profound intervention.

74. The judge was entitled to take into account the fact that AB would be unable to care for her baby and to place weight on the traumatic effect on AB of having her baby taken from her, but in my judgement she went beyond what the evidence could support in finding that AB risked losing her baby and her home.

75. In many of the passages set out above, and in particular in her conclusion at [62], the judge made no mention of AB's wishes and feelings or of the views of CD, the social worker or the Official Solicitor This was, in my opinion a significant omission.

76. The requirement is for the court to consider both wishes and feelings. The judge placed emphasis on the fact that AB's wishes were not clear and were not clearly expressed. She was entitled to do that but the fact remains that AB's feelings were, as for any person, learning disabled or not, uniquely her own and are not open to the same critique based upon cognitive or expressive ability. AB's feelings were important and should have been factored into the balancing exercise alongside consideration of her wishes.

77. These were all important features of the case and needed to be part of the decision-making process, all the more so given that the medical evidence was, substantially, based on an attempt (albeit by experts) to assess AB's likely emotional reaction to each of two traumatic events.

78. I am conscious that, to borrow from Lord Sumption in Barton v Wright Hassall LLP [2018] UKSC 12, [2018] 1 WLR 1119, this is an appeal:

> *"15…..against a discretionary order, based on an evaluative judgment of the relevant facts. In the ordinary course, this court would not disturb such an order unless the court making it had erred in principle or reached a conclusion that was plainly wrong."*

79. To this I add that I also have in mind that the judge made her decision having heard the oral evidence and having written a careful and thoughtful judgment produced under considerable pressure of time. However, in my judgement, she clearly gave inadequate weight to the non-medical factors in the case, while the views expressed by the doctors were necessarily significantly predicated upon imponderables. In the end, the evidence taken as a whole was simply not sufficient to justify the profound invasion of AB's rights represented by the non-consensual termination of this advanced pregnancy.

Procedural matters

Eleanor King LJ was very concerned about how matters had come to court:

> *The Trust issued its application on 21 May 2019 by which time AB was 18 weeks pregnant. Keehan J gave directions on 3 June 2019 and listed the matter for hearing on 20 June. In her judgment Lieven J deprecated that proceedings were not issued by the Trust for some 5 weeks after they were aware of the pregnancy. I endorse her view. In fairness to the Trust however, it should equally be noted that having issued the proceedings, a further 4 weeks elapsed before the matter was heard. I am conscious that Trusts are rightly reluctant to make such applications and properly aim to reach agreement with the family in such fraught situations. I am also conscious that the courts are overwhelmed with urgent work and also that any judge giving directions for trial, in a case of this type, will be alert to the need to ensure that the trial judge has, in particular, the medical evidence necessary to inform the decision-making process. In my judgement however, an application for a declaration which will permit a Trust to carry out termination on a woman lacking capacity should be regarded and litigated as a medical treatment issue of the utmost urgency.*
>
> *14. Given the critical urgency of such a case, it may be that, where it appears to a Trust that there is a potentially intractable divergence of views with the family, consideration should be given to an application being made at an early stage following the making of the "best interests" decision. The application should then be listed as a matter of urgency, even if it is subsequently withdrawn. If the pregnancy is allowed to reach a very late stage and a termination is then determined to be in the best interests of the mother, she will be unnecessarily exposed to what is on any view a highly invasive and, for a woman lacking capacity, bewildering procedure. (In saying this I accept, of course, that there will inevitably be occasions where the pregnancy does not come to the authorities' attention until it is well established.)*

Comment

The decision of Lieven J made very considerable waves, and caused (sometimes ill-informed) criticisms. It is very unusual for a judgment on best interests to be overturned by an appellate court on the basis that it was wrong, but it is difficult to escape the feeling that this was justified on the extremely difficult and finely balanced facts of this case; it is also difficult to escape the feeling that the decision at first instance might have been different had there been more time properly to undertake the exercise mandated by s.4 MCA 2005. We also anticipate that paragraph 71 of the Court of Appeal's judgment will feature regularly in future judgments as encapsulating the correct approach to best interests decision-making.

Capacity and sexual relations – trying to make it personal

LB Tower Hamlets v NB & AU [2019] EWCOP 27 (Hayden J)

Mental capacity – sexual relations

Summary

Hayden J has made further observations about the test for capacity to consent to sexual relations. We use the term "observations" advisedly, because his judgment does not, in fact, reach a conclusion as to whether the woman in question, NB, has or lacks capacity to consent to sexual relations.

The case is one that has been before Hayden J for some time, and generated a judgment ([2019] EWCOP 17) in which he expressed, in particular, real concern about the manner of reporting of a previous interim hearing. In this most recent judgment, reserved from the previous hearing, Hayden J identified that the questions concerning the protection of the vulnerable in media coverage "*will require to be addressed by the ad-hoc Court of Protection Rules Committee*."

For present purposes, the key feature of the case was that the question of capacity to consent to sexual relations was being posed in relation to a couple who had been married since 1992, with a daughter born in 1998, and NB now being beyond child-bearing age. In his interim judgment, Hayden J had indicated that he was reserving his judgment "*in order that I can take the time to look carefully and in some detail at the case law and its applicability to the facts of this case. It would appear, that it requires to be said, in clear and unambiguous terms that I do so in order to explore fully NB's right to a sexual life with her husband and he with her, if that is at all possible*." A critical element in this was whether the test – held by the Court of Appeal to be issue- or act- specific – could in some way be tailored in the case before him to take into account the particular situation of NB and AU.

Subsequent to that hearing, the Court of Appeal delivered judgment in *B v A Local Authority* [2019] EWCA Civ 913, delivering a fairly heavy hint that it would not look askance at an approach which enabled a conclusion to be drawn that NB **had** capacity to consent to sexual relations. Hayden J was in receipt of further written submissions from both the Official Solicitor and the local authority; the husband, AU, apparently unable (or unwilling) to play any further part. It is fair to say that Hayden J does not seem to have had much time for the submissions of any party before him, and his judgment therefore essentially represents his own exegesis of the position.

Hayden J reviewed the case-law, and made the following series of observations:

> *27. The omnipresent danger in the Court of Protection is that of emphasising the obligation to protect the incapacitous, whilst losing sight of the fundamental principle that the promotion of autonomous decision making is itself a facet of protection. In this sphere i.e., capacity to consent to sexual relations, this presents as a tension between the potential for exploitation of the vulnerable on the one hand and P's right to a sexual life on the other.*

28. These are difficult issues involving intensely personal interactions. The lexicon of the law, perhaps even that of ordinary discourse, presents a challenge when seeking to distil the essence of the concepts in focus. With hesitation and some diffidence, it seems to me to be important to recognise and acknowledge, that in this interpersonal context, relationships are driven as much by instinct and emotion as by rational choice. Indeed, it is the former rather than the latter which invariably prevail. This fundamental aspect of our humanity requires to be identified and appreciated as common to all, including those who suffer some impairment of mind. To fail to do so would be to lose sight of the primary objective of the MCA. It would require a disregard of at least two decades of jurisprudence emphasising P's autonomy. Moreover, it would seriously risk discriminating against vulnerable adults with learning disabilities and other cognitive challenges.

29. It strikes me as artificial, at best, to extract both instinct and emotion from an evaluation of consent to sex, they are intrinsic to the act itself. In many ways, of course, instinct and emotion are the antithesis of reason. However, whilst they may cloud decision making, perhaps even to the point of eclipsing any calculation of risk, they are nonetheless central to sexual impulse. To establish an inflexible criterion to what may properly constitute 'consent' risks imposing a rationality which is entirely artificial.

30. It also needs to be emphasised that the law does not identify the criterion which are being considered here. The MCA 2005, in some ways like the Children Act 1989, is a distillation of principles which require to be applied in the context of a careful balance, one in which proportionality of intervention will always be an indivisible feature. Much of the applicable criteria concerning assessment of capacity, across a broad range of decisions, finds its way into this process via the conduit of expert evidence. This is all profoundly helpful to the practitioners and the professionals but the danger is that conceptual silos are created which fail to appreciate the individual and the infinite variety of people's lives.

[…]

41. It is important to identify that depriving an individual of a sexual life in circumstances where they may be able to consent to it with a particular partner, is not 'wrapping them up in cotton wool'. Rather, it is depriving them of a fundamental human right. Additionally, I repeat, AU's Article 8 rights are also engaged in this context. He too has a right to a sexual life where there is true consent and mutual desire.

42. One of the central difficulties faced by practitioners, both in the court setting and in the wider community, is that the relevant tests for capacity are framed by psychologists, psychiatrists etc and a practice has developed of applying these tests as if they had the force of statute. It is necessary to emphasise that when an application is made to a judge, it is the judge who evaluates the broad canvas of evidence to determine the question of capacity.

43. In simple terms, in these circumstances, it is judges not experts who decide these issues. Judges have the enormous advantage of hearing a wide range of evidence about P from a diverse field of witnesses, often including family members. As I have sought to illustrate in my analysis of the law […]*, the Courts have repeatedly emphasised that the tests are to be applied in a way which focus upon P's individual characteristics and circumstances. Whilst it is difficult to contemplate many*

> *heterosexual relationships where a failure to understand a risk of pregnancy or sexual disease (consequent upon sexual intercourse) will permit a conclusion that P has capacity, it should not be discounted automatically. This is to elevate the expert guidance beyond its legitimate remit.*
>
> *44. Moreover, expert evidence gains its force and strength when challenged and robustly put to the assay. Theories grow, develop and, as the Courts have seen in recent decades, are sometimes debunked. Attributing to expert evidence the status of legislative authority serves also to deprive it of its own intellectual energy and inevitably, in due course, some of its forensic utility.*

Rejecting the Official Solicitor's submission that the court should identify a category of individuals for whom pregnancy and sexually transmitted disease will not require assessment, Hayden J considered that this would be to:

> *48. […] overburden the test and to introduce unnecessary technicalities. It is also, with respect to Mr Bagchi, difficult to reconcile with his own acceptance of the 'tailored' approach which he characterises as 'pragmatic and flexible'. At risk of labouring the point further, I am emphasising that the tests require the incorporation of P's circumstances and characteristics. Whilst the test can rightly be characterised as 'issue specific', in the sense that the key criteria will inevitably be objective, there will, on occasions, be a subjective or person specific context to its application.*

Hayden J went on to develop, in different ways, the theme that:

> *51. The applicable criteria in evaluating capacity to consent require to be rooted within the clear framework of MCA 2005 ss 1 to 3. The individual tests are not binding and are to be regarded as guidance 'to be expanded or contracted' to the facts of the particular case. They are to be construed purposively, both promoting P's autonomy and protecting her vulnerability.*
>
> […]
>
> *54. That there is no need to evaluate an understanding of pregnancy when assessing consent to sexual relations in same sex relationships or with women who are infertile or postmenopausal strikes me as redundant of any contrary argument. Nor, with respect to what has been advanced in this case, can it ever be right to assess capacity on a wholly artificial premise which can have no bearing at all on P's individual decision taking. It is inconsistent with the philosophy of the MCA 2005. Further, it is entirely irreconcilable with the Act's defining principle in Sec. 1 (2) … 'a person must be assumed to have capacity unless it is established that he lacks capacity.'*
>
> […]
>
> *56. […], a monogamous marriage of some thirty years duration, where there is no history of sexually transmitted disease, is probably a secure base from which to predict that this is a very low risk for the future. It is in this context that Mr Bagchi's absolutist approach runs the risk of 'dressing an incapacitous person in forensic cotton wool', to use Hedley J's striking phrase in A NHS Trust v P [2013] EWAC 50 (COP). It is not the objective of the MCA to pamper or to nursemaid the incapacitous, rather it is to provide the fullest experience of life and with all its vicissitudes. This must be kept in*

> *focus when identifying the appropriate criteria for assessing capacity, it is not to be regarded as applicable only to a consideration of best interests.*
>
> […]
>
> *60.* […] *What I am emphasising here is the application of 'the Act specific test' (to use the favoured argot), deployed in a way which promotes P's opportunity to achieve capacity. This, as I have laboured to highlight, is nothing less than a statutory imperative. It cannot be compromised.*
>
> […]
>
> *66. The Court of Protection deals with human beings who, for a whole variety of reasons, have lost or may have lost capacity. This may be temporary, permanent, fluctuating or limited to a constrained sphere of decision taking. A declaration of incapacity whether tightly circumscribed or expansive in its scope, should not impose sameness or uniformity. The personality and circumstances of the incapacitous are as rich, varied and complex as those of anybody else. All this requires to be taken in to account when evaluating capacity in every sphere of decision taking. As practitioners and indeed as judges we must be vigilant to ensure that the applicable tests do not become a tyranny of sameness, in circumstances where they are capable of being applied in a manner that may properly be tailored to the individual's situation. To do otherwise would, for the reasons I have set out, lose sight of the key principles of the MCA 2005.*

On the facts of the case before him, Hayden J "profoundly disagreed" with the assertion made by the local authority that:

> *65.* .[…] *NB's assumed capacity to consent to a sexual relationship with her husband has been rebutted. On the contrary, the preponderant evidence suggests that she is capacitous. This was foreshadowed in Mr Bagchi's earlier submissions, referred at para 44 above (though I recognise that they were not structured around the test as now identified). The Local Authority may wish to consider a reassessment of NB's capacity in the light of this judgment. This will, of course, depend on whether the marriage survives.*

Comment

Whilst it is always dangerous to seek to summarise an extensive judgment such as that delivered in this case, its clear message is that it is both legitimate and indeed mandatory to consider the question of whether a person has capacity to consent to sex on the basis of the full facts of their situation, and with a clear eye to the interference with rights that a conclusion that they lack capacity will give rise to.

One may or may not agree that the relevant tests for capacity have been framed by psychologists, psychiatrists etc, as opposed to judges (a clear example of judicial framing being that of Cobb J in *Re A*, concerning capacity to make decisions as to social media), but it is undoubtedly the case that in a case that has come to court, it is the judge, not the expert(s) who must ultimately decide whether the person has or lacks capacity to make the decision in question.

What, of course, the judgment does not address is how a practitioner **outside** the court arena is to decide whether the person has or lacks capacity to consent to sexual relations. It may be that Hayden J considers that the level of interference with the person's rights is such that **only** a judge should ever conclude that a person lacks capacity to consent to sexual relations. Such could certainly be construed as an example of the calibration of the procedural guarantees implied into Article 8 ECHR (see, e.g. *AN v Lithuania* [2016] ECHR 462). It is to be hoped that, if, indeed, Hayden J does consider this to be the case, he makes this clear (and the basis upon which he considers this to be so) in what is presumably going to be the final judgment in this case in which he definitely determines whether or not NB has or lacks capacity to consent to sexual relations.

Until and unless Hayden J identifies a legal requirement for all such cases to come to court, practitioners should continue to consider the test for capacity to consent to sexual relations in relation to those individuals before them. They should do so, we suggest, by reference:

1. To the informational guidance endorsed by the Court of Appeal in *B*;
2. The act-specific test as endorsed by the Court of Appeal in both that case and the earlier *IM v LM* one.

However, in applying the test, it is clear in light of this decision that practitioners should be mindful:

1. that information must be tailored to the specific facts of the individual case so, for instance, it will not be relevant to consider whether the person can understand, retain and use/weigh information about the potential for pregnancy if this is of no relevance to their factual position;
2. of the support principle in s.1(3) MCA 2005; and
3. of the consequences of a conclusion that a person lacks capacity to consent to sexual relations.

We note, finally, that it remains of significance (and a factor not discussed by Hayden J in his judgment) that, as the Court of Appeal confirmed in *B* (at paragraph 51) that the ability to understand the concept of and the necessity of one's own consent is fundamental to having capacity: in other words that "P knows that she/he has a choice and can refuse".

Birth arrangements, interventions and the art (not science) of capacity

NHS Trust v JP [2019] EWCOP 23 (Williams J)

Best interests – birth arrangements – medical treatment

Summary[4]

In *NHS Trust v P* [2019] EWCOP 23, Williams J was asked to endorse the covert carrying out (under general anaesthetic) of a Caesarean section on a young woman, JP. JP, who had learning disabilities (the extent and impact of which were the subject of detailed consideration), was seen by the community midwife in February 2019 and was pregnant. She was in a relationship but at that time was living at home with her mother and spending time at her boyfriend's family home. Her due date was 14 July 2019. Over the ensuing 4 months, the community midwifery team, clinicians from the relevant NHS Trust, a learning disabilities team, and local authority adult and children's social workers had been involved with JP and her pregnancy. By 11 May, she had moved out of her mother's home into a supported living placement. Over the ensuing months those around JP had been seeking to support her through the pregnancy and to reach a decision as to how the delivery was to be managed.

The team at the applicant Trust eventually concluded that the only safe way to manage the labour for JP was for her to have a caesarean section under general anaesthetic. That was contrary to JP's wishes; she had expressed a wish to have a natural birth, and hence the care plan would involve an element of deception. The plan also envisaged that the local authority would take steps to remove JP's baby from her after birth (whether temporarily or permanently was not clear from the judgment).

The Trust did not make the application for declarations as to JP's capacity and best interests until 31 May, by which time JP was roughly 33 weeks pregnant. Williams J was unclear why this was the case, and noted that:

> *7. The listing of the final hearing on a date between the 36th and 37th weeks of her pregnancy introduced unnecessary pressure into the process. Unless it is unavoidable because of late awareness of a pregnancy, I see no reason why it should not be possible for these applications to be issued and heard before they become time critical.*

Capacity

On the Trust's application, Williams J expressed himself concerned as to the evidence of JP's decision-making capacity. The COP3, completed by JP's consultant obstetrician and gynaecologist, Dr Sullivan, was founded upon a diagnosis of "*Microcephaly (behavioural disorder).*" Williams J declined to determine JP's capacity on the basis of the doctor's evidence, supported by hospital notes, but he declined to do so, holding, at paragraph 25 that:

---

[4] Katie having been involved in the case, she has not contributed to this summary.

> *I consider that where an applicant Trust asserts that a patient is suffering from a condition such as microcephaly leading to a significant learning difficulty that appropriate evidence demonstrating the condition (microcephaly) and its consequences (learning disability or significant learning difficulties) is placed before the court. Whilst I would not rule out the possibility of a consultant obstetrician and gynaecologist, particularly one with the expertise of Dr Sullivan, providing the only evidence of a learning disability, it seems to me far from satisfactory in matters of such profound importance to JP for the evidence of the impairment or disturbance in the functioning of the mind or brain to come from a clinician other than a consultant psychiatrist or psychologist, particularly where it is known that JP is known to a psychiatric team. Where such evidence is likely to be available because JP is and has been under the care of a learning disabilities team for some 2 ½ years the first port of call for such information ought to be from that specialist team, preferably the lead consultant.*

The proceedings were adjourned (for a short period) to enable confirmation as to the impairment or disturbance from JP's learning disability psychiatrist. Ultimately, on the basis of the combined evidence, Williams J declared himself:

> 28. [….] *satisfied on the basis of the medical evidence set out above that JP currently lacks capacity both to conduct these proceedings and to take a decision for herself on the issue of her medical treatment relating to her ante-natal care and the delivery. In particular she is unable to make a decision for herself because she does not understand the information relevant to the decision and is unable to use or weigh that information as part of the process of making the decision. The evidence from the health visitor and Dr Sullivan make it clear that many attempts have been made to convey information in a way tailored to JP's learning disability about the process of delivery and the risks attendant upon it and the options available but because of her learning disability JP has been unable to understand that information or to use or weigh it. This inability to make a decision for herself is caused by the impairment or disturbance of the functioning of her mind or brain arising from her diagnosed learning disability. The evidence of the efforts made by the health visitor, learning disability support and Dr Sullivan make clear there is no means by which she could currently be enabled to make a decision. The lack of capacity is likely to be permanent but will certainly endure until after the baby is born.*

Best interests

With specific reference to the element of deception, Williams J directed himself that:

> *21 It is a fact of the proposed care plan that it will involve an element of deception of JP. In NHS Trust-v-K and Ors [2012] EWCOP 2922; Re AB [2016] EWCOP 66; Re P [2018] EWCOP 10 and NHS Trust (1) and (2) -v-FG [2014] EWCOP 30 the court has confirmed that deception can be compliant with the individuals Article 8 rights provided the best interests exercise has been carried out. It seems to me that if it is in JP's best interests for deception or misrepresentation to take place then the court would be obliged to authorise that. The question of the level of deception would no doubt feed into the evaluation of whether the best interests of JP were met by the plan which involved that deception; the greater the deception the more it might potentially weigh against JP's best interest and vice versa but as a matter of principle seems to me that deception cannot be a bar to authorisation of a*

> *procedure. To hold otherwise would be to supplant the best interests of JP by some other principle, perhaps of public policy, that the court should not condone white lies.*

Williams J accepted the medical evidence that, objectively, a vaginal delivery was likely to be profoundly distressing for JP and extremely risky in terms of her health, and that the "*alternative of a planned caesarean under general anaesthetic is the least worst of all of the options that exist*." All the clinicians and JP's support worker agreed that the proposed plan was in her best interests, as did the Official Solicitor – who, via the solicitor instructed on JP's behalf – had been unable to engage with her.

Williams J noted that:

> *41. In so far as it has been possible to discuss matters with JP it is clear that her wish is to give birth naturally. It is clear that she wishes to retain autonomy over what happens and her body. Those are very important factors.*
>
> *42. Section 4(6) requires that in evaluating 'best interests' I consider past and present wishes, beliefs and values that would be likely to influence JP's decision if he or she had capacity and the other factors she would be likely to consider if she or she were able to do so. The evidence demonstrates that JP does not tolerate pain well and welcomes intervention which reduces pain. She appears to believe that gas and air will eliminate the pain of childbirth. Regrettably that is likely to be an erroneous belief. It is more likely that JP would experience considerable pain, discomfort and distress from the process of childbirth. This is in part a natural physical consequence but the emotional distress that she might experience will in my view be all the greater because she does not understand truly what will be happening to her. If she were able to understand the great physical and emotional toll that giving birth naturally can give rise to it seems likely that she would wish for an intervention that would minimise or eradicate that pain. Were she to have capacity I conclude that she would, along with many other expectant mothers, opt for an elective caesarean probably under general anaesthetic.*

Williams J noted that the following matters weighed against the approval of the proposed treatment plan:

> *43. i) It is against JP's expressed wishes. She is likely to experience distress, distrust, anger, frustration at both the deception that may be necessary and the carrying out of a surgical procedure against her will in respect of such a profoundly important matter. This is likely to be all the greater because it is proposed that the baby will be removed from her care.*
> *ii) It appears likely to be against the expressed wishes of some family members close to her, including the putative father of the baby.*
> *iii) There are risks associated with the administration of general anaesthetic in the hospital environment.*
> *iv) There are far higher risks associated with the administration of anaesthetics outside the hospital environment if that became necessary.*

However,

> *44. Taking a broad approach to the factors which bear upon JP's best interests I am satisfied that it is in her best interests overall to approve the proposed treatment plan. The risks attendant upon an attempted vaginal delivery are so high that they plainly outweigh the risks linked to the proposed treatment plan. The other disadvantages to JP of approving the proposed treatment plan are not such as to outweigh the overall medical advantages to her of approving it. The reality is that this is a case where the proposed treatment plan is the least worst option. There is no ideal solution.*

Postscript

Because of the way in which the application had been brought, Williams J had had to make his order first and then finalise his judgment subsequently. Before it was finalised, he received:

> 48. […] *the happy news that JP has indeed gone into labour, I believe on the 19 June, and had delivered her baby without the care plan I had authorised being implemented. Thus JP, against my evaluation of the probabilities, was able to give birth to her baby naturally. The capacity for individuals to confound judges' assessments is a reminder (to me at least) of the gap between probability and actuality.*

It is not obvious from the postscript whether JP's baby was, in fact, removed.

Comment

This case stands as a reminder both of the 'high-end' nature of the interventions that the Court of Protection can be invited to make in obstetric cases, and of the importance of ensuring that where judicial endorsement for such interventions are being sought that the need is recognised at an early stage. It also serves as a reminder of the need for in care in establishing the nature of the material impairment or disturbance in the functioning of the mind or brain and the causative nexus between that impairment/disturbance and the functional inability to make the decision in question. And, as the judge wryly noted, the outcome of the case shows that the assessment and determination of capacity is as much an art as it is a science (hence, by way of shameless plug by Alex, the importance of the work being done under the auspices of the Mental Health and Justice project to refine the practice of that art).

Finally, in terms of representation, this case could be added to the list of those discussed in this article where we might feel uneasy at the "best interests" construction of the function of litigation friends. Whilst there is no reason at all to think that all concerned with the Official Solicitor's office did not direct themselves very carefully before agreeing with the plan as being in JP's best interests, the fact remains that she did not have anyone before the court actively advancing arguments supporting her clear wish to retain autonomy over what happens and her body.

Medical treatment, best interests, and the desire to live

Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust v TG & Anor [2019] EWCOP 21 (Cohen J)

Best interests – medical treatment

Summary

If proof were needed that *Bland* has politely been consigned to the history books, it can be found in the decision in *Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust v TG & Anor* [2019] EWCOP 21 which appeared on Bailli several months after being decided in February 2019.

The case concerned the question of whether it was in the best interests for intubation to continue for a woman, TG, an inpatient in the critical care unit of the Royal Bournemouth Hospital. TG had been at church 16 December 2018 when she collapsed, having suffered a massive subarachnoid haemorrhage, and then a secondary cardiac arrest.

Some 8 weeks later, TG still had her endotracheal tube in place. She was attached to a ventilator but received little support from it in the sense that it was not something that appeared to be an important part of keeping her alive and it was anticipated that she will be likely to be removed from it within the near future. The scans which have taken place and the EEG sequences show that TG had suffered severe cerebral dysfunction and that there is very extensive damage to the cerebral cortex. There were no wave patterns which suggest sentience. She was in a vegetative state at the moment. She had eye opening and blinking and had some movements to her right shoulder and neck area. It did not appear that her level of consciousness or the degree of responsiveness hadchanged significantly over the course of the eight weeks since her arrest.

The agreed medical evidence, including from the independent expert, was that the chances of meaningful improvement were very small and there was no chance of meaningful recovery. The independent expert considered that there was

> *8. a small chance of recovery to MCS minus which would be the best outcome. If that happened, she may be able to have awareness of pain but nothing more than minimal consciousness at a very low level.*
>
> *9. There is, he says, no chance of her recovering to a stage of MCS plus, a level which might permit very simple vocalisation and answers to basic questions and the ability to recognise someone who was close to her. That would, at best, enable her to follow with her eyes or respond to pain or touch but he says, in this case there is no chance of that degree of recovery being reached. He says her memory will almost certainly completely have disappeared and her previous personality will not emerge.*

> *10. His view, shared by the other professionals who have expressed their opinion, is that it is not in her best interests to continue with intubation and that nature should be allowed to take its course with the likely result of an early death.*

What was **not** being said on the face of the judgment, either by the Trust or the expert, that continued intubation would either (1) be clinically inappropriate; or (2) would be physiologically futile in the sense of not continuing to keep her airways clear.

The neurological expert expressed the view that, if contrary to his advice, intubation considered, it would referable in the near future for discussions to take place with the family with a view to a tracheostomy. If successfully done, his view was that this would :

> *11.* […] *enable, at least in theory, a range of other options for her care because at the moment she is confined and has been since admission to the critical care unit. If a tracheostomy succeeded then it may be that care in the community, either in a special nursing home or at home might become possible. If the tracheostomy became complicated and caused problems, that may mean that she would have to remain in hospital, albeit in a less acute unit.*

Although not stated expressly on the face of the judgment it is clear that the Trust – rightly – brought the application following because, as had been identified by the Supreme Court in *NHS Trust v Y* [2018] UKSC 46, at the end of the medical process there was a lack of agreement between the Trust and family.

The Trust took the view that there was no benefit in the continuation of treatment except the fact that TG would remain alive. Relying upon the decision of the House of Lords in *Bland* in which there was no prospect of any improvement in the patient's position,

> *18.* […] *by analogy the Trust sought to persuade me that medical treatment should not be persisted with when it is futile and secondly, that the patient in this case, as in Bland, would be completely indifferent to the medical treatment, whether it continued or not and whether she remained alive or not.*

However, Cohen J identified that:

> *18* […] *that case needs to be seen on its facts. It was, of course, a case decided before the arrival of section 4 of the Mental Capacity Act, to which the individuals wishes, feelings, beliefs and values are central feature. Certainly, in the Court of Appeal judgments in Bland, Butler-Sloss LJ as a starting point, put at the centre self-determination, and I return to that in a moment.*
>
> *19. <u>The law has moved on since Bland</u> and there are two other passage of the authorities of particular relevance. The first is paragraph 62 of Briggs (no. 2) <u>[2017] 4WLR 37</u>, where Mr Justice Charles said this:*

> *"But in my view, when the magnetic factors engage the fundamental and intensely personal competing principles of the sanctity of life and of self-determination which an individual with capacity can lawfully resolve and determine by giving or refusing consent to available treatment regimes:*
>
> *(i) the decision maker and so the judge must be wary of giving weight to what he thinks is prudent or what he would want for himself or his family, or what he thinks most people would or should want, and*
> *(ii) if the decision that P would have made, and so their wishes on such an intensely personal issue can be ascertained with sufficient certainty it should generally prevail over the very strong presumption in favour of preserving life."*
>
> *20. These matters were also considered in the case of Lambert v France* [2000] 30 EHRR 346 *(application number 46043/14), a judgment delivered by the European Court of Human Rights in June 2015. At paragraph 142 the court said this:*
>
> > *"In a case such as the present one, reference should be made, in examining a possible violation of Article 2, to Article 8 of the Convention and to the right to respect for private life and the notion of personal autonomy which it encompasses. In Pretty the Court was not prepared to exclude that preventing the applicant by law from exercising her choice to avoid what she considered would be an undignified and distressing end to her life constituted an interference with her right to respect for private life as guaranteed under Article 8 of the Convention. In Haas it asserted that an individual's right to decide in which way and at which time his or her life should end was one of the aspects of the right to respect for private life."* (emphasis added)

Cohen J therefore delved into TG's wishes, although before doing so he noted that he did not consider that the issue of indignity was one that featured large in this case, arriving at that conclusion for a number of reasons:

> *22.* […], *first of all it is quite clear from the statements made by the family and friends that personal dignity is not something that featured large in TG's life or thoughts. Secondly, I am satisfied that the issue of pain is not one that impacts in this case as it is not felt by the patient. If pain does emerge, as it might if she were to regain a minimal degree of consciousness, that should be amenable to treatment with medication*

Praising the quality of the statements of TG's husband and son, Cohen J noted that they had two principal strands:

> *24.* […]. *They have two principal strands: first, that if her presence was a comfort to others (as I find it to be) she would want to be there whatever the cost to her. Family was central to her and she would want to remain a part of the family no matter what form it would take for as long as possible. Secondly, she had the utmost respect for life because of its intrinsic value and that it was for no-one other than the Lord to take away. It is for Him alone to end and she would never accept anyone else facilitating death. I also take into account the statement of her friend M who had a discussion with*

> *her about Dignitas in the context of a programme on television and she recalls TG saying, "Why do people want to go?" before adding something like "They're not God and they don't know what will happen in the future." It is absolutely clear from everything that I have read that her Catholic faith and her belief in God were and are a crucial part of her life.*

Cohen J agreed that this represented "compelling evidence" that TG would not have consented to the withdrawal of intubation, and that her wishes and feelings and beliefs and values were plainly for the continuance of life. He noted that he had:

> *26.* [...] *asked counsel if they were aware of any case in which the court has terminated life support against the wishes of the patient and they were unable to tell me that there ever was one; with the quality of expertise before me I am sure that there must therefore not have been such a reported case.*

Into the mix Cohen J also put the fact that he was being asked to make the decision two months after injury when the Royal College of Physicians' guidance indicated that in the case of a non-traumatic injury such as this, six months is required before a vegetative state is regarded as being permanent, such that he was being asked to make a decision at a point when it was possible that when it was possible that TG might make some recovery and be able to return to live at home even if she would be unaware of the fact.

The balance sheet identified by Cohen J (reconstructed here from continuous prose) was as follows:

Benefits of removal of tube	Benefits of maintenance of tube
First, it would be the end of the process which brings, or is likely to bring no significant benefit to TG.	On the other side there is the continuation of life
Secondly, it removes the possibility of indignity and/or pain.	there is the recognition of her wishes for herself and for her family
	thirdly, it enables her life to progress and be ended in accordance with the will of God
	fourthly, it permits the possibility, faint though it may be, of some improvement in her state and
	fifthly, although this may be repetitious, it provides the ability for her to play a part in her family as she and they would wish, even though she would be unaware of it.

Cohen J therefore came to the:

> *30. [...] clear decision that it is in the patient's best interests that intubation should continue. I recognise that this places a huge burden on the treating team. It is against their advice and their wishes and of course also those of Dr Newman but I remind myself constantly, this is her life and her wishes as I have found them to be and nobody else's. It may be that if the position were to remain the same in six months' time or no successful tracheostomy had been carried out that different considerations might apply but I am not looking at the future, I am looking at things as they are now and for those reasons I reach my decision and refuse the application.*

Comment

It is clear that the courts in this context now take very seriously their task of starting with the person's known wishes and feelings and following the logical implication of those wishes and feelings to their end. That can mean stopping treatment even in the face of opposition from a 'pro-life' team; conversely, as in this case, and as in *HB* (about CPR) taking the court on P's behalf very close to (but not quite over) the line of dictating to clinicians to provide treatment that they do not consider to be beneficial. It is undoubtedly the case, as Cohen J has identified, that the law has therefore moved on substantially since *Bland*, both in the increased focus on the (near) determinative place of wishes and feelings, and in the narrowing of futility from the broader concept of not providing wider benefit to the question of whether the intervention in question would actually work – in this case, to keep TG's airways clear.

The MHA and the MCA in the community

Birmingham CC v SR; Lancashire CC v JTA [2019] EWCOP 28 (Lieven J)

DoLS authorisations – DoLS ineligibility – Mental Health Act 1983 – Interface with MCA

Summary

Two local authorities made streamlined *Re X* applications on COPDOL11 forms to authorise the deprivation of liberty of two individuals who were either about to be (SR), or had been (JTA), conditionally discharged from ss37/41 of the Mental Health Act 1983. SR had mild learning disabilities and autism and would require 1:1 supervision in the community to prevent him consuming alcohol and to prevent risk of re-offending. SR wished to live in the proposed supported living placement and was happy with the proposed care arrangements. JTA had a learning disability, communication difficulties and bipolar disorder. In 2016 the tribunal had conditionally discharged him on conditions that included one of residence and that he "*shall not be permitted to leave his accommodation unless accompanied and supervised at all times*".

There was no dispute that both individuals lacked capacity to consent to their care arrangements which gave rise to a deprivation of liberty. The fundamental issue was, in light of the Supreme Court's decision in *MM v Secretary of State for Justice* [2018] UKSC 60, it was lawful to authorise a deprivation of liberty under the Mental Capacity Act 2005. In *M*, the individual had the relevant capacity and it was held that the conditions of a conditional discharge cannot deprive liberty because the MHA does not permit it. But did the MCA permit it? This was left open by Lady Hale:

> *27. Whether the Court of Protection could authorise a future deprivation, once the FtT has granted a conditional discharge, and whether the F-tT could defer its decision for this purpose, are not issues which it would be appropriate for this court to decide at this stage in these proceedings.*

Government guidance was produced in light of the *MM* decision which distinguished between (a) those whose best interests require a care plan depriving liberty to help them perform daily living activities or self-care, and (b) those who deprivation of liberty is primarily to protect the public. It suggested using the MCA to authorise the former and MHA s.17(3) escorted leave for the latter.

Lieven J held that both SR and JTA would fall into case B of the eligibility categories because, at the time the COP order comes into effect, they would be subject to a hospital treatment regime but not detained under it. Thus, they were eligible to be deprived of liberty under the MCA so long as this was not contrary to a MHA requirement. Her Ladyship concluded that it was in the best interests of both individuals to be deprived of liberty in their respective placements. As to protecting the public:

> *41. In the case of SR, it might be argued that the purpose of the deprivation of liberty and some of the other elements of the care package is the protection of the public, rather than the care of SR. However, for the reasons given by Moor J in ZZ I think that is a false dichotomy. It is strongly in SR's best interests not to commit a further offence, or to place himself at risk of recall under the MHA, if the Secretary of State were to conclude that the risk of other offences was too great. In those circumstances the provisions of the care plan in terms of supervision and ultimately deprivation of liberty is, as Moor J put it, "to keep him out of mischief" and thereby assist in keeping him out of psychiatric hospital. This is strongly in his best interests, as well as being important for reasons of public protection.*
>
> *42. It is for this reason that I am not convinced that the division the Secretary of State makes in the Guidance between patients whose care plan is in the patients' best interests, and those where the deprivation of liberty is primarily for the purpose of managing risk to the public, is one that stands up to close scrutiny. However, on the facts of this case I have found that both patients would fall into the first category in any event.* (emphasis added)

Accordingly, Lieven J authorised the deprivations of liberty.

Comment

Parliament clearly planned for the scenario whereby a conditionally discharged patient lacking the relevant capacity could be deprived of liberty under the MCA 2005. So long as there is no compatibility (eg as to residence), such a two-pronged approach is in our view lawful. It is not entirely clear from the judgment but, in light of *M*, it would be unlawful for the MHA conditions in JTA's case to deprive liberty. Whether any watering down of the condition regarding constant community supervision was envisaged is unclear, the judgment merely observing, "*There is no inconsistency between the two orders, it is merely that under the MHA, as interpreted in M, there is no power to deprive the patient of his/her liberty. That does not prevent the MCA powers being used*" (para 46).

The approach of Lieven J also accords with that of Hayden J in an unreported CTO case determined on 5 July 2019. The Vice-President took the view that there was no jurisdictional bar to the Court of Protection authorising P's deprivation of liberty, so long as the CTO conditions did not give rise to confinement. Hayden J has given permission for the relevant recital to the order to be published, and it is reproduced below:

> ***AND UPON*** *the Court being satisfied that neither the decision in Secretary of State for Justice v MM [2018] UKSC 60, nor that in Welsh Ministers v PJ [2018] UKSC 66, prevents the Court of Protection making an order under s.16(2)(a) Mental Capacity Act 2005 authorising (by s.4A(3)) the deprivation of liberty in the community of an individual lacking the material decision-making capacity who is subject to a Community Treatment Order, so long as that Community Treatment Order does not contain conditions that on their face give rise to the confinement of the individual.*

The SR/JTA decision will enable incapacitated restricted patients to be lawfully discharged from MHA hospital detention and deprived of liberty under the MCA in the community which is a welcome development. We anticipate, however, that increasing attention will be paid to the claim that it is in SR's best interests not to commit further offences. After all, the MCA is not a policing statute. It is designed to protect P from harm. However, the consequences of *Cheshire West* are testing the boundaries of MCA ss5-6 as practitioners cry out for Article 5 procedures to authorise the expansive notion of deprivation of liberty.

Strictly speaking, para 41 is *obiter* because para 42 confirms that the best interests of both SR and JTA required a care plan depriving liberty to help them perform daily living activities or self-care. Other cases may not be so clear cut on the facts. But it is worth bearing in mind that, as the MHA Code states at para 14.10, "*it is not always possible to differentiate risk of harm to the patient from the risk of harm to others*". For no person is an island.

PROPERTY AND AFFAIRS

Fraud and vulnerability

Two new reports highlight different aspects of financial vulnerability.

Protected by Design, a new report by Demos into fraud and the vulnerable and how to protect them, published in July 2019, makes 23 recommendations mainly though not exclusively aimed at the financial services industry concerning how to protect the vulnerable from financial abuse. The recommendations range from better identification of the vulnerable and those at risk, to special products designed for vulnerable investors to a call for more oversight of LPAs (a call that will find support from the former senior judge of the Court of Protection Denzil Lush).

A Little Help from My Friends, a report from the Money and Mental Health Foundation, looks at tools to support financial decision-making for people with mental health problems. The report looks at the potential benefits of enabling third party access (for instance via powers of attorney) but identifies that existing mechanisms are felt to risk abuse, delegate excessive power, undermine privacy and be too difficult to set up and use.

News from the OPG

As highlighted in this post, Alan Eccles has retired from his post as Public Guardian and chief executive of the OPG and on 1 July Nick Goodwin was appointed to that role.

One of Alan's more notable achievements has been the greatly increased uptake of LPAs, though as noted above, there are those who feel that this is not without its problems.

The OPG has published a brief guide to how it carries out safeguarding investigations. In 2018/19 the OPG carried out 2883 investigations, an increase of about 1000 on the year before. A cause for alarm? Perhaps not when account is taken of the fact there are nearly 4m registered LPAs and deputyships.

On 12 June the OPG published its business plan for 2019/2020. It included the intent to raise awareness of LPAs and the digital future. There is a call for comments.

On 28 May the OPG updated its guidance on investment, available here.

Deputyship and legal incapacitation – don't (always) believe what you read

Bashir v Bashir [2019] EWHC 1810 (Ch) High Court (Chancery Division) (Master Clark)

Deputies – property and financial affairs

Summary

It is rare, but unfortunate, when a judge misdirects themselves as to the law, but in *Bashir v Bashir*, Master Clark did so in the context of a complicated claim seeking the order of a property, and in so doing gave a distorted picture of the effect of a deputyship appointment.

The claimant lacked capacity to conduct litigation, and sued by his litigation friend, who was also his property and affairs deputy; the defendant, his sister, also lacked capacity and defended the claim by her litigation friend, who appeared in person. The underlying facts of the claim are complex, and for these purposes irrelevant, save and to the extent that they turned upon the question of whether there was a binding agreement between claimant and defendant. The claimant had suffered a brain injury in a criminal assault; his affairs were managed initially by his sister before she was removed as a deputy following an investigation.

Master Clark raised as a preliminary issue, of her own motion, the question of whether "*even if the claimant had regained capacity by the date of the alleged settlement agreement, he could enter into a binding agreement whilst he remained under the jurisdiction of the Court of Protection*." She raised the issue at a case management hearing, but the claimant's counsel made no submissions on it in her skeleton argument, and did not refer me to any authorities on the point in her oral argument.

Master Clark nonetheless considered it necessary to consider the point. Her conclusion was as follows:

> *44. Under the framework provided for by previous legislation (most recently, s.99 of the Mental Health Act 1983), it was held that once a patient had been placed under the jurisdiction of the Court of Protection, they could not make any valid lifetime disposition of their property, even in a lucid interval: Re Beaney [1978] 1 W.L.R.770 at 772, summarising the effect of Re Walker [1905] 1 Ch.160 and Re Marshall [1920] 1 Ch.284. This was because upon the making of the order their property had passed out of his control. Any disposition was inconsistent with that control, and therefore void.*
>
> *45. With effect from 1 October 2007, Pt VII of the Mental Health Act 1983 was repealed and replaced by the provisions of the Mental Capacity Act 2005. This established a new Court of Protection with more comprehensive powers (along with a new statutory office of Public Guardian). The 2005 Act provides that the Court may by order make decisions on behalf of the person incapable or may appoint a "deputy" to make decisions on his or her behalf. The deputy will have such powers as the court determines. The role of the deputy is therefore similar to that formerly of a receiver under the Mental Health Act.*
>
> *46. There appears to be no direct authority on the effect of the appointment of a deputy on the patient's ability to dispose of or deal with property: in this case, his rights against the defendant in respect of the judgment debt. However, in my judgment, the principle established under the previous legislative framework applies to mentally incapable persons within the jurisdiction of the new Court of Protection. In this case, the order of 19 August 2011 conferred general authority on Ms Giles to take possession or control of the property and affairs of the claimant; and any purported disposition or dealing with that property would be void.*

> *47. It follows that even if the claimant had regained capacity during the relevant period, he could not, as a matter of law, enter into a binding agreement with the defendant.*

Master Clark, in the alternative, decided that on the evidence before the claimant did not, in fact, have the capacity to enter into the agreement in question.

Comment

It is unfortunate, and perhaps reflecting the fact that Master Clark was not given assistance by the parties, that Master Clark's conclusions in relation to the effect of deputyship was reached without consideration of s.20(1) MCA 2005, which provides that "[a] *deputy does not have the power to make a decision on behalf of P in relation to a matter if he knows or has reasonable grounds for believing that P has capacity in relation to a matter*." This provision, which had no equivalent in Part 7 Mental Health Act 1983, means that the framework in relation to deputyship is no longer the legal incapacitation which occurred upon the appointment of a receiver, but is intended to be calibrated to the **current** ability of P to make the decision(s) in question. It is reflected in the standard wording of the deputyship order, which provides that the deputy is appointed "to make decisions on behalf of X that he/she is unable to make for him/herself in relation to his/her/property and affairs." *Re Walker* and *Re Marshall* are therefore no longer good law.

Because of the way in which she approached matters in the alternative, Master Clark's ultimate decision does not appear on its face impugnable, but it should be emphasised that the claimant's legal incapacity to enter into the decision did not flow from the fact that he was subject to deputyship, but rather from his mental incapacity in relation to the specific decision.

Deputyship can undoubtedly serve as a tool for legal incapacitation if not properly utilised, in particular if the deputy does not (as they are bound both by statute and the orders appointing them) abide by the principle in s.1(3) MCA 2005 that a person is not to be taken as unable to make a decision unless all practicable steps have been taken to support them. But the decision in *Bashir* does not stand as authority to suggest that the compatibility gap between the MCA and the CRPD (and/or the CRPD as interpreted by the Committee) is anywhere near as great as paragraphs 46-7 would make it appear.

PRACTICE AND PROCEDURE

Court of Protection fees

With effect from 22 July, and via The Court Fees (Miscellaneous Amendments) Order 2019, Court of Protection fees are changing. Application fees are reduced to £365; appeal fees to £230 and hearing fees to £485. A new filing fee with the Supreme Court Costs Office of a short form of a full bill of costs is £85, replacing the previous £115 for short form, and £225 for a full bill.

Contingency planning and the Court of Protection

United Lincolnshire Hospital NHS Trust v CD [2019] EWCOP 24 (Francis J)

Mental capacity – best interests – birth arrangements – medical treatment

Summary[5]

Francis J has grappled with a subject that has been perennially difficult for practitioners: what to do where a person currently has capacity to make a relevant decision but it is likely that they may lack it in due course. Can the Court of Protection be involved, or is it prevented from doing so on the basis that the person, at present, does not fall within its jurisdiction? As Francis J noted, it is surprising that there has been no reported decision upon this to date (although in a judgment alluded dating back to 2009, the current President, Sir Andrew McFarlane had done so).

The case arose in the context of a woman with schizophrenia, detained under the MHA 1983. She was 35 weeks' pregnant, and question of the arrangements for her birth. As Francis J summarised it:

> *The difficult and, I am told, novel issue that arises in this case is that it is common ground among the treating clinicians that CD does not presently lack capacity to make decisions in respect of the birth and the treatment and necessary procedures in connection therewith. However, based on her history, her clinicians are agreed that there is a substantial risk that she may become incapacitous in relation to such decisions at a critical moment in her labour. CD also suffers from polyhydramnios (excess of amniotic fluid in the amniotic sac). At that point, defined as once either CD's membranes have ruptured or CD's waters have broken, the clinicians agree that there would almost certainly be insufficient time to make a renewed application to the court, even though I have agreed to make myself available by telephone throughout the day and night for this case so far as consistent with other professional obligations.*

The Trust therefore asked for anticipatory and contingent declarations, allowing for interventions (including those amounting to a deprivation of liberty) to take place in the event that CD lacked the relevant decision-making capacity.

Francis J went through, in turn, each of the five possible ways in which the court could proceed, as

---

[5] Katie having been involved in the case, she has not contributed to this summary.

identified by the Official Solicitor.

The first was to bring the proceedings to an end, on the basis that CD did not currently lack capacity to make decisions for herself. However,

> *The practical position, however, is that if (as those treating CD consider very likely) CD subsequently loses capacity to make decisions about her delivery, this is likely to be in an urgent situation where a renewed application would cause unacceptable delay with potentially catastrophic consequences as discussed above. In my judgement it would be dangerous and plainly wrong to do nothing. This court cannot and will not take what is regarded by all as an unacceptable risk. If, as has been summarised above, a medical emergency were to arise and if it were to be determined that CD has again lost capacity to make decisions about herself, the treating clinicians would find themselves in the invidious position of possibly carrying out invasive surgery and administering anaesthetic or other drugs without lawful authority.*

The second was to adjourn the proceedings, but Francis J considered that this was possibly, if not probably, have the effect of leaving things too late and insufficient time for an emergency order to be obtained.

The third was to make an interim order pursuant to s.4B, which authorises the deprivation of liberty "*while a decision as respect any relevant issue is sought from the court*." However, Francis J considered that it was not appropriate:

> *Whilst I agree with Mr Patel that all three conditions of subsection 4B could be said to be met in the circumstances of this case, the court is fully seized of the issues and I am in a position to make a decision now. I agree with the submission made by Mr Patel on behalf of the Official Solicitor that using section 4B to make an interim order would be a device to fit CD's circumstances within section 4A/B. It would involve adjourning the s16 order until after the birth, which is entirely artificial since it is in relation to treatment <u>during labour</u> that the issue arise.* (Emphasis in original).

The fourth was to make a final order. Francis J acknowledged that he was:

> *not currently empowered to make an order pursuant to section 16(2) because the principle enunciated in section 16(1), namely incapacity, is not yet made out. However, as I have already said, there is a substantial risk that if I fail to address the matter now I could put the welfare, and even the life, of CD at risk and would also put the life of her as yet undelivered baby at risk. As I have said, I am not prepared to take that risk. I am prepared to find that, in exceptional circumstances, the court has the power to make an anticipatory declaration of lawfulness, contingent on CD losing capacity, pursuant to section 15(1)(c).*

Francis J made clear – as was agreed before him – that he was doing so on the basis that:

> *For so long as CD retains capacity to make decisions about her obstetric care and the delivery of a baby, she will of course be allowed to do so, even if those decisions are considered to be unwise. If, however, her mental health deteriorates and she loses capacity I consider that it would be in the best*

> *interests to try for a normal vaginal delivery if possible and this is consistent with either CD's expressed wish or best interests. The care plan drawn up by the applicant records the expectation that CD will comply with what is proposed but also includes fall back options, including for appropriate minimal restraint, should this not be the case. Restraint would potentially be used to transfer her to the maternity suite, insert a cannula (although only if medically required) or provide general anaesthetic in order to proceed to a caesarean section. A caesarean section would be very much a last resort.*

In terms of the form of the order, and picking up on a discussion in the *Court of Protection Practice 2019*, which had identified that it was not entirely clear whether indications as to when lack of capacity would arise should be in the declaration itself, or in the accompanying judgment (cross-referenced to in the recital to the order), Francis J considered that any anticipatory order should be made in the declaration itself, rather than in an accompanying order:

> *It is the declarations and orders of the court which authorise the applicant to take the particular course of action, not the wording of the Judgment. Moreover, these cases are by definition going to be urgent and a hospital trust, or other person with the benefit of such an order, will not want to be trawling through what could be a long Judgment. I am not in any doubt that, if making such a declaration, it needs to be on the face of the court order.*

Finally, Francis J considered the inherent jurisdiction. He considered it "*obvious*" that he should work within the MCA 2005 if it all possible. However, he observed:

> *were it necessary for me to say that the unusual circumstances of this case are not covered by that Act, I would have no hesitation in making an order pursuant to the inherent jurisdiction if faced with a situation where the choice is to make such an order or to risk life itself.*

Comment

Alex having been involved in the unreported case before McFarlane J in 2009 noted by Francis J, and others on the team having had unreported cases involving similar issues, we can confirm that it is immensely helpful that we now have a reported decision in which the court has considered and determined the question of what to do in the situation where the person currently has capacity, but it is sufficiently foreseeable that they may lack capacity in due course that proper contingency planning should be undertaken.

Perhaps counter-intuitively, the difficulties that arose here do not exist outside the court arena, because the question is at any given time whether the relevant person carrying out the fact reasonably believes that the individual lacks capacity. It appeared, though, that the court might be (inadvertently) rendered unable by the wording of ss.15/16 MCA 2005 to play sensible part in 'high end' contingency planning of the nature in contemplation here. The flight-path through those jurisdictional hoops has now, helpfully, been made clear.

Turning to the perinatal setting more specifically, this case would appear to be a paradigm example of one in which advance care planning might have obviated the need to come to court at all. That might have required some careful consideration of (1) whether CD could consent to what would otherwise be a deprivation of her liberty if she did, indeed, need to be confined in her own interests during the course of her birth; and (2) the circumstances under which one could seek to refuse a Caesarean section by way of advance decision to refuse medical treatment (a question which may be as much ethically demanding as it is legally demanding).

Costs and s21A applications

BP v LB Harrow [2019] EWCOP 20 (District Judge Sarah Ellington)

COP jurisdiction and powers – costs

Summary[6]

This was a s.21A MCA 2005 application made on behalf of "P" who objected to being in a care home. He wanted to return to the family home, where his wife lived. His family were opposed to his return home but declined to become parties to the application or to make any formal statement to the Court.

On behalf of BP, the Official Solicitor eventually sought a trial period at home: this was on the basis that a standard authorisation had imposed a condition that such a trial be conducted but the condition had not been complied with and because BP wanted to return home.

The local authority consistently opposed a trial at home, until the morning of the first day of the 2-day final hearing. The local authority had maintained that opposition at a round table meeting in August 2018.

As a result of the local authority's offer of a trial period at home, the final hearing was adjourned, the trial at home took place, and it resulted in P being returned to the care home within a relatively short time. Final orders were agreed that it was in P's best interests to remain at the care home. On behalf of BP, the Official Solicitor sought an order that the local authority pay the costs of the final hearing claimed in the region of just over £10,000 excluding VAT.

The Judge held that there had been no new information and no change of position between the local authority's refusal to agree to a trial period at home during the round table meeting three weeks before the hearing, and their offer to facilitate a trial period at home on the morning of the first day of the trial.

DJ Ellington's approach to the costs application was to conclude that the conduct of the local authority did not to the necessary degree "*represent a blatant disregard of the processes of the Act and the Respondent's obligation to respect BP's rights under ECHR as in [Manchester City Council v. G, E and F [2010] EWHC 3385]*" (paragraph 40). She therefore made no order as to costs, although she noted that breach

---

[6] This draws in part, and with thanks, upon the report prepared by Sian Davies for the 39 Essex Chambers.

of a condition of a standard authorisation would be relevant pre-action conduct for the purposes of CoP Procedure Rules 19.5(2) in relation to costs:

> *…the standard authorisation granted in November 2017 was subject to a condition that the Managing Authority was to work with social services and BP's family to arrange trial periods at home. No trial period at home was arranged. This would be relevant pre-action conduct for the purposes of Rule 19.5 (2).*

Comment

The decision not to award costs against the local authority is somewhat surprising. The judge had pointed out during the judgment that the January 2019 hearing was the second two day hearing in this matter which had not been effective. Thus the court had allocated four days of court time to this case which had not been used. Given the pressure on the Court of Protection, there is a real need for parties to come to early decisions about cases that can be compromised so as to free the courts up for those cases that need judicial intervention. There will of course always be those cases which cannot be compromised until the last minute because new evidence/information is still emerging, but this was not such a case. The local authority appears to have simply changed its mind at the very last minute.

It seems to us that the Court could have come to the opposite conclusion on the facts of this case given the duty on the court to give effect to the overriding objective (see COP Rules 2017 rule 1.1 which includes dealing with cases justly and at proportionate costs which means saving expense and allotting to each case the appropriate share of the court's resources having regard to the need to allot resources to other cases).

Litigation friends and firm views

A considerable time after the substantive decision was published, an important procedural judgment in the case of *D* has now been published ([2016] EWCOP 67), in which the mother of a soldier with a serious brain injury was found not to be an appropriate litigation friend in proceedings to determine whether it was in his best interests to travel to Serbia to undertake stem cell therapy.

D's mother, who had brought the application on his behalf, had firm views as to the merits of the proposed treatment, but "*rightly refer*[red]" Baker J "*to authority* [presumably *Re AVS*] *that the fact that a proposed litigation friend has a view as to the outcome does not disqualify that person from acting as litigation friend.*" The Ministry of Defence contended that D's mother could not, because of her firm views, fairly and competently conduct proceedings on his behalf.

Baker J noted that:

> *15. In the course of argument, I was referred to the decision of Charles J in Re UF [2013] EWHC 4289 (COP). The facts of that case are somewhat different from those of the present case. In particular, it should be noted that that case concerned a dispute between family members as to the right course*

> *to be taken in respect of P. It does, however, in my view, provide important guidance, albeit only from the court of first instance, and I note in particular the observation of Charles J at para.21 onwards of the judgment, where he says:*
>
>> *"… it seems to me that Rule 140 must be read and applied in the context of the overriding objective and having regard to the circumstances of each case. The overriding objective is set out in Rule 3 as follows:*
>> *'(1) These Rules have the overriding objective of enabling the court to deal with cases justly and having regard to the principles contained in the Act.*
>> *(2) …*
>> *(3) Dealing with a case justly includes, so far as is practicable –*
>> *(a) ensuring that it is dealt with expeditiously and fairly;*
>> *(b) ensuring that P's interests and position are properly considered;*
>> *(c) dealing with the case in ways which are proportionate to the nature, importance and complexity of the issues;*
>> *(d) ensuring that the parties are on an equal footing;*
>> *(e) saving expense; and*
>> *(f) allotting to it an appropriate share of the court's resources, while taking account of the need to allot resources to other cases.'"*
>
> *16. As to the application of the principle on the facts of that case, Charles J continues, at para.23:*
>
>> *"I agree that members of a family, even if there is a family dispute concerning P's best interests could, albeit I think rarely, appropriately act as P's litigation friend in proceedings relating to that dispute. However, it seems to me that he or she would need to demonstrate that he or she can, as P's litigation friend, take a balanced and even-handed approach to the relevant issues. That is a difficult task for a member of the family who is emotionally involved in the issues that are disputed within the family and it seems to me an impossible task for AF to carry out in this case. One only has to look at her statements to see that she is clearly wedded to a particular answer. You do not see within her statements a balanced approach or anything approaching it, such as: 'This is the problem. These are the relevant factors for and against'. That is not a criticism. Rather it seems to me that it is a product of the result of there being long-standing family disputes and the existing clear divisions of opinion within the sibling group as to what will best promote UF's best interests."*
>
> *17. Although, as I have said, and is clear from the passage I have just recited, the decision in Re UF concerns a case where there was a dispute within the family, it seems to me that the approach and principles identified by Charles J are relevant to this case, and indeed all cases where the court is considering whether a family member can act as a litigation friend.*

Baker J had no reason to doubt that D's mother was motivated solely by what she believes to be in the best interests of her son: "*I accept that she only wants what is best for him and that she would not take any action which she thought would cause him harm or expose him to unnecessary risk.*" Baker J rejected the suggestion that she may have influenced her son:

> *19.* […] *to express views that he has expressed, positive views, about the prospect of the stem cell treatment. At the moment, I do not accept any suggestion that she has unduly influenced D to express such views. I acknowledge that she has supported the proposal that an independent expert be instructed to provide an opinion before the court makes its decision. On the other hand, it does seem to me that she is, to use the phrase adopted by Charles J in Re UF, "clearly wedded" to the view that this treatment is in D's best interests.*
> *20. My impression is that, although she is not unshakeable in that view, it would take a lot to lead her to change her mind. Now, I do not blame her for holding that position. I can well understand a parent in that position taking that approach but, having regard to the overriding objective which underpins procedures in the Court of Protection, in particular the need to ensure that a case is dealt with expeditiously and fairly, and that P's interests are properly considered, and that the case is dealt with in a way that is proportionate to the nature, importance and complexity of the issues, it does seem to me that it may be difficult for her to act as a litigation friend with the degree of competence and fairness required in this case, which seems to me to raise unusual, indeed seemingly novel, issues for this court.*

Baker J therefore invited the Official Solicitor to act as litigation friend in the proceedings. Presciently, he noted that nothing in his procedural judgment should be read as implying that he had formed any view of the ultimate outcome, and that "[t]*he court's obligation is to make a best interests decision on the basis of all the evidence, including D's own wishes and feelings and the views of members of his family*." As we know, Baker J ultimately, and in the face of submissions to the contrary from not just the Ministry of Defence but also the Official Solicitor on D's behalf, found that, in principle, it was in his best interests to go to Serbia to undertake the treatment, D's wishes and feelings being central to his determination.

Mediation in the Court of Protection

Charlotte May, whose work we have been following and supporting for some time, has published her research 'Court of Protection Mediation Research: Where are we in the UK?' which can be found here.

The research analysed 25 MCA cases that had been mediated. The majority of them were mediated prior to Court of Protection proceedings being issued. The issues covered in the mediation case studies included residence, care, contact, finance and property, statutory wills and medical treatment.

The research makes findings on a number of issues including the best time to mediate, the best way to facilitate P's participation in the mediation, what the key obstacles to parties engaging in mediation are, the levels of awareness of mediation and whether the mediation made matters worse or better. Of considerable interest is the fact that there was an overall success rate of 77% over the 25 cases and in 59% the agreements were incorporated into a court order.

The key recommendations coming out of the research related to (i) improving awareness as to how to secure P's participation in the mediation; (ii) raising awareness about mediation among those engaged with mental capacity law; (iii) seeking clarity as to when funding for mediation is available, either through P's estate by way of judicial order or by the Legal Aid Agency providing guidance and clarification as to when legal aid is available; and (iv) making recommendations as to the skills required of mediators mediating such disputes.

Charlotte May is part of the working group (along with Katie) implementing a Court of Protection mediation scheme which will launch this Autumn.

Mediation and participation

Separately to the project outlined above, Dr Jaime Lindsey of the University of Essex is undertaking a research project on impact of mediation on participation in Court of Protection cases (this is separate from the evaluation of the CoP scheme that Katie Scott asked me to be involved in). She is after legal and mediation professionals who have experience of mediated mental capacity disputes to complete a short survey available here. In addition to the survey, she will be carrying out interviews with non-legal participants in mediations (including P, P's family and other professionals).

THE WIDER CONTEXT

ENGLAND, WALES AND NORTHERN IRELAND

National Mental Capacity Forum Third Annual Report

Baroness Finlay, Chair of the National Mental Capacity Forum, published on 11 July her 3rd annual report. The report details work done over the past year, and the Forum's priorities for the next year, as follows:

> 1. *The Code of Practice for the MCA must be revised and updated, using real-life examples from events that have occurred over the past ten years.*
>
> 2. *Specific guidance in the Code of Practice must be produced on the new Liberty Protection Safeguards to ensure a timely roll-out of the new assessment processes and associated areas, with evaluation of the effectiveness of the new system when a person is being deprived of liberty.*
>
> 3. *The rights and ability of people to form a relationship and show affection, including sexual expression of affection, between consenting adults needs review because assessment of capacity to enter into a sexual relationship is often restrictive and may be seriously impairing the Article 8 rights of some people.*
>
> 4. *Supporting people to make their own decisions needs promotion to ensure that the support builds on the strengths and abilities of the individual. The principle of support must not be used as a way to coerce a person into making the decision that others wish them to agree to.*
>
> 5. *The term Persistent Vegetative State should be abandoned in favour of Profound Persistent Disorder of Consciousness.*
>
> 6. *A specific report needs to be commissioned into the deterioration in culture that occurs in some care settings, particularly how it relates to ongoing training and other aspects of individual staff support provided in these settings.*

Sex, dementia and consent

On 3 July 2019 The Guardian published an article by Juliet Rix on "Sex and dementia: the intimate minefield of consent in a care home". In particular, the article examined the difficult conflict between an adult's human right to choose their relationships (including the right to make "bad" decisions) and the need to ensure sexual activity is consensual and protect vulnerable people from abuse. Alex is featured in the article, observing that "*the* [legal] *bar for capacity to consent to sexual relations is deliberately set quite low*"; just because somebody lacks capacity to handle their bank account does not mean they can't consent to sexual relations. With this in mind, "[m]*anagers need to have big shoulders and not be too risk-averse*." He also suggests that it would be helpful for the CPS to publish guidelines clarifying the likelihood of prosecution in the context of a loving relationship where nobody believes there is any problem.

Getting learning disabled and autistic people out of Assessment and Treatment Units and long stay mental health hospital beds

In May 2019 the team behind the Rightfullives project were asked by a journalist what sort of changes they would like to make to the inpatient hospital system and the way in which people with learning disabilities and autistic people are supported. Because the journalist was in a hurry, they quickly came up with their Eight Point Plan, but they knew that their ideas on their own were not enough so during May and June they consulted on their plan, and the result of the consultation and their revised Eight Point Plan can be found here (on the excellent "My own front door" website, an online magazine and web-resource for self-advocates, families, practitioners and everybody campaigning for the rights of autistic people and people with learning disabilities).

Know your rights

The British Institute of Human Rights have recently launched an online 'Know Your Human Rights' Tool, aimed – in particular – at people with mental health or mental capacity issues, and those who advocate on their behalf, including formal advocates, families and carers. It aims to give information about how human rights can help individuals have more control over their own life and be treated with dignity and respect. It gives you tips on how individuals can identify whether an issue they have with their care or treatment is a human rights issue, through a step by step online process. It gives suggestions about how individuals can use human rights to overcome these challenges using real life examples.

Although primarily designed for those on the receiving end of services, the tool is also likely to be of real assistance to those who are delivering services and seeking to do so in a human rights compliant fashion. We hope that the BIHR can, in due course, develop equivalent tools expressly designed for such professionals to accompany their excellent fact-sheets and face-to-face training.

The CQC on the MHA Code of Practice

The CQC has published a report into how the Mental Health Code of Practice is being used since its last update in 2015.

Disappointingly, its review found that providers still lacked understanding on how to promote, apply and report on the guiding principles of the Code and were, as a result, failing to support staff sufficiently to enable them to have meaningful and productive conversations with patients.

The CQC, understandably, highlights the recommendations that it makes to those charged with revising the main MCA Code of Practice, and drawing up the new LPS Code (whether separately or as part of one master code).

Reducing the need for restraint and restrictive intervention

Whilst we await the Joint Committee on Human Rights' report into its inquiry into detention of children and young people with learning disabilities and/or autism, the Government has issued guidance on how to support children and young people with learning disabilities, autistic spectrum conditions and mental health difficulties who are at risk of restrictive intervention.

Almost the most important part of the guidance is this paragraph:

> *NHS and local authority commissioners will need to assure themselves that the providers of the services they commission have the necessary knowledge, skills and competencies to support effectively those whose behaviour challenges and have arrangements in place to promote positive behaviour, reduce risk, and eliminate unnecessary or inappropriate use of restraint. This includes assuring themselves that providers of care and/or education services meet the needs of the children and young people concerned; providers are regularly and rigorously reviewed; and that failure to comply with contractual obligations leads to prompt action to safeguard and promote the welfare of children. Settings and those who commission services should ensure that the services they commission are consistent with the advice in this guidance.*

Social workers and a new Mental Health Act

In May All-Party Parliamentary Group (APPG) on Social Work and the British Association of Social Workers (BASW) launched a new inquiry: Social Workers and a New Mental Health Act. The inquiry was established in response to the Independent Review of the Mental Health Act 1983, published in December 2018 and chaired by Sir Simon Wessely. The APPG proposed to look at the role that social workers play in upholding these principles and how that role could be enhanced in new legislation. The report following that inquiry has now been published and sets out 9 recommendations designed to

> *address the importance of supporting the social work profession in upholding the values of the social model and as professionals at the heart of successful integration. These recommendations have been chosen for their potential to be included in new legislation, but their successful implementation would have a much wider impact.*

Older people, the police and CPS

Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services and Her Majesty's Crown Prosecution Service Inspectorate have published a report entitled "The Poor Relation," examining the police and CPS response to crimes against older people. As the foreword notes:

> *Crime against older people isn't well understood, despite the vulnerability of older people and the importance that society attaches to looking after people in their old age. There has been little police analysis of the problem, including the links to disability hate crime and domestic abuse. We found that police forces had only a superficial understanding of the problems, although all had recognised that fraud was an increasingly common concern for older victims.*

> *No single national group or body exists to co-ordinate the work of criminal justice agencies to monitor and improve the response to crimes against older people (in the same way as there are, for example, joint policing and CPS working groups). This affects the understanding and grip on crimes against older people nationally. For example, we were concerned to find that the number of crimes against older people referred by the police to the CPS has declined for two consecutive years, but there has been no co-ordinated action to find out why and what should be done.*
>
> ***The police and the CPS need to work together better***
>
> *The police alone cannot solve these problems. For example, we believe they can find better ways of working with the CPS. A significant first step would be to agree a simple joint definition for what we mean when we talk about 'crimes against older people'. This could recognise that old age does not itself make someone more vulnerable, but that when older people do become the victims of crime they are more likely to require extra support.*
>
> *We believe the police can bring more focus and co-ordination to crimes against older people by developing a strategy to outline what steps the police service needs to take to address some of the current challenges, and to prepare for the future.*
>
> *In this way, more focus can be brought to the problem and the links with, for example, domestic abuse can be understood better. This should also help to improve the response to vulnerable older people when they are victims of crime, matching the work we have seen in other areas of vulnerability such as child and domestic abuse.*
>
> *For an increasingly ageing population with a disproportionate amount of complex needs, we believe that this approach is now necessary to kickstart the change we need.*
>
> ***We have concerns about adult safeguarding arrangements***
>
> *In this inspection, for the first time, we assessed adult safeguarding arrangements. Our findings are of grave concern.*
>
> *Adult safeguarding was described to us as the 'poor relation' of safeguarding arrangements, with inconsistent local partnership work to consider what protections or support might need to be put in place for vulnerable adults. Forces told us of a focus on children over adults, and we found a lack of understanding of what their duties were under the Care Act 2014 regarding adults at risk.*
>
> *We found that from national policy and training, through to safeguarding practice in forces, much work is needed to make sure that older people – and adults at risk more generally – receive a consistently good service, and that the police work effectively with others.*

Dementia and disability

The All Party Parliamentary Group on Dementia has published a new report, "Hidden no more: Dementia and Disability." The report expressly seeks to frame itself by reference to

> *the social model of disability which views people as being disabled primarily by barriers in society, not by their impairment or difference. The social model, on which the CRPD is founded, suggests that there are a number of factors which create or contribute to the challenges, exclusion and discrimination faced by people with dementia. These factors are the social arrangements, behaviours, norms and practices in wider society. It is these environmental factors and personal attitudes that need to be addressed in order to tackle disability in society, and not the individual impairments related to dementia. Both the CRPD and the Equality Act use the language of 'impairment', not 'diagnosis', because of the prejudice, stigma and discrimination that medical diagnoses can generate (especially in psychiatry).*
>
> *The APPG challenges the mainstream biomedical model of disability, which (in contrast to the social model) views disability as a product of an impairment or difference in the individual. The biomedical model looks at what is 'wrong' with the person, rather than what they might need to have independence, choice and control. Respondents to the inquiry also highlighted the 'medicalised language' which is often used in relation to dementia. This language can perpetuate the idea of something being 'wrong' with the person, and neglect the role that public services and society have in enabling people with dementia to live well. '*

The APPG noted that

> *Our research revealed a very important finding: 81% of respondents to our online survey confirmed that they see dementia as a disability and that it should be identified as such. This was confirmed by the majority of people in our focus groups and those who provided us with written evidence. However, it was clear that many respondents were still defining disability in terms of the individual's challenges, rather than a wider social challenge. This indicates that the biomedical model of understanding disability is probably more common than a social model of understanding disability.*

'The APPG report set out recommendations in order to change the way government, the public and organisations think about dementia, detailing how social change and inclusion can become a reality for people with dementia in six key areas of daily life: employment, social protection, social care, transport, housing and community life. The report highlights the need for particular changes in the field of employment where people with dementia are at significant risk.

Advancing our health: prevention in the 2020s

Almost the last thing done by the Government under the May regime was to publish a consultation on preventative measures to secure the health of the public in the 2020s. For present purposes, of most relevance and interest are the discussions of the steps that can be taken in relation to dementia, and also the steps recognising the social determinants of mental ill-health.

Short note: capacity and appealing unfitness to stand trial and its consequences

In *R v Roberts* [2019] EWCA Crim 1270, the Court of Appeal (Criminal Division) considered what to do where a person found unfit to be tried under s.4 of the Criminal Procedure (Insanity) Act 1964 and (under s.4A) to have committed the acts underpinning the prosecution sought, themselves, to appeal against the finding that they had committed the acts. Somewhat surprisingly, it appears that this question had not been the subject of full judicial consideration before, and the Court of Appeal therefore set out guidance for the future:

> *38* […] *once a finding of unfitness has been made and where there is a subsequent determination by the jury that the accused did the act or omission charged, it is the duty of the person appointed by the court to present the defence case to consider, as a matter of professional obligation, whether an appeal might properly lie against either determination or, indeed, against the ultimate disposal* […] *It is a matter for that person to assess whether there are properly arguable grounds. In making such assessment the appointed person may have such regard, if any, as thought appropriate to the "instructions" of the accused. That will be a matter of judgment in each case. But those "instructions" will not bind the representative: just because they emanate from a person adjudged to be unfit to participate in the trial process.*
>
> *39. If the appointed person considers that there is no arguable ground of appeal and declines to settle a Notice of Appeal, it follows that there can be no valid appeal. The accused will not be competent (in terms of mental fitness) to pursue an appeal in person: nor will the accused be competent (in terms of mental fitness) to instruct fresh counsel or solicitors to pursue an appeal on his or her behalf.*
>
> *40. However we do not think that it would be best practice for the Criminal Appeal Office, acting administratively, simply to reject such an application at the outset without there being any judicial consideration as to whether it is in the interests of justice for a person to be appointed to put the case for the applicant. We think that the better course would be first to check with the appointed representative in the Crown Court that no arguable grounds of appeal were identified as available; and then to refer the papers to the Single Judge to review the papers and consider, under s.31B of the 1968 Act, whether to give any procedural direction that such a person be appointed. If the Single Judge can find in the papers nothing to suggest properly arguable grounds then no such direction will be given and the application will be rejected by the Single Judge: and there can thereafter be no right of renewal to the Full Court. In so rejecting the application, the Single Judge will be finding that the application is to be rejected on the ground that it is ineffective by reason of lack of mental capacity on the part of the applicant to pursue it; but the Single Judge will no doubt in any event give such reasons as the Single Judge thinks fit with regard to the grounds actually sought to be advanced, in indicating that they in any event lack arguable merits sufficient to justify appointing a person to put the case. If, on the other hand, the Single Judge considers on the papers that there potentially may be arguable grounds (notwithstanding that the appointed representative in the Crown Court has identified none) then we think it a legitimate exercise of the powers available that the Single Judge be entitled to direct that fresh counsel be appointed to consider whether there are viable grounds of appeal and, if there are, to settle them and then present the case on behalf of the accused in the Court of Appeal: first before the Single Judge – preferably the same Single Judge - on the papers and then (if, and only if, leave to appeal is granted or the application is referred) before the Full Court. If fresh counsel, on the other hand, is so appointed but concludes (in common with the appointed*

> *representative in the Crown Court below) that there are no viable grounds to be advanced, then the matter is again to be referred back to the Single Judge, who will then doubtless reject the application.*
>
> *41. It may be that there could be a case where an applicant claims subsequently to have recovered mental capacity, such that he may say that an appeal can properly be pursued either by new counsel instructed by the applicant or by the applicant in person. That will not be accepted in the absence of appropriate fresh (ordinarily psychiatric) evidence. If, however, such evidence is lodged in support of the application for permission to appeal, along with the appropriate formal application for leave to adduce such evidence and any necessary application for an extension of time, then again the papers are likewise to be referred to the Single Judge: who will then consider whether it is in the interests of justice for a person to be appointed to put the case for the applicant and to give the appropriate procedural direction under s.31B.*

The Court of Appeal identified a number of further procedural issues (including in relation to legal aid), and that "*since a number of these matters* [....] *are not currently the subject of the Criminal Procedure Rules, it may be that the Criminal Procedure Rules Committee would wish to consider whether to introduce any new rules to cover the position.*"

Wales and the CRPD

On 11 June 2019 the Welsh Deputy Minister and Chief Whip, Jane Hutt, made a statement to the National Assembly for Wales entitled "An Update on Advancing Equality and Human Rights in Wales". As part of this statement she explained that consideration was being given to the implementation of the United Nations Convention on the Rights of Persons with Disabilities:

> *We're also commissioning research to explore wider options, including how we might incorporate UN conventions, including the convention on the rights of disabled people, into Welsh law. We will take an inclusive approach with regard to different aspects of equality and human rights, drawing on all available evidence, including the data from the annual population survey on ethnicity, disability status, marital status and religion that's been released this morning on the StatsWales website. And I expect this work to be complete by the end of 2020."*

INTERNATIONAL DEVELOPMENTS

Vincent Lambert update

Vincent Lambert, a former nurse who was in a persistent vegetative state for over a decade, died on 11 July 2019 after doctors decided to end life-sustaing treatment following a lengthy legal battle.

Mr Lambert had been seriously injured accident in 2008 which had left him a quadriplegic, with severe brain damage. The question of whether his life sustaining treatment should be withdrawn was the subject of a long-running legal battle between his devoutly Catholic parents, who sought to keep him alive, and his wife and some of his siblings, who argued that life sustaining treatment should be withdrawn which is what they believed would be in accordance with his wishes. The case having been to the Grand Chamber of the European Court of Human Rights in 2015, a French court decided in early 2019 that doctors could withdraw life sustaining treatment. This decision was upheld in April 2019 by France's State Council, and the process of stopping the treatment began on 3 May 2019. However, hours later a further court order was obtained by Mr Lambert's parents requiring the treatment to be re-inserted on the basis that the final decision should await the conclusion of the complaint made by his parents against France to the UNCRPD Committee. This decision was subject to a further appeal to which earlier this month reversed the decision ordering that life sustaining treatment could be withdrawn. We do not know at this stage whether the CRPD Committee will continue to consider the complaint, or whether it will deem it inadmissible now that he has died.

The social and underlying determinants of health in advancing the realisation of the right to mental health

In an important report published on 24 June 2019, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health outlines important opportunities and challenges associated with a human rights-based approach to actions on the determinants needed for mental health promotion. He argues that good mental health and well-being cannot be defined by the absence of a mental health condition, but must be defined instead by the social, psychosocial, political, economic and physical environment that enables individuals and populations to live a life of dignity, with full enjoyment of their rights and in the equitable pursuit of their potential.

The Special Rapporteur highlights the need for and States' obligations to create and sustain enabling environments that incorporate a rights-based approach to mental health, and which value social connection and respect through non-violent and healthy relationships at the individual and societal levels, promoting a life of dignity and well-being for all persons throughout their lifetimes.

The report is considerably more nuanced than some of the other reports that have been published recently in this context. As the Special Rapporteur notes:

> *10. Terminology in the sphere of mental health is a contested terrain. There is a need to accept different terms according to how people define their own experiences of mental health. "Mental health" itself can signal a biomedical tradition for explaining and understanding lived experiences, psychic or emotional distress, trauma, voice hearing or disability. The Special Rapporteur acknowledges this contested area and the importance of the health sector and the medical model when used appropriately. He challenges stakeholders to reflect on how biomedical dominance has led to overmedicalization in the health sector, particularly in mental health, diverting resources away from a rights-based approach to the promotion of mental health. The Special Rapporteur welcomes a diversity in terminology, which can promote different approaches to mental health that are equally important.*

The following passages from the report bear setting out in full:

> *48. Acceptable and high-quality therapeutic relationships (those between providers and users of services) must be based on mutual respect and trust. The Special Rapporteur regrets that trends in modern mental health legislation and clinical practices worldwide have allowed the proliferation of non-consensual measures. Coercion is widely used in mental health-care services, and there is evidence that the prevalence of coercive measures in mental health-care services is growing. These tendencies risk eroding trust in mental health services, damaging the image and reputation of mental health service providers and, most importantly, continue to raise serious concerns about systemic human rights violations in the field of mental health care.*
>
> *49. Current mental health policies have been affected to a large extent by the asymmetry of power and biases because of the dominance of the biomedical model and biomedical stakeholders with the resources and power to support meaningful transformation in global mental health is the need to close the "treatment gap". The Special Rapporteur is concerned that this message may further the excessive use of diagnostic categories and expand the medical model to diagnose pathologies and provide individual treatment modalities that lead to excessive medicalization. The message diverts policies and practices from embracing two powerful modern approaches: a public health approach and a human rights-based approach.*
>
> *50. Any effective engagement with violence as a determinant of mental health therefore needs to address the role of mental health services in perpetuating violent and paternalistic practices, which have reinforced the myth that individuals with certain diagnoses are at high risk of perpetuating violence and posing a threat to the public. There is no scientific evidence to support this myth, which is instrumentalized by discriminatory mental health laws that deprive people of liberty and their autonomy.*
>
> *51. Regrettably, many parts of mental health-care systems, such as residential institutions and psychiatric hospitals, too often themselves breed cultures of violence, stigmatization and helplessness. The models that have reinforced the legacy of discrimination, coercion and overmedicalization in mental health care should be abandoned. Efforts should be refocused towards non-coercive alternatives that respect the rights of persons with a lived experience of mental health conditions and mental health-care services. Such alternatives should address holistic well-being, and place individuals and their definition of their experiences, and their decisions, at the centre.*

Deprivation of liberty – an Irish (and CRPD) perspective

The Department of Health has published the public consultation report on its legislative proposal "*to meet our obligations under Art. 14 of the UNCRPD* [by which] *legislation is required to provide procedural safeguards to ensure that people who cannot consent to their care arrangements in relevant facilities are not unlawfully deprived of their liberty*." With masterly understatement, the Department notes that "*a number of complex policy and legal issues remain to be resolved*." The two key points to note are:

(1) The breadth and mutual incompatibility of so many of the responses (echoing consultations undertaken elsewhere);

(2) The Centre for Disability Law and Policy at the NUI Galway, which has been very influential in shaping the thinking of the CRPD Committee in relation to legal capacity, proposes (at 1.111) that the definition of deprivation of liberty "*must be broad and must include all situations in which a person has not provided free and informed consent to be in the relevant setting, or where the decision to place the person in such a setting is not made in accordance with the person's will and preferences, or where the person's will and preferences are unknown.*"

Intriguingly, the emphasised sentence is more nuanced than the approach taken in the recent report by the Special Rapporteur on the Rights of Disabilities, who focused solely on the question of whether the person has given free and informed consent. It chimes with the approach that Alex has been urging of a broader definition of the concept of "valid consent" to circumstances of confinement; an approach endorsed by the Joint Committee on Human Rights, not taken up in the Mental Capacity (Amendment) Act 2019, but still very much open for judicial consideration before the courts of England & Wales.

Deprivation of liberty – the Peruvian perspective

A recent Peruvian Constitutional Court decision has grappled in fascinating fashion with both domestic deprivation of liberty and the implications of Article 14 CRPD in the context of a habeas corpus suit filed on behalf of Juan José, a man with a chronic organic cerebral psychotic syndrome, and "profound mental retardation" (the Court's terms). He lived with his mother, who was also his legal guardian (under the substitute decision making regime that has subsequently been repealed), who had in effect caged him in his room.

We are very grateful to Renata Anahí Bregaglio Lazarte and Renato Antonio Constantino Caycho for their summary translation of the judgment (available here in Spanish).

1. The court's references to and analysis of international standards on personal liberty:

The court reviewed a number of standards in International Human Rights law relating to the right to liberty. The court began by analysing Article 14 CRPD, and the Committee's interpretation of that article. The court observed that the Committee's guidelines on the application of Article 14 do not allow for the restriction of liberty on the grounds of disability, even when there is a possible danger to the person or to other. The ruling then referred to the UNHCR's position, as well as the positions of the UN Special Rapporteurs on the Rights of Persons with Disabilities, Torture, Discrimination against Women, and Health. The court considered that the Rapporteurs adopted a position similar to that of the CRPD Committee, in the sense that they adopted the view that there was an absolute prohibition of the deprivation of liberty of persons with disabilities in international human rights law. However, the court also referred to the position of the Human Rights Committee and the Sub-Committee on the Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment and the European Court of Human Rights, to the effect that there was a standard allowing for exceptions in cases of danger to oneself or others.

Having reviewed these standards, the court held that there was no consensus in international human rights law regarding the deprivation of liberty of persons with disabilities, or the interpretation of Article 14 CRPD. The court therefore considered that, while it was clear that disability *per se* could be the only reason used to deprive someone of their liberty, the standard was unclear when disability was used as a motive in conjunction with guaranteeing the safety of the person or others.

Although at the time of the judgment there was no law regulating mental health in Peru (this had changed since), the court identified that Peruvian norms seemed to aim towards a community mental health system. Consequently, the court held that the general rule in Peru was that persons with disabilities could not be deprived of liberty on the basis of disability (real or perceived) alone. The court, however, found that it was possible to restrict personal liberty in exceptional cases, when doing so would guarantee the security of the person or others. The court held that the decision had to be taken following the necessary procedural and substantive guarantees (which were not specified), and must be used as a last resort. Furthermore, the court held that the State should move to progressively eliminate forms of treatment that require a restriction of liberties and move towards a full community-based mental health system.

2. The Court's reasons for considering that placing metal bars in the man's room was a deprivation of liberty.

The mother had placed Juan José in a bedroom, in which she placed two cage doors: one in the entrance to the patio, and on in the room's door to the rest of the house. As a result, her son was trapped in a space of some 10m.[2]

The court took the social model of disability as a premise for its analysis of Juan José's circumstances. The court held that habeas corpus suits protect freedom of movement throughout the State's territory (*stricto sensu*), and freedom to move in and out of specific places (*lato sensu*). The court then evaluated Juan José's living conditions, mentioning the following:

1. The room he was held in was poorly lit and poorly ventilated, and the windows also had metal bars in their openings and Juan José was often left home alone, locked in the room;

2. The current status quo is that he spent most of his time in the room, while his mother was at work. Although she argued that the cage doors were security measures designed to protect her, the court rejected this argument on the basis that Juan José had full legal capacity under Peruvian law as it now stood. Any concerns regarding his security should have been addressed during a supported decision-making process, without infringing his rights and dignity. With regards to personal integrity, the Court holds that any security measure should – once again – have respected his rights, will and preferences.

3. The court's final decision

The court held that Juan José's right to personal liberty had been violated, and ordered his mother to remove all metal bars and cell-like doors from Juan José's room. It held that the judge should convert the interdiction process into a supported decision making process, in the context of which appropriate security measures should be established. Likewise, the court held that Juan José's parents should take measures to ensure adequate health and living conditions for their child. Finally, the court held that – given the nature of the case – the court in charge of executing this decision should keep them informed, so as to monitor compliance with their ruling.

RESEARCH CORNER

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

This month, we highlight the fascinating and important special issue of the Journal of Ethics in Mental Health on "disordering social inclusion," with a whole host of articles looking at the complexities of 'mad studies,' including the law's place in 'Mad' movements and the role of user/refuser perspectives in law.

BOOK CORNER

Alex has been failing to get through the pile of books that he has been sent for review,[7] but of these, we should highlight in particular by way of mini-review:

NHS Law and Practice, by David Lock QC and Hannah Gibbs (Legal Action Group, 2018, £70-£100.10). One of the reasons that Alex has been failing to review this properly is because it is never on his desk in Chambers, doing the rounds continuously amongst colleagues who need to get a quick and reliable answer to one of the inordinately complicated questions that always seem to arise in the context of the law of the NHS. It is a book that does LAG, and the authors, proud, and our one request is that consideration is given to regular updates/editions so as to ensure that it retains its – rightly – authoritative status.

Safeguarding Adults and the Law: An A-Z of Law and Practice (Jessica Kingsley Publishers, 2019, third edition, £26-33.40). If there is a subject to rival NHS law for complexity, it is safeguarding. This book, thankfully now in its third edition, provides an extremely clear and helpful reference guide to issues that arise in the context of safeguarding under the Care Act 2014 Arranged in an A-Z format, and not

---

[7] He is always happy to accept books for review in the field of mental health and mental capacity law (broadly defined).

designed, in fairness, to be read through rather than mined for specific information, the juxtaposition of entries stands as a reminder of the number of practical, legal and ethical dilemmas that are encompassed under the one simple term ‘safeguarding.’

SCOTLAND

What constitutes support? Update

Readers will be aware that we have been covering the case of *MM*, on what constitutes 'support' for purposes of receipt of Personal Independence Payments. On 18 July the Supreme Court unanimously allowed his appeal in the limited sense of interpreting the relevant legal provisions differently from the Inner House. We will return to the Supreme Court's – significant decision – in the September issue.

What are sufficient averments of undue influence?

Mrs Wilson lived in a house that she owned in Kirriemuir. In 2012 her son-in-law Mr Watkins lost his job. Mrs Wilson invited Mr Watkins and his wife (her daughter) to live with her in her house. Mr and Mrs Watkins sold their own house and moved in. In 2013 Mrs Wilson executed a Disposition of the house in favour of Mr and Mrs Watkins, reserving a liferent to herself. After an incident in 2015 Mrs Wilson left the house and went to reside with her other daughter. Mr and Mrs Watkins continued to reside in the house. Mrs Wilson raised proceedings in the Court of Session against Mr and Mrs Watkins seeking *inter alia* production and reduction of the Disposition on grounds that the Disposition had been impetrated by Mr and Mrs Watkins exercising undue influence upon Mrs Wilson to their own benefit. In *Adeline Margaret Wilson against Peter Watkins and Another* [2019] CSOH 44, Lord Brodie considered whether the averments for Mrs Wilson were sufficient to entitle her to proof of her case of reduction on the ground of undue influence. In his decision dated 12th June 2019, he held that they were not. It was argued for Mr and Mrs Watkins that Mrs Wilson had not given fair notice of what her case against them was. Her pleadings lacked specification. Lord Brodie observed that this was not such a case as sometimes occurs where the person said to have been unduly influenced is deceased, nor was she "in some way facile or less than fully competent". When granting the Disposition she had received legal advice. The averments suggested that she was quite capable of understanding a legal document (and capable of independent living). It was averred for Mrs Wilson that she "did not understand what she was signing", but Lord Brodie observed that there was "little by way of context in the pursuer's pleadings to explain just what the pursuer means by it. It stands with the pursuer's bare denial of quite detailed averments by the defenders as to the giving of instructions to solicitors and the preparation and execution of the Minute of Agreement and Disposition. The pursuer does not explain what she thought she was doing when she signed such documents as she accepts that she did sign.". There were sufficient averments of a relationship of confidence and trust as between Mrs Wilson on the one hand and Mr and Mrs Watkins on the other, but Lord Brodie agreed with counsel for Mr and Mrs Watkins that "it requires the one party to be dominant or ascendant and the other party to be in some way subordinate or amenable. I simply cannot find the averments to instruct such a relationship.". Likewise, there were no specific averments of Mrs Wilson having been misled or pressurised.

Lord Brodie accepted that “there may be cases where the nature of the gratuitous benefit is so substantial and so unexpected as to raise an inference of an abuse of trust”, but that was not the case here. Lord Brodie concluded that “In my opinion, in the present case the pursuer has failed to make averments which, if proved in their entirety, entitle her to the remedy that she seeks.”.

Adrian D Ward

World Congress

Five World Congresses on Adult Guardianship have taken place at two-yearly intervals from 2010 to 2018, in Japan, Australia, United States of America, Germany and Korea. The scope of these World Congresses has expanded substantially beyond the topic of guardianship, and the concept of guardianship has come under increasing criticism in some quarters (the United Nations Committee on the Rights of Persons with Disabilities having called for the abolition of all guardianship regimes, though there is dispute as to whether that position is justified by a proper interpretation of the UN Convention on the Rights of Persons with Disabilities). The International Advisory Board, which among other functions allocates World Congresses, agreed that successive organisers might propose amended titles (and sub-titles) for the event. The 6th World Congress will be held in Buenos Aires, Argentina, in 2020, and at the request of the organisers the agreed title and sub-title will be (in English-language version):

> *6th World Congress on Adult Support and Care*
> *From Adult Guardianship to Personal Autonomy*

A further amended title has now been agreed for the 7th World Congress to be held at the Edinburgh International Conference Centre from 6th – 9th June 2022. The title and sub-title will be:

> *7th World Congress on Adult Capacity*
> *Enhancing Autonomy, Support and Protection*

Preparations for the event in Edinburgh continue.

Adrian D Ward

Book notice

“La voluntad de la persona protegida: Oportunidades, riesgos y salvaguardias” (“The Will of the protected person: Opportunities, risks and safeguards”) is the name of a major project led by Professor Montserrat Perena Vicente of Rey Juan Carlos University, Madrid, and now the name of a book published by that University, all of the chapters being based on presentations at a conference at that University on 20th and 21st September 2018. Five chapters are in English, four in French, and the remainder all in Spanish. Even for those whose language skills are limited to English, the book is worth reading. Under the title “The right to make choices: supported decision-making activities in the United

States", Peter Blanck and Jonathan G Martinis describe the background and work of the National Resource Center for Supported Decision-making, established by Quality Trust for Individuals with Disabilities, the Burton Blatt Institute at Syracuse University, and Kansas University Center on Developmental Disabilities. Pietro Franzina of the University of Ferrara (Italy), well known for his leading role in the European Law Institute Project on the International Protection of Adults, writes (in English) on: "The relevance of private international law to the effective realization of the fundamental rights of vulnerable adults in cross-border situations". Among other things, the chapter analyses the advantages of a widespread ratification of Hague Convention 35 on the International Protection of Adults. Christopher Schnieders and Elyn Saks present a "Conversation about the Saks Institute for Mental Health Law, Policy and Ethics and our focus on the mental health consumer", perhaps of particular Scottish relevance in the context of the Scott review. Our own Adrian Ward writes on; "Rights, empowerment and medical consent: the impact of Article 12 of the United Nations Convention on the Rights of Persons with Disabilities", arguing that it is a fiction to address issues of medical consent, and indeed issues generally of capability to act and decide with legal effect, in terms of the absolutes of complete capacity and complete incapacity. He demonstrates the danger that the space between these extremes can in practice be filled with a presumption of incapacity, and describes techniques, including new techniques, supportive of the exercise of legal capacity, to fill that space.

Scott review

We are pleased to report that it has now been confirmed that Kirsty McGrath, who until now has led the Scottish Government review of adult incapacity legislation, will lead the secretariat. She will be joined in the secretariat by Ruth Wilson, who has been working in Scottish Government's Mental Health Law team for the last three years. Further staff to support the review are likely to be recruited in due course.

Adrian D Ward

Editors and Contributors

Alex Ruck Keene: **alex.ruckkeene@39essex.com**

Alex is recommended as a 'star junior' in Chambers & Partners for his Court of Protection work. He has been in cases involving the MCA 2005 at all levels up to and including the Supreme Court. He also writes extensively, has numerous academic affiliations, including as Wellcome Research Fellow at King's College London, and created the website www.mentalcapacitylawandpolicy.org.uk. To view full CV click here.

Victoria Butler-Cole QC: **vb@39essex.com**

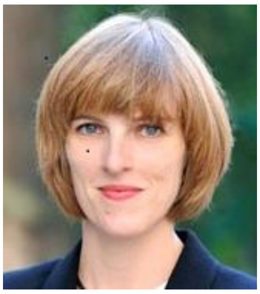
Victoria regularly appears in the Court of Protection, instructed by the Official Solicitor, family members, and statutory bodies, in welfare, financial and medical cases. Together with Alex, she co-edits the Court of Protection Law Reports for Jordans. She is a contributing editor to Clayton and Tomlinson 'The Law of Human Rights', a contributor to 'Assessment of Mental Capacity' (Law Society/BMA 2009), and a contributor to Heywood and Massey Court of Protection Practice (Sweet and Maxwell). To view full CV click here.

Neil Allen: **neil.allen@39essex.com**

Neil has particular interests in human rights, mental health and incapacity law and mainly practises in the Court of Protection. Also a lecturer at Manchester University, he teaches students in these fields, trains health, social care and legal professionals, and regularly publishes in academic books and journals. Neil is the Deputy Director of the University's Legal Advice Centre and a Trustee for a mental health charity. To view full CV click here.

Annabel Lee: **annabel.lee@39essex.com**

Annabel has experience in a wide range of issues before the Court of Protection, including medical treatment, deprivation of liberty, residence, care contact, welfare, property and financial affairs, and has particular expertise in complex cross-border jurisdiction matters. She is a contributing editor to 'Court of Protection Practice' and an editor of the Court of Protection Law Reports. She sits on the London Committee of the Court of Protection Practitioners Association. To view full CV click here.



Nicola Kohn: **nicola.kohn@39essex.com**

Nicola appears regularly in the Court of Protection in health and welfare matters. She is frequently instructed by the Official Solicitor as well as by local authorities, CCGs and care homes. She is a contributor to the 4th edition of the *Assessment of Mental Capacity: A Practical Guide for Doctors and Lawyers* (BMA/Law Society 2015). To view full CV click here.

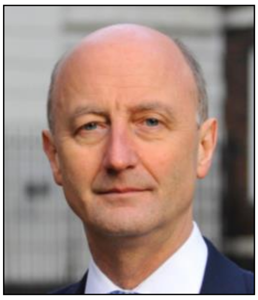
Editors and Contributors

Katie Scott: **katie.scott@39essex.com**

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

Katherine Barnes: **katherine.barnes@39essex.com**

Katherine has a broad public law and human rights practice, with a particular interest in the fields of community care and health law, including mental capacity law. She appears regularly in the Court of Protection and has acted for the Official Solicitor, individuals, local authorities and NHS bodies. Her CV is available here: To view full CV click here.

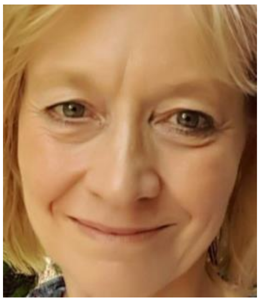


Simon Edwards: **simon.edwards@39essex.com**

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

Adrian Ward: **adw@tcyoung.co.uk**

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



Jill Stavert: **j.stavert@napier.ac.uk**

Jill Stavert is Professor of Law, Director of the Centre for Mental Health and Capacity Law and Director of Research, The Business School, Edinburgh Napier University. Jill is also a member of the Law Society for Scotland's Mental Health and Disability Sub-Committee. She has undertaken work for the Mental Welfare Commission for Scotland (including its 2015 updated guidance on Deprivation of Liberty). To view full CV click

Conferences

Conferences at which editors/contributors are speaking

Liberty Protection Safeguards: Implementation of the Mental Capacity (Amendment) Act 2019

Alex is chairing and speaking at a conference about the LPS on Monday 23 September in London, alongside speakers including Tim Spencer-Lane. The conference is also be held on 5 December in Manchester. For more information and to book, see here.

Clinically Assisted Nutrition and Hydration Supporting Decision Making: Ensuring Best Practice

Alex speaking at a conference about this, focusing on the application of the BMA/RCP guidance, in London on 14 October. For more information and to book, see here.

.

Advertising conferences and training events

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

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

Michael Kaplan
Senior Clerk
michael.kaplan@39essex.com

Sheraton Doyle
Senior Practice Manager
sheraton.doyle@39essex.com

Peter Campbell
Senior Practice Manager
peter.campbell@39essex.com

Chambers UK Bar
Court of Protection:
Health & Welfare
Leading Set

The Legal 500 UK
Court of Protection
and Community Care
Top Tier Set

clerks@39essex.com • DX: London/Chancery Lane 298 • 39essex.com

LONDON
81 Chancery Lane,
London WC2A 1DD
Tel: +44 (0)20 7832 1111
Fax: +44 (0)20 7353 3978

MANCHESTER
82 King Street,
Manchester M2 4WQ
Tel: +44 (0)16 1870 0333
Fax: +44 (0)20 7353 3978

SINGAPORE
Maxwell Chambers,
#02-16 32, Maxwell Road
Singapore 069115
Tel: +(65) 6634 1336

KUALA LUMPUR
#02-9, Bangunan Sulaiman,
Jalan Sultan Hishamuddin
50000 Kuala Lumpur,
Malaysia: +(60)32 271 1085