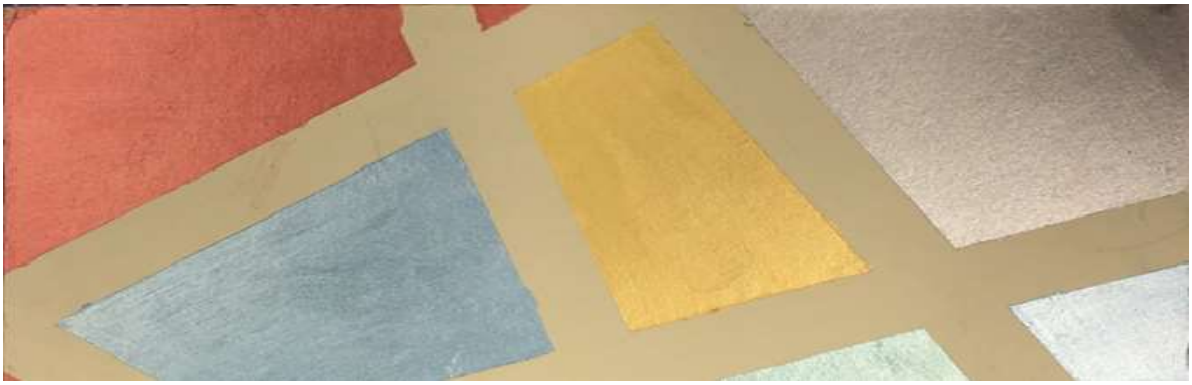

Welcome to the March 2020 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: a cautionary tale about re-using material for DoLS assessment and capacity complexities in the context of medical treatment;

(2) In the Property and Affairs Report: an important case on the limits of powers of professional deputies to act without recourse to the Court of Protection;

(3) In the Practice and Procedure Report: medical treatment – delay, neglect and judicial despair, developments relating to vulnerable parties and witnesses, and Forced Marriage Protection Orders under the spotlight;

(4) In the Wider Context Report: Mental Capacity Action Days, when not to presume upon a presumption, and a number of important reports from bodies such as the CQC;

(5) In the Scotland Report: the DEC:IDES trial.

We have also recently updated our capacity guide and our guide to the inherent jurisdiction. You can find them, along with 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.

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

Contents

HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

Sir Andrew McFarlane

We trust our readers will join us in wishing Sir Andrew, the President of the Family Division and Court of Protection, well in respect of his forthcoming open heart surgery.

DoLS forms – a cautionary tale

An experienced best interests assessor has been suspended by Social Work England for 12 months after plagiarising DOLS Form 3s and/or doctor's Form 4s. Concerns were raised by the DOLS team and an audit revealed forms for 8 people were identical in various parts of the capacity assessment and not all relevant to the individuals involved. There was a risk that people could have potentially been unlawfully deprived of liberty.

The BIA said he had used a "stock template" for Form 3, recognised he had placed people at risk of harm, but maintained he had not acted dishonestly. The fitness to practise panel found:

> *36.* […] *that the social worker had plagiarised large aspects of the Forms, with wholesale movement of information from one service user to another. These contained inaccurate information including comments attributed to them, incorrect assessment in things such as communication and wrong historical backgrounds including information about past safeguarding issues. The justification for the ultimate decision was copied almost in its entirety.*

The panel's conclusion was that he had acted dishonestly and must have been aware that the information for the individuals was wrong and incorrect at the time he prepared and signed the forms. As a social worker and fully trained BIA it was his responsibility to ensure this was done properly and failed to do so. On that basis it concluded that an ordinary and decent person would consider such conduct to be dishonest. His fitness to practise was impaired on both public protection and public interest grounds, and he was suspended for 12 months.

Medical treatment, due haste, and capacity complexities

Sherwood Forest Hospitals NHS Foundation Trust v C [2020] EWCOP 10 (Hayden J)

Best interests – medical treatment – Practice and procedure (Court of Protection)

Summary

Possibly as a result of lessons learned in relation to the case of Mrs H, the same NHS Trust has brought a further application in relation to the treatment for cancer of another person, this time with very significantly greater speed. In the present case, the Trust were concerned with a woman, C, in her 60s. For some time, she had had paranoid schizophrenia. She had been admitted, most recently, between June and October 2019, when she had stopped taking her medication. Although the precise mechanism was not explained in the judgment, it appears that in consequence of that decision, she had suffered kidney failure, which could have been fatal. Happily, it was not. The woman attributed her recovery to God's intervention.

Shortly afterwards, she presented to her GP with symptoms of post-menopausal bleeding. This led to a referral to the Trust. As Hayden J noted:

> *Two features require to be highlighted. Firstly, it was C who decided to seek out medical treatment in the first place and, secondly, C who pursued further treatment at the hospital to investigate the cause of the bleeding. All agree that, in this period, C appeared capacitous in her decision making. It requires to be clarified, though, that what she was determined to do was to investigate the source and cause of her bleeding and to see what the treatment options were. That, as emphasised by Ms Paterson, on behalf of Official Solicitor, is different from what has been in focus at this hearing, namely whether C should have a hysterectomy.*

C underwent two investigations, to both of which it was considered she was able to give consent. They revealed Grade 2 endometrial cancer. She was referred to the cancer MDT, although the team were not aware of C's diagnosis of

paranoid schizophrenia. Hayden J considered that, "[a]*s far as a treatment pathway is concerned, it is irrelevant. But it is a troubling omission.*" When it was explained what the proposed treatment pathway was for her cancer, C

> *was markedly unresponsive and incommunicative: he describes her as "almost mute". Because he was not alert to her underlying mental health difficulties, Mr Dudill* [the consultant gynaecologist] *was unsure as to whether this response was an indicator of shock at hearing such news or related to something more significant. He told me that, in those circumstances, he thought it best for C to spend some time with the cancer nurse, Ms Halsall, for a more informal chat in which she might feel more comfortable in articulating her concerns or expectations. Having facilitated that meeting, Mr Dudill later re-joined them, but noticed that C continued to be very withdrawn. However, despite her presentation, C agreed to go ahead with the operation and also signed the necessary consent forms.*

However, it became clear in the following weeks that C had disengaged. When it was pursued, she was adamant that she did not want the treatment:

> *She expressed the view that "only God could cure [her] cancer" and, though properly and, in my judgement, sensitively challenged, she rejected any idea, for example, that God might act through the intervention of medical treatment.*

A joint assessment of her capacity was undertaken on 19 February 2020 by a Mr Srini Vindla, a consultant gynaecologist and a Dr Caroline Innes, a consultant psychiatrist, described by Hayden J thus:

> *16.* […] *Although neither is C's treating clinician, it is perhaps significant to note that C was happy to engage with them, albeit constraining herself to her already expressed view. Dr Innes reminded C of a previous occasion when she had been treated by the doctors following an admission pursuant to the Mental Health Act, once when she experienced kidney failure and on another occasion, infected abscesses. C remembered these and told Dr Innes that she had recovered because it had been God's will. She said that God had made her start drinking again. She attached no significance to the impact of the depot antipsychotic medication. At the interview Dr Innes reports C as being calm. She did not appear physically unwell and she had not obviously lost weight. There was no evidence of self-neglect. The pauses in her conversation might indicate some auditory hallucination but I did not get the impression from her statement that Dr Innes was convinced of this. Dr Innes described C's presentation as "objectively flat but not depressed". Her speech was said to be "quiet but coherent". She refused to explain any of her reasoning but her concentration did not appear to be impaired.*
>
> *17. Dr Innes concluded that C still had symptoms of chronic schizophrenia and that there were suggestions of delusional beliefs. She considered C is unable to weigh the evidence required to make an informed decision in relation to her treatment and her inability to engage in weighing the consequences indicated a lack of capacity relating to her consent to treatment. It is important that I*

> *emphasise that Dr Innes considered whether a change in C's treatment or medication for her mental illness might serve to promote capacity, but concluded that it would not.*

The Trust therefore brought an application for a decision as to C's capacity to consent to the treatment, and for endorsement (by way of a decision under s.16(2)(a)) of the plan. It is not quite clear when the application was brought, but as it was seen by Hayden J on 26 February, it is must have been brought within a matter of days after the capacity assessment.

Hayden J was initially:

> *22.* […] *very concerned that with a diagnosis of this kind, made on 30th December 2019, surgery was not contemplated until March 2020. I was also concerned that what was anticipated in these proceedings, by the lawyers, was a series of investigations, envisaging a hearing in a few weeks' time. There has been delay. However, having heard all the evidence, particularly emphasising the limited aggression of the cancer (stage 2), I am satisfied that the delay will not have had adverse impact on C. By this I mean the cancer has not been neglected.*
>
> *23. Here, the delay was attributable primarily to the fact that C appeared, up to and including 9th January 2020, to have been entirely capacitous. Only when suspicions were aroused did it emerge that she was not. Although the initial referral to the hospital had flagged up the fact of her paranoid schizophrenia, it is clear that the information relating to that diagnosis was not shared to the extent that it should have been with the team of treating clinicians. I see no reason why that should have occurred. In the future, where there is such a diagnosis, it should be regarded as requiring prominence in the medical records. This is not intended in any way to stigmatise the patient, but to seek to ensure that they are provided with treatment in a way which places them on an entirely equal footing with capacitous individuals in the same situation.*
>
> *24. The second reason leading to the delay arises from the anxiety that all medical professionals understandably face when they are required to contemplate the restraint or coercion of a resistant, incapacitous patient. These are incredibly difficult challenges, but delay only serves to compound that challenge. Those faced with these difficulties must always recognise that delay is likely to be inimical to their patient's care and that the time scales for intervention constructed around the patient must focus unwaveringly upon that patient's best interests. The delay here has not exacerbated the risk arising from the cancer but it may have, indeed I consider it likely to have added avoidable stress to C and her family.*
>
> […]
>
> *27. Because I was not prepared to countenance delay, the case was called in and it has been possible, with the assistance of extremely experienced counsel, to resolve the issues today.*

In considering C's best interests, Hayden J noted the following:

> *18. When C was a younger woman, before the cloud of paranoid schizophrenia descended upon her life, she was noted to have been a very happy*

and outgoing young person. Her interest in religion began only after her mental health problems developed. I hope that these religious beliefs may, in some way, have been a comfort to C. But it requires to be identified that her expressed religious beliefs have become a facet of her mental health problems and a channel for delusional thoughts. For example, she has in the past believed herself to be pregnant, carrying the child of God. This has been a delusion of such vibrancy for her that she has carried it through to purchasing baby clothes for the child she believed she was carrying. It is important therefore to disentangle capacitously held religious beliefs from the delusional views here. It requires some sensitivity.

19. The preponderant evidence that I have sought to highlight indicates a woman who wanted to address her post-menopausal bleeding, to identify the appropriate treatment and cooperate with the investigative process. As I have stated, whilst C still appeared capacitous she signed forms consenting to treatment. Subsequently, perhaps in consequence of the shock, she clearly lacked capacity and her rejection of the treatment, which is clinically so manifestly in her best interests, is predicated on a delusional belief structure which manifests itself in the language of religion.

20. Of course, the fact that the clinical best interests are clear does not mean, automatically, that C's 'best interests' more generally, lie in her having the surgery. That can only be determined by a wider examination of C's circumstances, consideration of her relationships, endeavouring to understand who she is and the code by which she lives her life.

21. In considering this wider canvas it emerges that C, with the support of her mother, has a full and varied life. She plainly has a strong, important relationship with her mother and she has an enduring commitment to her niece, of whom she speaks with affection. When capacitous, there is nothing at all to indicate that she is in any way disenchanted or weary with life. On the contrary, the indicators are that she is enthusiastic for it, notwithstanding the challenges that her mental health condition has posed to her over the years.

Hayden J was therefore:

27 […] *satisfied that it is in the best interests of C to have the surgery. I do not find that to be a delicate balance. There is amongst all lawyers, doctors and judges a strong instinct to preserve human life (Aintree University Hospital NHS Trust v James [2013] UKSC 67; Kings College Hospital Foundation Trust v Haastrup [2018] EWHC 127 (Fam)). Here there is clear evidence of a likely prospect of a successful outcome, where the alternative is that C would die. Moreover, as I have indicated, there is much to indicate that C, when capacitous would want to live. Her decision, as I have detailed above, to seek out treatment and in fact consent to it orally and in writing I consider to be a powerful indicator of her wishes when capacitous. Accordingly, I am able to make the declarations the Trust seeks.*

However:

28. In this case, it has not been possible for the Trust to put a plan together

> *outlining the details of the coercion and/or restraint that would be considered to be proportionate in the event of C's resistance. The absence of this plan is a direct consequence of my decision to cause the case to be heard quickly. I am able to make the best interest declarations I have indicated but they are not to be given effect until the plan has been put together and approved initially by the Official Solicitor and subsequently by this court. In the event that such approval is not forthcoming the case is to be restored before me, on short notice if necessary.*

Comment

Procedurally, this case indicates how it is possible for clinicians to work effectively with the Trust's legal services to move speedily when it has been recognised that an application is required (as to which, see further the recent Practice Guidance).

On the facts of the case, as presented here, it is not entirely easy to escape the impression that a certain amount of (understandable) intellectual footwork was required to address the position that the doctors had proceeded on the basis that C had had capacity to make the decision until such point as she had disengaged. Such a phenomenon is not uncommon (see also the discussion of this, again in the context of paranoid schizophrenia, in *Heart of England NHS Foundation Trust v JB* [2014] EWCOP 342). The recording of the capacity assessment carried out by the Trust did not explain the change in position, and it is interesting that Hayden J clearly felt that he did need to give an explanation – suggesting that it was "perhaps in consequence of the shock." Although it is not possible, nor – for these purposes – relevant, to reconstruct the earlier position, it may equally be said on the logic of the recording of the capacity assessment before the court that C had not had capacity at any point to make the decision.

Although for different reasons, this might be thought to put into context Hayden J's observation that a diagnosis of a mental health condition should be given prominence in medical records. On one view – and as he himself recognised – this could be seen as stigmatising. On another view, this could be seen as precisely the sort of situation in which there was cause to consider whether or not any consent given by C would be capacitous – at which point the cancer MDT should have been alerted to it. After all, had she consented, not disengaged, and the treatment gone ahead, we might legitimately want to know whether this was on the basis that she had given consent, or on the basis that there was no such consent, but the doctors could rely upon the provisions of s.5 MCA 2005.

Finally, and as Hayden J was aware the case is another example of how the law finds the interplay between mental disorder and religious belief complex. In centuries past, and indeed in many communities today, the sentence "*her rejection of the treatment* […] *is predicated on a delusional belief structure which manifests itself in the language of religion*" might not make immediate logical sense.

Short note: deprivation of liberty and false imprisonment

In *R (Jalloh) v Secretary of State for the Home Department* [2020] UKSC 4, the main issue was whether the meaning of 'imprisonment' at common law should be aligned with the concept of 'deprivation of liberty' in article 5 ECHR. In

short, the answer was 'no'. Jalloh was subject to immigration restrictions, requiring him to report to an officer three times a week, to reside at a specified address, to wear an electronic tag, and to be subject to a curfew for 8 hours every day.

Lady Hale, giving the judgment of the Supreme Court, noted that the essence of the tort of false imprisonment is being made to stay in a particular place by another person whereas the Article 5 ECHR concept of deprivation of liberty is multi-factorial in its approach:

> *24…* [The] *essence of imprisonment is being made to stay in a particular place by another person. The methods which might be used to keep a person there are many and various. They could be physical barriers, such as locks and bars. They could be physical people, such as guards who would physically prevent the person leaving if he tried to do so. They could also be threats, whether of force or of legal process… the person is obliged to stay where he is ordered to stay whether he wants to do so or not.*

Thus, the classic understanding of imprisonment is very different to the more nuanced ECHR concept and at common law there was no need to distinguish between restricting and depriving liberty. Moreover, common law imprisonment can be justified in circumstances not covered by the permissible grounds of Article 5. It follows that one could be imprisoned at common law without being deprived of liberty under Article 5. The opposite seemed most unlikely.[1] And the court held that Jalloh was imprisoned.

The opening of paragraph 24 might raise a wry smile amongst some, given what Lady Hale had said previously in *Secretary of State for the Home Department v JJ & Ors* [2007] UKHL 45*:*

> *What does it mean to be deprived of one's liberty? Not, we are all agreed, to be deprived of the freedom to live one's life as one pleases. It means to be deprived of one's physical liberty: Engel v The Netherlands (No 1)(1976) 1 EHRR 647, para 58.* ***And what does this mean? It must mean being forced or obliged to be at a particular place where one does not choose to be: eg X v Austria*** *(1979) 18 DR 154. But even that is not always enough, because merely being required to live at a particular address or to keep within a particular geographical area does not, without more, amount to a deprivation of liberty. There must be a greater degree of control over one's physical liberty than that. But how much? As the Judge said, the Strasbourg jurisprudence does not enable us to narrow the gap between "24-hour house arrest seven days per week (equals deprivation of liberty) and a curfew/house arrest of up to 12 hours per day on weekdays and for the whole of the weekend (equals restriction on movement)": [2006] EWHC 1623 (Admin), para 33, referring to the cases cited by my noble and learned friend Lord Bingham of Cornhill, at paras 14 and 18 above.* (emphasis added)

[1] Lady Hale suggesting (at paragraph 34) that the question of whether the Court of Appeal in *Austin* and in *Walker* were right to say that there could be a deprivation of liberty without there being imprisonment at common law "*in the light of the Bournewood saga, but it is not necessary for us to express an opinion on the matter.*"

However, it needs to be understood in this case that the Secretary of State was seeking to align the concepts of (objective) confinement for purposes of Article 5 ECHR and imprisonment for purposes of the tort of false imprisonment so that, in lay terms, he could get an **easier** ride from the courts than he thought he would get under Article 5 ECHR.

Whether that is necessarily correct is perhaps debatable, given that the courts have found that a deprivation of liberty can arise in a very short time indeed (see *ZH* in which the deprivation of liberty arose within 40 minutes).

However, on its face, the decision suggests that the intensity of the care arrangements need not be as severe for a false imprisonment claim as it is for an Article 5 ECHR claim, with the focus then being on whether the imprisonment was justified. Importantly, it also means that a deprivation of liberty is most likely to amount to imprisonment at common law with its more generous 6-year limitation period (by contrast to the position under the Human Rights Act: see this costly lesson learned), and the possibility of aggravated and exemplary damages depending on the facts.

PROPERTY AND AFFAIRS

Deputies, advice, litigation and conflicts of interest

Re ACC, JDJ and HPP [2020] EWCOP 9 (Senior Judge Hilder)

Deputies – Financial and property affairs

Summary

In these cases, three deputies brought applications concerning the extent to which the orders appointing them authorised expenditure of P's estate in respect of getting legal advice and conducting proceedings on P's behalf. The deputies were in 2 cases Irwin Mitchell Trust Corporation Ltd and in the other case a partner in Irwin Mitchell LLP.

In each case P was joined as a party and represented by the Official Solicitor and, because the issues related to the supervision of deputies, the Public Guardian was joined in the proceedings.

The Senior Judge set out a summary of her conclusions in an appendix and that is set out below in full (references in square brackets are references to paragraphs in the judgment):

> *1. The "general" authority to manage property and affairs which is granted by the standard deputyship order encompasses those common or ordinary tasks which are required to administer P's estate efficiently. [paragraphs 46 – 48]*
>
> *2. Authority to make a decision / do an act in respect of P's property and affairs encompasses such ordinary non-contentious legal tasks, including obtaining legal advice, as are ancillary to giving effect to that authority. [paragraph 53]*
>
> *3. In particular:*
>
> > *a. authority to purchase or sell property includes conveyancing [paragraph 53.2]*
> >
> > *b. authority to let property includes dealing with leases or tenancy agreements [paragraph 53.3]*
> >
> > *c. authority to conduct P's business includes dealing with employment contracts of that business [paragraph 53.4]*
> >
> > *d. "general" authority encompasses:*
> >
> > > *i. the preparation of an annual tax return, and therefore obtaining advice as to completion of the return [paragraph 53.7(a)];*
> > >
> > > *ii. discharging P's financial responsibilities under a tenancy, and therefore obtaining advice as to liabilities under the tenancy [paragraph 53.7(b)];*
> > >
> > > *iii. applying P's funds so as to ensure that the costs of his care arrangements are met, and therefore dealing with employment contracts of directly employed carers [paragraph 53.7(c)]*
>
> *4. Specific authority is required to conduct litigation on behalf of P [paragraph 51] except where the contemplated litigation is in the Court of Protection in respect of a property and affairs issue [paragraph 52.4] or to seek*

directions in respect of a welfare issue [paragraph 52.10].

5. Where a deputy has authority to make a decision / do an act in respect of P's property and affairs, such authority encompasses steps in contemplation of contentious litigation in the realm of that authority up to receiving the Letter of Response but no further [paragraph 54.4]. In particular:

a. authority to let property encompasses taking steps to form a view as to whether there are grounds to evict a tenant of such property [paragraph 53.13];

b. "general" authority to manage P's funds includes taking steps to form a view about whether a debt said to have been incurred by P is properly payable pursuant to section 7 of the Mental Capacity Act 2005 [paragraph 53.13];

c. "general" authority to manage P's funds includes steps up to but not including the delivery of a letter of appeal in respect of a decision that P is not eligible for continuing healthcare funding [paragraph 54.8(a)];

d. where authority encompasses steps in contemplation of contentious litigation, that includes obtaining Counsel's opinion. [paragraph 54.5]

6. "General" authority of a property and affairs deputyship order does not encompass seeking advice or other steps preliminary to litigation in respect of welfare issues; it does encompass making an application to the Court of Protection for further directions /specific authority in respect of welfare issues. [paragraph 54.6]

7. "General" authority of property and affairs deputyship does not encompass steps in contemplation of an appeal against the decision of an Education, Health and Care Plan. [paragraph 54.8(b)]

8. If circumstances arise where the protection of P's interests requires action to be taken so urgently that prior authority to litigate cannot reasonably be obtained, a deputy proceeds at risk as to costs but may make a retrospective application for authority to recover costs from P's funds. There is no presumption that such application will be granted – each application will be considered on its merits. [paragraph 55]

9. Where a deputy wishes to instruct his own firm to carry out legal tasks, special measures are required to address the conflict of interest:

a. the deputy may seek prior authority [paragraph 56.7(a) – (e)];

b. the deputy is required to seek – in a manner which is proportionate to the magnitude of the costs involved and the importance of the issue to P - three quotations from appropriate providers (including one from his own firm), and determine where to give instructions in the best interests of P [paragraph 56.7(f)(i)];

*c. the deputy **must** seek prior authority from the Court if the anticipated costs exceed £2 000 + VAT;*

d. the deputy must clearly set out any legal fees incurred in the account to

the Public Guardian and append the notes of the decision-making process to the return. [paragraph56.7(f)(iv)]

10. Specific authority is required to use P's funds to pay a third party's legal costs, even if those costs relate to litigation for the benefit of P. [paragraph 57]

11. The Official Solicitor is willing to act as litigation friend for P without charge in any of the existing classes of cases in which she acts where her usual criteria are met. [paragraph 58]

12. If P has capacity to give instructions for particular work, he will also have capacity to agree the costs of that work. [paragraph 59].

Comment

This is a very useful statement of what a P&A deputy can and cannot do in relation to seeking legal advice and taking steps in litigation.

A number of further points arise from the judgment that do not appear in the summary.

Paragraph 4 of the summary refers to the need to apply for specific authority to conduct litigation on P's behalf because the general order does not give such authority. Paragraph 51.4 of the judgment suggests that in such an application, the deputy should consider whether there should be limitations as to the extent of the authority, for example to a certain stage in the proceedings.

Furthermore, because the general order does not give authority to conduct litigation, it must follow that CPR 21.4(2) will not apply to allow a deputy to be appointed litigation friend unless he gets specific authority to conduct the litigation (though he could be appointed under 21.4(3) in the same way as a non-deputy is appointed but with risk as to costs).

As regards the lack of general authority to incur costs regarding welfare issues referred to at paragraph 6 of the appendix, that was said with specific reference to matters relating to deprivation of liberty in the wake of the *Staffordshire* case. In such cases, and in a useful judicial clarification of how matters should proceed, Senior Judge Hilder made clear the P&A deputy should bring the situation to the attention of the appropriate authorities first and then the COP if those authorities fail to act (see paragraph 52.10 of the judgment). The Court of Protection would then consider what should be done including asking the deputy to investigate and report, considering if someone else should bring proceedings or authorising the deputy to do so (see paragraph 52.12).

Paragraph 5 of the appendix deals with steps prior to litigation. At paragraph 54.5 of the judgment, it is stated that those steps will include getting counsel's advice which is commonly required where a deputy is seeking authority to conduct litigation.

Paragraph 11 of the appendix states that the Official Solicitor is willing to act as litigation friend for P without charge in any of the existing classes of cases in which she acts where her usual criteria are met. This was in response to the application in one case (HPP) where the damages claim had not concluded and where there was no suitable family member to act for an order in effect authorising the deputy to pay a solicitor in Irwin Mitchell to act as litigation friend. That application was refused on the grounds that it could not be in P's best interest

for there to be a paid litigation friend where the OS would perform the task without payment (see paragraph 63 of the judgment), the court and the OS were, however, obviously unhappy about the fact that such a solicitor had been appointed litigation friend and had gone on to instruct Irwin Mitchell without, it seems, any regard for the "obvious" conflict of interest that had arisen. In that case, the court "reluctantly" gave retrospective authorisation for the instruction of Irwin Mitchell as the proceedings were so far down the line and indeed had settled by the time of the final judgment.

Plainly where a deputy wants to instruct the firm with which he is associated, then paragraph 9 of the appendix will apply. Here the litigation friend was not the deputy but a solicitor in the firm. In much personal injury litigation, proceedings are started before a deputy is appointed. If there is no family member to take that role, a solicitor in the firm involved may seem to be a good choice. It is the clear implication from this case, however, that the OS may well be a better one as it would get over the inevitable conflict of interest that would otherwise arise. This would be the more so if it were contemplated that the deputy should be a person associated with the litigation firm.

As regards the latter situation, this judgment does not directly deal with it but it does focus on the issue of conflicts of interest. It is routine for a deputy appointed in cases arising out of awards in personal injury litigation to be associated with the litigation firm. Plainly the grant of such applications is in the gift of COP. Perhaps, to avoid the suggestion of a conflict of interest, COP should insist on seeing 3 quotations from possible deputies for the work (to include one from the associated person) to ensure P is getting at least best value (especially as the costs can amount to very large sums).

The implications of this judgment will take some time to work out. By way of example, we reproduce here observations made by Caroline Bielanska (member of the Law Society Mental Health and Disability Committee) in an email to the editors of the report:

> *I am concerned that the general authority of a PFA deputyship order would not extend to going through the complete NHS continuing health care (CHC) review process, and will be used by the NHS as an obstacle to a challenge. I do not believe that this should be considered 'litigation' for the following reasons:*
>
> *(a) A challenge to an adverse decision is not an appeal- it is a review, and cannot be compared to the appeal of an adverse EHCP decision.*
>
> *(b) There is no requirement in the CHC review process to have a person with express and specific authority to pursue a claim on behalf of a person who lacks capacity. There is no need for a litigation friend. If the person does not have a welfare LPA or welfare deputy, the review team will decide whether the person seeking a review on behalf of the incapacitated person would be a suitable representative, based on a best interest decision.*
>
> *(b) The review process for CHC, including the independent review panel stage is not litigious. It is not the forum to challenge legal issues. The National Framework Practice Guidance spells this out at para 53.1, 'the eligibility process is focused around assessing an individual's needs in*

the context of the National Framework rather than being a legal or adversarial process.' And at para, 58.2, ' If the individual chooses to have a legally qualified person to act as their advocate, that person would be acting with the same status as any other advocate nominated by the individual concerned. The MDT process is fundamentally about identifying the individual's needs and how these relate to the National Framework.' This is further stated in the National Framework at para 202, 'Independent review panels have a scrutiny and reviewing role. It is therefore not necessary for any party to be legally represented at independent review panel hearings, although individuals may choose to be represented by family, advocates, advice services or others in a similar role if they wish.'

4. The time limits for CHC reviews are tight and as such it will always be necessary to obtain an urgent Court order for authority or seek retrospective authority.

5. If it does not fall within the remit of general authority to go through the CHC process, it begs the question, does making a complaint to the local authority or NHS about the funding of aftercare services under s117 Mental Health Act 1983 or social care funding fall outside the remit of the general order. In all cases, the local complaints process should be used and should be exhausted before making a complaint to the Ombudsman. Neither of these processes would generally be considered as litigious, and due to the era of austerity, it is very common for deputies to go through the process to get funding and care provision for their client.

5. This will inevitably lead to a significant increase in applications to the court.

Finally, we note that a recent hearing in the Court of Protection before Cheema-Grubb J touched on related issues: the defendant insurance company in a personal injury claim had sought to challenge the continued appointment of an English deputy in circumstances where, since the initial deputyship order was made, P had moved back to Poland to live and a Polish guardian had been appointed. In the course of the hearing, which did not lead to a judgment, Cheema-Grubb J expressed the view that it seemed obvious that P's best interests would be served by the Polish guardian taking control of his assets, rather than an English deputy dealing with them remotely, yet the claimant was seeking the future costs of the English deputy as part of the personal injury claim and had not brought the matter to the attention of the Court of Protection – again, the solicitors in the personal injury claim were associated with the appointed deputy.

PRACTICE AND PROCEDURE

Medical treatment: delay, neglect and judicial despair

Cardiff & Vale University Health Board v P [2020] EWCOP 8 (Hayden J)

Best interests – medical treatment – Practice and procedure – other

Hayden J has had to grapple with a further case in which delay in bringing a case to court has had serious consequences for the person.

The case concerned a young man aged 17, with a longstanding disability and described as severely autistic. He was unable to communicate either verbally or, for the most part, in any consistently effective way at all. He lived with his parents but he received some respite care, particularly at the weekend, at a specialist establishment for people with learning difficulties. In January 2019, he was given a CT scan under general anaesthetic in order that his dental state could be properly assessed. A plan had been made for him to walk into the clinical area and, if necessary, for restraint to be used. He walked part of the way with his father, who was a mental health nurse, but then refused to go into the clinical room. The Trust's Strategies and Intervention Team, which managed people facing similar challenges to him and who sometimes exhibit their distress in aggressive behaviour, briefly restrained him on a bed for approximately two minutes in order that venous access could be gained and anaesthetic agents safely administered. His father was able to calm the young man when he was restrained, and on waking he was relaxed and did not require any further restraint.

The examination that was undertaken revealed some tooth decay, but it also revealed that the young man had impacted wisdom teeth. The fact that they are impacted did not mean that they were necessarily painful. They may remain impacted for many years and cause no pain, but sometimes they do, and quite commonly this arises in late teens and early twenties.

However, from around October 2019, and with increasing frequency, the young man was observed by his parents violently to bang his head, sometimes banging his head against walls. As Hayden J observed "[t]*he parents, of course, have the opportunity to see their son more than anybody else. Whilst he may not be able to communicate directly, by a whole raft of cues, many of which they will not be aware of, they have become intuitive to his needs. They believed that his behaviour was in response to dental pain.*"

In November 2019, the young man was taken to the local A&E by his parents with an obvious bruise to his forehead. They believed that his behaviour was so markedly changed that they feared he had some sort of concussion and may have fractured his skull. As Hayden J observed "[i]*t is, to my mind, self-evident that there was an urgent medical emergency that should have been investigated within hours or days, but in fact there has, as yet, been no CT scan at all."* Because there were potentially two pathologies to consider, a variety of disciplines became involved. In December, a multi-disciplinary meeting was convened. The parents were becoming increasingly concerned, however, and had the sense that they were not being listened to sufficiently.

It was clear on the evidence before the court that the young man lacked the capacity to consent to

treatment or to understand the various issues involved.

In the circumstances, Hayden J observed that:

> *7. It might seem, from the above account, that some dental assessment was required quickly and now as long ago as November or early December 2019. Plainly, it was. But the application was only made by the Health Board on 20th February 2020. The proposed inspection and/or treatment is not to take place until early March. For anybody who has had toothache, even delay between now and then looks like an eternity. But this young man, it seems, has been suffering, and significantly so, for nearly five months. This is little short of an outrage. It is indefensible.*
>
> *8. What is most concerning is that the delay has occurred despite the fact that P is supported by parents who are vigilant to articulate his needs. F, I repeat, is a mental health nurse, and as such is particularly well-placed to act as an advocate on his son's behalf. P is also surrounded by professionals, who I do not for one moment doubt are committed to his treatment and care. Nonetheless, nothing has happened.*

Hayden J first had sight of the case on 20 February 2020, and reconvened the next day:

> *12. Ms Watson, counsel on behalf of the Health Board, today makes it absolutely clear that, since the case was heard yesterday afternoon, a great deal of work has been done and a great deal of thought given to the circumstances that P now finds himself in. She tells me candidly that when it became necessary to analyse the chronology of the proceedings, the full force of the delay and its impact on P became inescapably obvious to the Cardiff and Vale University Local Health Board. They have made, properly in my view, no attempt at all to evade their responsibility. They offer P and his parents a profound apology, the sincerity of which I have absolutely no cause to question. Today, the Clinical Director of the Dental Hospital has attended at court. He inevitably knew nothing of the case until yesterday. He, too, through counsel, makes no effort to defend the delay. It is indefensible.*
>
> *13. When Ms Watson drills down into the history of the case, in an attempt to understand why this has occurred, she comes to the very clear conclusion that it has arisen in consequence of "insufficient collaborative cooperation", to use her phrase, between the various disciplines required to identify P's best medical interests. In other words, a failure to share information and a failure to work together effectively. The failings here do not arise as a result of lack of resources. Neither are they the result of pressure or volume of responsibility on any individual. It is, sadly, yet again, a situation in which there has been a fundamental failure to communicate effectively by those responsible for P's care. This message has now been the conclusion of so many reviews, including serious case reviews, that it has become almost trite. There is no point identifying lessons to be learned if they are not, in fact, learned. Sharing information and effective communication is intrinsic to good medical practice. This is true generally but it requires heightened emphasis, if that is possible, in the context of the incapacitous, whose voice can easily and inadvertently go unheard.*

For reasons that are not developed in the judgment, it appeared that it was not practically possible to ensure inspection/treatment before March 2020. Amongst the consequences of this, Hayden J was careful to observe was that, as his parents told him, the deterioration in his behaviour responding to his pain:

> *16.* […] *has altered, as they put it, P's "profile". Their ambition for him is that, at 18 years of age, he might be able to obtain a place in a residential unit, which would provide some important opportunities for him. The relative containability of his behaviour throughout adolescence made that a reasonable prospect. But his parents are now very anxious that P's present behaviour might create an impression of a more challenging youngster than they believe him to be and cause such units greater anxiety when considering any application on his behalf.*
>
> *17. It is for that reason that I deliver this ex tempore judgment, a copy of which will be transcribed for P's parents, so that those who are considering options for P in the future will know that his recent behaviour appears likely to have been triggered by a neglectful failure to address a dental/medical problem. It should not be regarded as a facet of his overall condition. If what I have said here is weakened in consequence of any CT scans or investigations, then it can, of course, be revisited. But the above is the position, as it appears to his parents today and which I consider to be a realistic evaluation.*

Comment

This is not the only case that Hayden J has had before him recently in which delay has caused adverse effects. We covered the *Mrs H* case last month, and its sequel [2020] EWCOP 6) reveals that the position was, as he feared, namely that the failure to make the application in a timely fashion meant that Mrs H's cancer was now inoperable.

In this case, and on the basis of paragraph 17 of Hayden J's judgment, and the very deliberate use of the term 'neglectful,' it would appear – in due course – that a claim could be brought on behalf of P to reflect the harm caused to him by the consequences of the delay. Paragraph 13 of his judgment both crystallises the problem and reflects what comes close to judicial despair as to how to ensure that such situations are not repeated.

Amidst all of this, it may come as a minor point, but it is perhaps rather striking that it appears that a year previously it had been considered entirely possible by those responsible for P's case to have carried out a CT scan under general anaethestic (in circumstances including restraint) without the need to go to court.

Vulnerable witnesses and parties

There have been a number of important cases and/or other developments recently of relevance, primarily by analogy, to the work of the Court of Protection. We summarise them here.

Civil Justice Council

The Civil Justice Council has, following a month long consultation in the autumn of 2019, published a series of recommendations for improvement of the current provision for vulnerable parties and witnesses accessing the civil justice system. The full report is lengthy and

detailed (for instance the discussion about the meaning of vulnerability), but for present purposes we highlight the recommendations, which are:

1. Amending the overriding objective within the Civil Procedure Rules to reflect a need to ensure that 'all parties can fully participate in proceedings' and 'all witnesses can give their best evidence as well as providing a new practice direction specifically addressing vulnerability and provides guidance on the circumstances in which a court may consider an individual to be vulnerable and the steps which can be taken to give them assistance. This recommendation includes a proposal that CPR 44.3(5) on costs should be amended to include additional work/expense generated by the fact of vulnerability of parties/witnesses

2. Amending claim forms and directions questionnaires to include a question on whether proceedings involve a vulnerable party or witness.

3. HMCTS should consider capturing the data in relation to the vulnerability of court users, specifically considering the number of vulnerable parties or witnesses who appear before the civil courts and the steps taken to assist them.

4. Mandatory training on vulnerability for all civil judges covering:

    a. The assessment or detection of vulnerability;

    b. Case management when a party or witness is vulnerable;

    c. Conduct of hearings, including questioning of witnesses.

5. Regulators and training bodies should assess the adequacy of their current available training on vulnerability; the court should expect all advocates who undertake questioning of vulnerable witnesses to have had some relevant training or at least to be familiar with the Advocate's Gateway and toolkits (https://www.theadvocatesgateway.org/).

6. A court managing a civil case in which there has been a conviction in respect of assault or abuse should clarify the basis (if any) upon which any conviction is being challenged and as a result consider what issues properly remain for determination and what orders should be made in respect of the evidence to be adduced. Such consideration should include (but not be limited to) consideration of the extent to which evidence within or transcripts of the criminal trial should form the evidence considered by the court and a requirement that the Defendant presents his/her evidence first.

7. Consideration should be given to the need to set ground rules for hearings involving vulnerable witnesses.

8. If a provision prohibiting cross-examination of a witness by a self-represented party who has been charged cautioned or convicted of a specified offence against them is enacted, a like provision should be extended to civil cases – with a discretion to order otherwise. Where there is a prohibition on cross-examination by a self-represented party,

provision must be made through central funding for the appointment of a legal representative.

9. The Ministry of Justice and HMCTS should review the availability and use of intermediaries in the Civil Courts as a matter of urgency, recognizing that there is a clear need to recruit and train intermediaries for the civil and family courts.

10. Any mediator employed or recommended by HMCTS must have appropriate training.

11. Any reforms should consider who vulnerable court users will be affected.

12. Court facilities, infrastructure, staffing and equipment should be audited immediately;

13. HMCTS must provide easily accessible, adequately resourced and comprehensive assistance to court users to facilitate their full participation in the court process;

14. A national protocol should be brought into force requiring each court centre to:

    a. Set up a team of staff (or for single court buildings a nominated member of staff) who should receive training to work with court users with mental health and physical conditions, learning disabilities, limited mental capacity and other vulnerabilities.

    b. Consider how to ensure that vulnerable court users are offered support before arrival at court, during and after a hearing or attendance at court (including ensuring that there is a single point of contact and the supervision/overseeing of the provision of support).

    c. Introduce the provision of pre-trial visits for vulnerable court users and promote of their availability.

15. The MoJ should improve its financial support to the Litigant in Person Support Strategy.

16. HMCTS should review information for vulnerable and other court users and ensure there is easy access to comprehensive guidance on what to expect at court and what the court process entails.

17. HMCTS should ensure that all staff who handle civil cases are given adequate training with regard to identifying, communicating with and assisting vulnerable court users.

18. The Judicial College should consider the need for guidance/training/re-enforcement of training as to applications for and the making of/refusal to make compensation orders in cases of sexual assault/abuse. The Crown Prosecution Service should also consider its current practices and training in relation to seeking compensation orders.

Two decades after the Youth Justice and Criminal Evidence Act 1999 came into force, recognising the needs of vulnerable witnesses and providing statutory basis for entitlement to an intermediary, the provision of support and assistance required for participation of vulnerable witnesses in the civil justice system remains woefully underdeveloped. The recommendations of the Civil Justice Council will no doubt be welcomed by all practitioners

who have struggled to access adequate resources to assist vulnerable clients.

Intermediaries

The Civil Justice Council report – understandably – highlights the potential role of intermediaries. There are circumstances when they would be of equal assistance before the Court of Protection, whether supporting a P who is competent to give evidence[2] or supporting another party giving evidence.

However, the need for intermediaries (who are a scarce resource) does need to be carefully thought through and their utility kept under review. In the personal injury case of *Morrow v Shrewsbury* [2020] EWHC 379 (QB), the Claimant claimed damages for personal injury arising out of an accident he suffered while spectating a rugby match. A rugby post next to which he had been standing collapsed and struck him on the head as a result of which he sustained facial and skull injuries. The Defendant admitted negligence; the Claimant claimed substantial damages for past and future lost earnings. Following a preliminary hearing before HHJ Bird, an intermediary was instructed to assist with the Claimant's evidence on the grounds that he suffered anxiety and depression, rendering him a vulnerable witness.

In her judgment following trial, Farbey J noted her concerns regarding the involvement of the intermediary, in particular her apparent lack of understanding of the precise nature of her duty (para 39). Although the intermediary was retained for the final hearing, following a ground rules hearing, the court imposed further restrictions on her involvement.

Farbey J ultimately noted:

> *46. The intermediary's contribution to the proceedings was negligible. On a couple of occasions, she asked whether the court could take a break during the evidence but I was unsure why she chose those moments to make such a request as opposed to other moments. She gave some minimal assistance to the claimant when he was looking for documents in the bundles but he was capable of finding the documents for himself.*
>
> *47. The claimant gave no indication that he could not follow questions or that he could not give the answers that he wanted to give. The intermediary did not raise any comprehension or communication difficulties with the court.*
>
> *48 Mr Brown [counsel for the Defendant] conducted his cross-examination with conspicuous fairness. He took matters slowly and carefully so that the claimant could follow the questions. As I have mentioned, I permitted the claimant to take blank paper into the witness box as an aid to concentration. He did not appear to use the paper. He gave evidence forcefully and fluently.*
>
> *49. I have strong reservations about whether any of the ground rules were necessary. The intermediary served no useful role. Nothing that the intermediary did could not have been done by counsel and solicitors performing their well-defined roles founded on training,*

[2] The role that they might play where P is either giving unsworn 'information' to the court, or in the context of supporting P to participate more broadly is more complex.

> *experience and professional ethics; or by the court in the exercise of its wide discretion to control proceedings and having the benefit of extensive expert evidence.*

In similar vein, in the criminal context, the Court of Appeal also recently noted in R v RT & Anor [2020] EWCA (Crim) 155 that:

> *36* […] *intermediaries are not to be appointed on a "just-in-case" basis or because the report by the intermediary, the psychologist or the psychiatrist has failed to provide the judge with a proper analysis of a vulnerable defendant's needs in the context of the particular circumstances of the trial to come. These are fact-sensitive decisions that call for not only an assessment of the relevant circumstances of the defendant, but also the circumstances of the particular trial. Put otherwise, any difficulty experienced by the defendant must be considered in the context of the actual proceedings which he or she faces.* […]
>
> *37.* […] *Criminal cases vary infinitely in factual complexity, legal and procedural difficulty, and length. Intermediaries should not be appointed as a matter of routine trial management, but instead because there are compelling reasons for taking this step, it being clear that all other adaptations to the trial process will not sufficiently meet the defendant's needs to ensure he or she can effectively participate in the trial.*

Vulnerable witnesses and weight of evidence

In *Re C (Female Genital Mutilation and Forced Marriage: Fact Finding)* [2019] EWHC 3449 (Fam), Gwynneth Knowles J made some important observations about the weight to be placed upon the evidence given by a vulnerable witness. Although given in the context of family proceedings (and hence by reference to the specific rules and Practice Direction) which cover the position in those proceedings, the central thrust of her observations are equally applicable in cases before the Court of Protection. We therefore set them out in full.

> *Assessing the Evidence of Vulnerable Witnesses*
>
> *15. It is important that I identify a matter which has been at the forefront of my mind in approaching my fact-finding task.*
>
> *16. As is apparent from paragraphs 38-43 of the judgment of King LJ in Re N (A Child) [2019] EWCA Civ 1997, it was only relatively recently that the Family Court has made formal provision for vulnerable adult witnesses in family proceedings – Part 3A and PD3AA of the Family Procedure Rules 2010 entitled "Vulnerable Persons: Participation in Proceedings and Giving Evidence" came into force on 27 November 2017. The provisions of Part 3A were intended to maximise the ability of those deemed vulnerable to give their best evidence to the court and participate as fully as possible in proceedings. Though there is no definition of "vulnerability" in Part 3A, they are individuals, the quality of whose evidence is likely to be diminished by reason of their difficulties, as opposed to "protected parties", namely those who lack capacity to conduct the proceedings. The measures set out in Part 3A - such as the deployment of special measures, the use of intermediaries and so on – address the form of the evidence or, as*

Mr Bagchi QC put it, the procedural framework in which evidence is given. However, they do not address the substance of the evidence given by a vulnerable person. In this case, the mother has made very serious factual allegations which, if true, would have life changing consequences for those accused, but because of her disabilities (and despite a raft of special measures), it was suggested that she was unable to give either a coherent account of events or an account which had some of the hallmarks of credibility. What allowances, if any, can and should the court make for this? Can evidence from a vulnerable and emotionally labile witness, without independent evidential support, provide a firm basis upon which to ground serious findings such as marital rape, forced marriage and FGM? Despite my very considerable sympathy for witnesses with significant vulnerabilities such as the mother in this case, my clear view is that there is one standard of proof which applies without modification irrespective of the characteristics of witnesses, including vulnerable witnesses to whom Part 3A and PD3AA apply. I observe that many vulnerable witnesses are just as likely as anyone else either to tell the truth or to lie deliberately or misunderstand events. It would be unfair and discriminatory to discount a witness's evidence because of their inherent vulnerabilities (including mental and cognitive disabilities) and it would be equally wrong in principle not to apply a rigorous analysis to a witness's evidence merely because they suffer from mental, cognitive or emotional difficulties. To do otherwise would, in effect, attenuate the standard of proof when applied to witnesses of fact with such vulnerabilities.

17. That does not mean that the court is unsympathetic to a vulnerable witness such as the mother in this case. However, it remains the court's duty to take an entirely dispassionate approach to the process of determining whether, on the available, relevant and admissible evidence, the facts alleged by a vulnerable witness are established on the balance of probability. I have reminded myself of the wise words of Hughes LJ (as he then was) in Re B (Allegation of Sexual Abuse: Child's Evidence) [2006] EWCA Civ 773 at [43] when he observed that:

> *"… the fact that one is in a family case sailing under the comfortable colours of child protection is not a reason to afford to unsatisfactory evidence a weight greater than it can properly bear. That is in nobody's interests, least of all the child's."*

The same forensic rigour is necessary in this case given the very serious nature of the allegations.

18. Having said that, I offer the following observations, none of them particularly novel, which might assist in assessing the evidence of vulnerable witnesses, particularly those with learning disabilities. First, it is simplistic to conclude that the evidence of such a witness is inherently unreliable. Second, it is probably unfair to expect the same degree of verbal fluency and articulacy which one might expect in a witness without those problems. Third, it is important not to evaluate the evidence of such a witness on the basis of intuition which may or may not be unconsciously biased. Finally, it is important to take into account and make appropriate

allowances for that witness's disability or vulnerability, assisted by any expert or other evidence available. I have taken all these matters into account in reaching my decision.

Reasonable adjustments and recording

In *Heal v University of Oxford & Ors (Practice and Procedure)* [2019] UKEAT 0070_19_1607, the Employment Appeal Tribunal gave useful guidance both as to the scope of the duty to make reasonable adjustments, and also about the position where the reasonable adjustment requested is to record the proceedings.

a. Tribunals are under a duty to make reasonable adjustments to alleviate any substantial disadvantage related to disability in a party's ability to participate in proceedings.

b. Where a disability is declared and adjustments to the Tribunal's procedures are requested in the ET1 form, there is no automatic entitlement for those adjustments to be made. Whether or not the adjustments are made will be a matter of case management for the Tribunal to determine having regard to all relevant factors (including, where applicable, any information provided by or requested from a party) and giving effect to the overriding objective.

c. The Tribunal may consider whether to make a case management order setting out reasonable adjustments either on its own initiative or in response to an application made by a party.

d. If an application is made for reasonable adjustments, the Tribunal may deal with such an application in writing, or order that it be dealt with at a preliminary or final hearing: see Rule 30 of the ET Rules.

e. Where the adjustment sought is for permission for a party to record proceedings or parts thereof because of a disability-related inability to take contemporaneous notes or follow proceedings, the Tribunal may take account of the following matters, which are not exhaustive, in determining whether to grant permission:

i. The extent of the inability and any medical or other evidence in support;

ii. Whether the disadvantage in question can be alleviated by other means, such as assistance from another person, the provision of additional time or additional breaks in proceedings;

iii. The extent to which the recording of proceedings will alleviate the disadvantage in question;

iv. The risk that the recording will be used for prohibited purposes, such as to publish recorded material, or extracts therefrom;

v. The views of the other party or parties involved, and, in particular, whether the knowledge that a recording is being made by one party would worry or distract witnesses;

vi. Whether there should be any specific directions or limitations as to the use to which any recorded material may be put;

vii. The means of recording and whether this is likely to cause

unreasonable disruption or delay to proceedings.

f. Where an adjustment is made to permit the recording of proceedings, parties ought to be reminded of the express prohibition under s.9(1)(b) of the 1981 Act [3] on publishing such recording or playing it in the hearing of the public or any section of the public. This prohibition is likely to extend to any upload of the recording (or part thereof) on to any publicly accessible website or social media or any other information sharing platform.

Choudhury J explored the question of recording further at paragraphs 34-7 should this be a situation which is troubling readers in relation to any specific case.

Forced Marriage Protection Orders – the Court of Appeal rolls up its sleeves

Re K (Forced Marriage: Passport Order) [2020] EWCA Civ 190 (Court of Appeal (Sir Andrew McFarlane P, Peter Jackson and Haddon-Cave LJJ))

Other proceedings – family (public law)

Summary

This judgment is the first consideration by the Court of Appeal of Forced Marriage Protection Orders (FMPOs) made under s.63A Family Law Act 1996. The issues that arose were whether there was jurisdiction to make an FMPO where the person concerned had mental capacity to make relevant decisions and opposed the FMPO, and whether an indefinite Passport Order could be made in relation to an FMPO.

The case concerned a 35 year old woman, K, who had contacted police in 2015 saying that her family had threatened to murder her if she did not marry a relative. Similar concerns had also been raised by neighbours. The police applied for and were granted an FMPO at a without notice hearing. There followed a contested hearing a few months later, by which time K had withdrawn the allegations. The court decided that the FMPO should nevertheless continue, and ordered that K's passport should be held by the police until further order. Shortly after the hearing, K fled the family home alleging assault, but again later withdrew the allegation. She was moved to a refuge. In 2017, K wanted to travel to Pakistan for the funeral of her mother, but her application for discharge of the FMPO and the Passport Order was refused, K not having engaged with professional advice about how to protect herself during foreign travel. K's application for permission to appeal was granted and sent to the Court of Appeal, which allowed the appeal only to the extent of imposing a 4 year time limit on the Passport Order, at which stage the court would need to review whether it should be continued.

The Court of Appeal noted that forced marriage was a '*fundamental abuse of human rights, a form of domestic abuse, and…a criminal offence*'. It was not confined to children or adults who lacked capacity, and 1 in 5 victims was male. It was not a one-off event: "*…the marriage forms the start of a potentially unending period in the victim's life*

[3] Section 9 of the Contempt of Court Act 1981, which would also apply in relation to proceedings before the Court of Protection.

where much of her daily experience will occur without their consent and against their will, or will otherwise be abusive. In particular, the consummation of the marriage, rather than being the positive experience, will be, by definition, a rape. Life for an unwilling participant in a forced marriage is likely to be characterised by serial rape, deprivation of liberty and physical abuse experienced over an extended period. It may also lead to forced pregnancy and childbearing. The fate of some victims of forced marriage is even worse and may include murder, other "honour" crime or suicide". As such, a forced marriage was likely to include behaviour sufficient to breach Article 3 ECHR.

The Court of Appeal was clear that Parliament had not sought to limit the use of FMPOs to people without mental capacity. There was no mental capacity test in the legislation, nor any linkage to the MCA 2005 – instead, the legislation provided that the wishes and feelings of the adult concerned were just one factor among many that the court had to consider. This could give rise to an obvious conflict between Article 3 and Article 8, so '*the court must strive for an outcome which takes account of and achieves a reasonable accommodation between the competing rights… The required judicial analysis is not a true 'balancing' exercise in consequence of the imperative duty that arises from the absolute nature of Article 3 rights. Where the evidence establishes a reasonable possibility that conduct sufficient to breach Article 3 may occur, the court must at least do what is necessary to protect any potential victim from such a risk. The need to do so cannot be reduced below that necessary minimum even where the factors relating to the qualified rights protected by Article 8 are particularly weighty*.'

In practice, this meant the court assessing the level of risk, the quality of available protective factors and the nature and extent of the interference with Article 8 rights that would be entailed by making an FMPO. This would include an analysis of the proportionality of making an order, so that consideration would have to be given to whether a less intrusive measure might suffice, and to balancing the effect of the order on the person concerned against the objective and the likelihood of that objective being achieved.

The Court of Appeal set out a 'routemap' for decisions in future cases:

- Stage 1: Establish the underlying facts based upon admissible evidence and by applying the civil standard of proof. The burden of proof will ordinarily be upon the applicant who asserts the facts that are said to justify the making of a FMPO.
- Stage 2: If the making of the order is contested at a hearing on notice, determine any relevant factual issues.
- Stage 3: Assess both the risks and the protective factors that relate to the particular circumstances of the individual who is said to be vulnerable to forced marriage. Consider drawing up a balance sheet. Decide whether there is a real and immediate risk that Article 3 is engaged.
- Stage 4: If the facts are sufficient to establish a risk that the subject will experience conduct sufficient to satisfy ECHR, Article 3, undertake the exercise of achieving an accommodation between the necessity of protecting the subject of the application from the risk of harm under

Article 3 and the need to respect their family and private life under Article 8 and, within that, respect for their autonomy. This is not a strict "balancing" exercise as there is a necessity for the court to establish the minimum measures necessary to meet the Article 3 risk that has been established under Stage Three.

The Court of Appeal noted that the length, breadth and specific content of an FMPO would be case-specific, and that it was '*unlikely in all but the most serious and clear cases'* that an indefinite order would be appropriate.

On the question of indefinite Passport Orders, the Court of Appeal concluded that this power clearly existed, even where the person concerned had capacity and was objecting, and could even extend to making an order against the person themselves. In practice though, an open-ended Passport Order should only be imposed '*in the most exceptional of cases'* and generally speaking, a time limit should be included.

Comment

The Court of Appeal's helpful routemap for judgments in this very difficult area is welcome. It is interesting to compare the FMPO legislation, which expressly permits the making of orders that interfere with the Article 5 and 8 rights of people who have capacity, with the situation in respect of 'vulnerable adults' who are subject to the High Court's inherent jurisdiction. In the latter case, the absence of any statutory framework means that Parliamentary consideration has not been given to the circumstances in which such interferences may be justified, and the level or nature of risk that would need to be present. In the continuing absence of any statutory framework, the guidance in respect of FMPOs may be of some assistance by analogy.

THE WIDER CONTEXT

Mental Capacity Action Days

The National Mental Capacity Forum is holding three action days this year, focusing on the 'support principle' in the MCA 2005. The days are 1 April in Manchester (at which Alex will be speaking), 28 April in Cardiff and 3 June in Bournemouth. For more details, see here.

Brain death and the courts: update

Further to the analysis in our February Report, the Court of Appeal dismissed on 14 February the appeal against the decision of Lieven J in *Manchester University NHS Foundation Trust v Namiq* [2020] EWHC 180 (Fam) (although varied her order to reflect the wording used in the earlier decision of Hayden J in *Re A (A Child)* [2015] EWHC 443 (Fam)) The Court of Appeal not only upheld the approach Lieven J took to the court's task, but also the approach she took to the naming of the treating clinicians, noting (at paragraph 102) that:

> *in the decade since Sir James Munby considered this matter the world has changed. The manner in which social media may now be deployed to name and pillory an individual is well established and the experience of the clinicians treating child patients in cases which achieve publicity, such as those of Charlie Gard and Alfie Evans, demonstrate the highly adverse impact becoming the focus of a media storm may have on treating clinicians.*

This is also an opportunity to highlight the talk that Tor and Ben Tankel gave at the recent Chambers seminar on brain death and the courts, available here.

Short note: when not to presume upon a presumption

The correct application of the presumption of capacity in s.1(2) MCA is a perennially difficult question. On the one hand, we have the situation of rushing too quickly to question capacity – often in the context of a decision that does not 'suit' the concerns of professionals. On the other, we have the problem identified by the House of Lords Select Committee in its post-legislative scrutiny of the MCA 2005 in 2014:

> *The presumption of capacity, in particular, is widely misunderstood by those involved in care. It is sometimes used to support non-intervention or poor care, leaving vulnerable adults exposed to risk of harm. In some cases this is because professionals struggle to understand how to apply the principle in practice. In other cases, the evidence suggests the principle has been deliberately misappropriated to avoid taking responsibility for a vulnerable adult. (para 105)*

In this context, the decision of the Employment Appeal Tribunal (Swift J) in *Royal Bank Of Scotland Plc v AB* [2020] UKEAT 0266_18_2702 is a very useful contribution to the debate. The facts of the case are not relevant, save that they concerned a challenge to an Employment Tribunal's decision not to conclude that an assessment of the applicant's capacity to litigate was wrong. As Swift J held:

> *22. Nevertheless, my conclusion is that in this case the Employment Tribunal was wrong to conclude that an assessment of AB's capacity to litigate was not necessary. It is right that any Tribunal must take care before concluding that*

assessment of a litigant's capacity to litigate is necessary. Simler P's words of warning, at paragraph 38 of her judgment in ***Jhuti***, are important. Tribunals must not permit arguments about litigation capacity to be used discriminately or unscrupulously. The risk of misuse must be carefully policed. However, where there is legitimate reason to doubt a litigant's capacity to litigate, that issue must be addressed. A litigant who lacks the capacity to litigate lacks the ability fairly to participate in legal proceedings. It is unfair to permit proceedings to continue in those circumstances until that litigant's interests are properly represented whether by a litigation friend or a court-appointed Deputy.

23. The way AB presented to the Employment Tribunal on the afternoon of 25 July 2017 did provide reason to suspect that she might not have had capacity to conduct the litigation. She did not appear to recognise her counsel; and she appeared unable to respond to simple questions. Although it is true that the presumption of capacity at section 1(2) of the 2005 Act can only be displaced by evidence that establishes a lack of capacity, the issue for the Employment Tribunal on 25 – 26 July 2017 was not to decide whether AB lacked capacity but whether there was good reason for concern that AB might lack capacity such that an assessment was required.

24. In reaching its decision that no such assessment was required, the Employment Tribunal relied on four matters: (a) the view of AB's lawyers that they were satisfied they were able to continue to act for AB; (b) the views of Dr Ornstein in a report dated 21 July 2017; (c) the fact that neither Dr Ornstein or Dr Stein had notified the Employment Tribunal that their opinion was that AB lacked capacity; *and (d) and the presumption at Section 1 (2) of the 2005 Act.*

25. Reasons (a) and (c) do not withstand scrutiny. Dr Ornstein's capacity report dated 21 July 2017, even though written a matter of days before the remedies hearing commenced (on 24 July 2017), was written only on the basis of Dr. Ornstein's prior engagement with AB. The last time he had examined AB was on 28 April 2017. More importantly Dr Ornstein had not been present at the Tribunal on the afternoon of 25 July 2017. Next, the Tribunal's reliance on the absence of a report from either Dr Ornstein or Dr Stein stating an opinion that AB lacked litigation capacity was illogical. As the Tribunal ought to have realised, neither Dr Ornstein nor Dr Stein had had the chance to examine AB or express an opinion in light of events of the afternoon of 25 July 2017. Moreover, this part of the Tribunal's reasoning indicates that it was failing to address the right question. The question at this stage was not whether AB lacked capacity to litigate but whether there was a permissible basis for enquiries to be made as to whether she lacked that capacity. Taken together, these points entirely undermine the Tribunal's reliance on the views expressed by AB's lawyers that they were "able to continue to act for AB". Given the way that AB had presented at the Tribunal hearing, and the obvious concern her lawyers had previously had in respect of capacity, which had led them to obtain Dr Ornstein's capacity report of 21 July

> *2017, and the lack of an up to date expert opinion, the Tribunal placed more weight on the assertions of AB's lawyers than those assertions could rationally bear.*
> 26. This leaves the Tribunal's reliance on the section 1(2) presumption of capacity. The presumption of capacity is important; it ensures proper respect for personal autonomy by requiring any decision as to a lack of capacity to be based on evidence. Yet the section 1(2) presumption like any other, has logical limits. When there is good reason for cause for concern, where there is legitimate doubt as to capacity to litigate, the presumption cannot be used to avoid taking responsibility for assessing and determining capacity. To do that would be to fail to respect personal autonomy in a different way. As Simler P pointed out in ***Jhuti***, a litigant who lacks capacity is effectively unrepresented in proceedings since she is unable to take decisions on her own behalf and unable to give instructions to her lawyers. Thus, although any Tribunal should be alert to guard against attempts by litigants to use arguments about capacity improperly, if, considered objectively, there is good cause for concern that a litigant may lack litigation capacity, an assessment of capacity should be undertaken. What amounts to "good cause" will always require careful consideration, and it is not a conclusion to be reached lightly. For example, good cause will rarely exist simply because a Tribunal considers that a litigant is conducting litigation in a way with which it disagrees, or even considers unreasonable or vexatious. There is likely to be no correlation at all between a Tribunal's view of what is the "common-sense" conduct of a piece of litigation and whether a litigant has capacity to conduct that litigation. Something qualitatively different is required.
>
> 27. In this case, the Tribunal's reliance on section 1(2) of the 2005 Act was in error. The Tribunal relied on the section 1(2) *presumption to create Catch-22: a conclusion that an assessment of AB's capacity to litigate would only be appropriate if there was already expert evidence that she lacked capacity to litigate. That was a misapplication of section 1(2) of the 2005 Act. Section 1(2) does require any lack of capacity to be "established"; but it does not require a lack of capacity to be established before a court can require an assessment of capacity. That proposition only has to be stated to be recognised as self-defeating. In the present case, the only issue for the Tribunal raised by RBS's application was whether there was good cause for concern that AB might lack capacity to conduct the litigation. In this case good cause for concern plainly did exist. The Tribunal ought to have concluded that an assessment of AB's capacity to conduct the litigation* should have been undertaken.

Paragraph 26, in particular, is hugely helpful in terms of finding its way through the presumption problem, not just in terms of litigation capacity but also more broadly.

New guidance on Prolonged Disorders of Consciousness

New guidelines were published on 6 March by the Royal College of Physicians and endorsed or supported by a further 15 health bodies offer updated guidance on the diagnosis, assessment,

care and management of patients with prolonged disorders of consciousness.

Prolonged disorders of consciousness following sudden onset brain injury: National clinical guidelines is an updated version of the 2013 guidelines, incorporating guidance on the new legal situation (see below) and developments in assessment and management. It will support doctors, other clinicians, families and health service commissioners to ensure that everyone is aware of their legal and ethical responsibilities.

Prolonged disorder of consciousness includes vegetative state (VS) and minimally conscious state (MCS) but not short-term coma. There is no reliable information on how many people may be in prolonged disorders of consciousness being cared for at home or in nursing/care homes across the UK. Estimates vary widely between 4,000 and 16,000 patients with long-standing VS and perhaps three times that number in MCS. The guideline recommends that a national registry should be set up to collect details of patients with prolonged disorders of consciousness which would include a register of doctors experienced in managing these conditions.

The guidelines provide key information about assessment, diagnosis and management of VS and MCS as well as advice for supporting families.

In the early stages following severe brain injury, it is often unclear which patients will and will not regain consciousness or the level of recovery they might achieve. Proactive treatment and specialist assessment/management provide the best opportunity for maximising any potential. However, the longer a patient remains in VS/MCS, the less likely it is that they will recover a quality of life that they would value. This poses difficult questions for families and treating teams about whether the patient would want to continue to receive life-sustaining treatment under certain circumstances.

While decision-making starts from the strong presumption that it is in the patient's best interests to prolong life, this presumption can be rebutted if there is evidence that the patient him/herself would not want to receive that treatment under the circumstances that have arisen.

Patients with prolonged disorders of consciousness may receive a number of life-sustaining treatment including clinically assisted nutrition and hydration (CANH). The guidance has been updated following the decision of the Supreme Court in *NHS Trust v Y* [2018] UKSC 42 that it is no longer necessary to apply to a court for approval to withdraw CANH provided certain conditions are met, specifically:

- the provisions of the Mental Capacity Act (MCA) 2005, which covers decision-making for those who lack capacity have been followed. The MCA highlights the responsibility of clinicians to ensure that any treatment or intervention is given in the patient's best interests taking into account their likely wishes; and
- relevant guidance is observed (including clinical/professional guidance); and
- there is agreement that continued treatment is not in the best interests of the patient.

The guidance addresses the practical workings out of this judgment, as well as the guidance in the recent Serious Medical Treatment Practice

Guidance from the Vice-President, relating to potential conflicts of interest.

As it is the giving, not withdrawing of treatment that must be justified under the Mental Capacity Act (MCA) 2005, the new guidelines emphasise that it is the responsibility of clinicians to initiate best interests discussions. These should be started from an early stage following severe brain injury and re-visited on a regular basis. The guidelines offer helpful advice and resources to support this process. Nevertheless, many clinicians still feel under-prepared for these conversations, and there is need for widespread training and education to implement this practice effectively.

Importantly, this is not just an issue for healthcare professionals – hospitals, care homes and commissioning services need to understand that this is a legal requirement, binding on everyone concerned with the management of patients with prolonged disorders of consciousness as an aspect of their duties towards them.

[Full disclosure: along with Yogi Amin, Alex was one of the two legal advisers to the Guideline Development Group.]

Promoting sexual safety through empowerment

> *It is a basic human right for people to express their sexuality and to be empowered, supported and protected when using adult social care services. We want this report to encourage a conversation about sexual safety, sexuality and respectful relationships in adult social care.*

Developing its previous work, the CQC's latest report, *Promoting sexual safety through empowerment: A review of sexual safety and the support of people's sexuality in adult social care* (February 2020) emphasises that talking about sexuality in adult social care should not be taboo. A 3-month review analysed 661 statutory notifications that described 899 sexual incidents/alleged sexual abuse that took place in adult social care services (3% of the total notifications of alleged/abuse). Almost half were categorised as sexual assault, and nearly 60% of incidents were alleged to be carried out by others using the services. In 16% of cases, the allegations were against employed staff or visiting workers.

Lessons

The CQC identified the following lessons from its review:

- People are better protected when they are empowered to speak out about unwanted sexual behaviour and can speak openly about their sexuality
- Effective adult social care leaders develop a culture, an environment, care planning and processes that keep people and staff safe, and support people's sexuality and relationship needs
- People want to be able to form and maintain safe sexual relationships if they wish
- The impact of people's health conditions on sexual behaviour is not well understood
- Women, particularly older women, were disproportionately affected by sexual incidents in our findings

- There are some actions that providers in all care settings can carry out to help keep people in their service safe from sexual harm
- There are emerging concerns about the use of social media, mobile phones and the internet in sexual abuse
- Joint-working with other agencies, such as local authorities and the police, is vital to keep people safe

The report highlights that a lack of awareness of good practice in sexual safety and sexuality can place people at risk of harm, and an open culture must be developed where people and staff feel empowered to talk about sexuality and raise concerns around safety. In some cases, the notifications related to consensual activity, indicating that staff did not fully understand the issues and risked inappropriate interference:

> *Staff witnessed [the man] with his hands down the front of [the woman's] trousers and appeared to be making a stroking motion. She had her hands placed over his crotch area over his trousers and her head lay on his shoulder. Staff intervened immediately and assisted both residents to separate using distraction techniques.*
>
> (Excerpt from notification)

Good practice

The CQC identified the following principles of good practice to be used in all adult social care services:

- Leaders should promote a culture of openness that allows people to both discuss issues of sexuality and raise issues of sexual safety, as part of a holistic approach to good person-centred care.
- People receiving adult social care are entitled to the same human rights as anyone else, and should be afforded the same dignity, choice, family life, privacy and respect, and should be able to feel safe from sexual harm.
- People who use services should be central to conversations about their needs and choices. Where seen as supportive and agreed to, family members, carers and advocates can also be included.
- Assessments should include information about people's sexuality needs (including current relationships, sexual orientation and understanding of sexual health, where appropriate) as well as any past criminal or predatory behaviour. Care plans should accurately reflect these assessments and note the needs and wishes of people.
- Training should include supporting staff to have informal, everyday conversations about sexuality and sexual safety.
- Recruitment and organisational values should have a human rights focus.
- Providers should work with relevant community groups to give staff and people who use services support and access to information on sexual safety and sexuality.

National Care Review of NHS learning disabilities hospital inpatient provision in Wales

NHS Wales National Collaborative

Commissioning Unit has published "Improving Care, Improving Lives," a National Care Review of Learning Disabilities Hospital inpatient Provision Managed or Commissioned by NHS Wales, as part of the Welsh Government Learning Disability – Improving Lives Programme. The Programme focuses on keeping individuals as independent as possible and out of long-term institutional care.

The Review was undertaken in 2019 and included all patients cared for in hospitals provided by NHS Wales or commissioned by NHS Wales from NHS England or the independent sector. It highlights key issues about the care and treatment of people who are inpatients in learning disability hospitals. Amongst the Review's key findings were:

- There is an aging patient cohort. The Review found that many patients with a learning disability have concurrent diagnosis such as dementia and autism and that required fit-for-purpose environments and trained, experienced staff to manage these complex presentations.
- Patients with long lengths of stay and many transferred between hospitals when alternatives could have been considered.
- Issues with some patients being deprived of their liberty and ensuring that the full protection of the legal safeguards were being applied.
- Not all patients had a care plan in place and not all care plans were being regularly reviewed.
- A high use of psychotrophic medications and a scarcity of therapy staff.
- Many occurrences of behaviours that challenge, and ensuring that staff were empowered, trained and present in sufficient numbers to take a positive patient-centred approach to preventing harm.
- Restrictive interventions were sometimes required and the Review found many occasions where they had been applied.
- Patients had been in regular contact with primary and urgent healthcare services and it was necessary to ensure that the physical well-being of patients was assessed, monitored and maintained.
- Many, but not all, patients were satisfied with their admission and felt that staff were supportive.
- A significant number of patients who may be considered for transition to the local community.

The Review makes 70 specific recommendations to be considered by providers and commissioners of care, as well as Welsh Government. Whilst not all 70 recommendations are set out here, they include:

- Recommendation 9: Commissioners should ensure that no hospital bed is classed as an individual's home and every endeavor should be made to see community care as the 'default option' for all patients.
- Recommendation 10: Commissioners should target resources at transitioning those patients in assessment and treatment units with a length of stay over one year, and those in other providers with a length of stay over five years.

- Recommendation 11: Providers should ensure that all patients, not subject to detention under the Mental Health Act or to Deprivation of Liberty Safeguards, have the capacity to consent to being an inpatient.
- Recommendation 12: Providers should ensure that all patients subject to detention under the Mental Health Act or to Deprivation of Liberty Safeguards are aware of their rights.
- Recommendation 13: Commissioners should ensure that all patients subject to detention under the Mental Health Act or to Deprivation of Liberty Safeguards are subject to regular review.
- Recommendation 16: Commissioners should ensure that care plans are reviewed regularly, within a maximum time period of six months.
- Recommendation 17: Providers should ensure that hospital support plans are reviewed regularly, within a maximum time period of three months.
- Recommendation 23: Welsh Government should consider establishing a national campaign to support the reduction in the inappropriate use of psychotropic medication.
- Recommendation 24: Providers should ensure that all medication is prescribed at the minimum dosage to alleviate the verified symptoms.
- Recommendation 27: Providers must ensure that the patient, local care team and carers are involved in the decision to commence or discontinue any psychotropic medication.
- Recommendation 35: Providers should ensure that any restrictive intervention involves the minimum degree of force, for the briefest amount of time and with due consideration of the self-respect, dignity, privacy, cultural values and individual needs of the patient.
- Recommendation 36: Providers should ensure that all incidents of restrictive interventions are recorded, reviewed and reported.
- Recommendation 53: Commissioners should ensure that patients with low Levels of Care that demonstrate that a less restrictive environment could meet their care needs are considered for transition.
- Recommendation 63: Commissioners should ensure that all transition plans are enacted.

Short note: capacity and representation before the Mental Health Tribunal

The Upper Tribunal ("UT") decision of *SB v South London and Maudsley NHS Foundation Trust* [2020] UKUT 33 (AAC) considers the position where a patient involved in proceedings before the Mental Health Tribunal ("the Tribunal") wishes to change the legal representative appointed for him by the Tribunal under Regulation 11(7)(b) of the Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care) Rules 2008. Reg 11(7)(b) empowers the Tribunal to appoint a legal representative where "the patient lacks the capacity to appoint a representative but the Tribunal believes that it is

in the patient's best interests for the patient to be represented".

The UT found that, as the appointment was made under rule 11(7) by Tribunal staff under delegated powers, the recipient should have been advised that he was entitled to apply in writing within 14 days for the decision to be considered afresh by a judge pursuant to rule 4(3).

As for the refusal by the Tribunal to rescind the appointment, the UT confirmed that this can only be done by way of a case management decision under rule 5. However, in this regard the Tribunal had exercised its discretion unlawfully for various reasons. In particular, recent evidence that the patient had capacity to request a change of legal representative was not brought to the Tribunal's attention despite the principle in s.1(2) Mental Capacity Act 2005 that a person must be presumed to have capacity unless it is established that he is incapacitous. Further, the Tribunal failed to give consideration to the fact that the relevant capacity test was a lower threshold than that required for conducting proceedings. In addition, the Tribunal seemed to accept as determinative the objection of the appointed legal representative to being discharged. However, this factor did not necessarily trump the need to have regard to the patient's wishes and feelings and the need to ensure that the parties are able to participate fully in the proceedings.

Short Note: compelling public authorities to act

R (M) v London Borough of Newham [2020] EWHC 327 (Admin) was a judicial review case brought by the father of a family which included a young woman, A, who had a range of physical disabilities and learning disabilities, who required a considerable amount of care which was provided by her mother.

The local authority accepted it had a duty to house the family back in 2005 but had failed to find suitable accommodation for them. A house was offered in 2017 which the local authority said was suitable, but the bathrooms were not big enough for A to use them, because of the specialist equipment required.

The family moved in anyway, while the dispute rumbled on. The local authority accepted that the house was not suitable in the long term, but by the time of the hearing, 2 more years had passed, and still nothing suitable had been found for the family. There was medical evidence that A needed to move urgently because of the risk to her health from lack of adequate washing and toileting facilities.

Unusually, the Administrative Court made a mandatory order compelling the local authority to find suitable accommodation for the family within 12 weeks. The court found that the local authority had already admitted the current property was unsuitable and that it was therefore in breach of its statutory duties, but even if it was right that the local authority be allowed a reasonable time to find suitable accommodation, such a time period had clearly expired. The Court was unimpressed with the local authority's evidence which suggested they had not taken the case seriously and had no excuse for the delay in finding suitable accommodation.

The case contains a useful review of the relevant authorities and may be of assistance

in Court of Protection cases where there are public law failings to make available suitable accommodation to disabled people.

Survey: online risk and adults with intellectual disabilities

The University of Suffolk and Cambridgeshire County Council are undertaking a collaborative research exercise (with Alex) on this difficult subject.

Background

Anyone who has worked with children and young people, will know that there are a range of resources and educational tools for children, young people and the professionals and families that support and enable them to engage with the online world safely. This all being supported by a plethora of academic research and supporting government schemes in this area.

However, there has been limited research internationally that has explored how the internet is used and accessed by adolescents and adults who have intellectual disabilities including Autistic Spectrum Disorder (ASD). As such, there has been little or no training or guidance specifically designed for health and social care practitioners to:

- enable adults with an ID to be digitally included/enabled,
- support adults with ID to manage online risks, and
- consider issues that give rise to concerns about a person's mental capacity to manage potential online risks.

Research Summary

The research will initially explore the experiences of professionals working in the adult social care sector, of supporting people with intellectual disabilities (including ASD) to engage with the online world and their experiences and perceptions of 'risk' in this area.

It will also explore what education and training health and social care professionals have accessed so far, what training tools or resources would improve professional knowledge in this area and include the development of initial guidance for professionals to access, based on the findings from the research.

Getting involved in the research

If you wish to take part in the research, the survey can be found here.

At this stage, the survey is only aimed at professionals in England and Wales, and is not to be completed by family carers or individuals with an intellectual disability. It is open to any health and social care professional who supports people 16 years and over who also have an intellectual disability (including ASD). This could include all health and social care professionals working for a local authority, best interest assessors, local learning disability and specialist ASD care services. It is also open to members of the police.

The survey is entirely anonymous and non-attributable to any identifying information. Any data is stored securely in a password protected, GDPR compliant, data store with access available only to researchers at the University of Suffolk. It has been evaluated by the University of Suffolk research ethics committee and has approved ethical governance.

If you wish to find out more about this project email Professor Emma Bond (e.bond@uos.ac.uk) or Professor Andy Phippen (andy.phippen@plymouth.ac.uk).

Further guidance about secure accommodation

The President of the Family Division, Sir Andrew MacFarlane, has given further guidance on the appropriate legal route for authorising the deprivation of liberty of children via secure accommodation. This was considered necessary in light of some confusion that has arisen following the Court of Appeal's decision in *Re B* [2019] EWCA Civ 2025.

The key point is that *Re B* does not require the court to use s.25 of the Children Act 1989 as the route for determining applications for a deprivation of liberty in a unit which has not been approved by the Secretary of State as "secure accommodation". Rather, such applications should continue to be considered under the inherent jurisdiction.

The guidance is available here.

Short Note: family life, discrimination and rights

In *Cinta v Romania* (Application no. 3891/19), a decision of the European Court of Human Rights dated 18 February 2020, the court found a breach of Article 8 ECHR, as well as Article 14, and awarded 10,000 euros in damages. This was in circumstances where the Romanian courts had approved significant restrictions on contact between a father with paranoid schizophrenia and his four year old daughter (Y).

The applicant and his wife (X) were in the process of getting divorced, with X arguing that the applicant's mental health problems meant that he posed a risk to Y such that contact had to be restricted. The authorities, and then the courts, accepted X's argument despite a lack of clear evidence about the way in which the applicant's condition meant that he was unable to care for Y or otherwise endangered Y. This was in the context of evidence from the hospital treating the applicant that he had been compliant with his medication and had not suffered any psychiatric episode in the last two years.

In these circumstances the court found that there no "objective element" (para 48) in the domestic decisions to substantiate X's allegations that the applicant's mental disorder posed a threat for Y, and was troubled by the absence of independent expert evidence. This resulted in the finding that Article 8 had been breached, the court observing that the margin of appreciation is substantially narrower where the interference with human rights concerns "*someone belonging to a particularly vulnerable group in society that has suffered considerable discrimination in the past, such as the mentally disabled*" (paragraph 41)

In finding a violation of Article 14 ECHR the court relied on similar factors as well, expressly, as the CRPD:

> *76. The international standards and recommendations* […] *encourage respect for equality, dignity and equality opportunities for persons with mental disabilities. Of particular relevance for the facts of the present case, mentally-ill persons must receive appropriate assistance from the State in the*

performance of their child-rearing responsibilities, and children must not be separated from their parents without a proper judicial review of the matter of the competent authorities.

Short Note: disability and the contractual balance

In *TUV v Chief of the New Zealand Defence Force* [2020] NZCA 12, the New Zealand Court of Appeal made some interesting observations about the common law approach to contractual capacity (which is the same in New Zealand as in England & Wales, but not to that in Scotland, which follows the civil law here). The orthodox approach to capacity provides that a contract is voidable (not void, as it is in Scotland and in civil law countries) if:

(a) that party lacked the mental capacity to enter into the transaction; and

(b) the other party knew or ought to have known of that lack of capacity.[4]

The facts of TUV arose in a factual matrix irrelevant for these purposes, but the following observations are of wider relevance:

The balance struck by the orthodox approach to capacity

[57] The law of contract seeks to strike a balance between respect for the autonomy of contracting parties and protection of the vulnerable, including those who are vulnerable as a result of mental illness.

[58] If a party lacks capacity, and the other party knows this, there can be no justification for enforcing a contract between them if the incapacitated party (or their representative) wishes to set it aside. Similarly, if the other party is on notice that an individual may lack capacity, they should not be permitted to turn a blind eye to those circumstances and take the benefit of a contract that exploits that incapacity. Rather, if they refrain from making inquiries, they take the risk that the contract will be set aside because the other party lacked capacity to enter into it.

[59] But on the orthodox approach, a contracting party dealing with an individual who is not a minor can proceed on the basis that that individual has contractual capacity unless they know the individual lacks capacity, or are aware of circumstances that would put a reasonable person on inquiry about the individual's capacity. They can enter into contracts with that individual without needing to actively inquire into questions of capacity, absent such notice, and do not face the risk of subsequent invalidation of the contract on the basis of a lack of capacity. That approach is consistent with the objective approach to contract formation that underpins the common law of contract. It promotes certainty. It also reduces barriers to contracting for individuals, because other people who deal with them can assume capacity and do not need to make inquiries or take other active steps to ascertain their capacity.

[60] If capacity could not be assumed, then in some (potentially quite broad)

[4] In New Zealand, the test is set down in the decision in *O'Connor v Hart*; in England & Wales, by *Imperial Loan Co Ltd v Stone* [1892] 1 QB 599; see also *Dunhill v Burgin* [2014] UKSC 1.

circumstances the risk of a contract being voidable for incapacity would incentivise businesses and other people entering into significant transactions with individuals to seek comfort on that issue: for example, by requiring a certificate in relation to capacity from the individual's lawyer or a doctor. That would increase the cost and practical difficulty of contracting for many individuals — not just those who do in fact lack capacity. The cost and inconvenience of steps of this kind could prevent entry into contracts that those individuals wish to enter into and would benefit from. In other cases, the contract would be entered into despite the cost and inconvenience of such steps, but that additional cost would be borne by the parties — including the individuals who were required to take steps to establish their capacity to enter into the contract. The purpose of the second limb of the test in O'Connor v Hart is to avoid creating barriers to contracting and costs of contracting of this kind.

[61] Nor, it should be noted, is this a test that has been developed solely — or even primarily — in a commercial context. O'Connor v Hart itself was a case about an elderly farmer selling a family farm. All cases about mental capacity by definition concern dealings by individuals. Many of these are family transactions rather than truly commercial transactions.

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 two outputs from the Wellcome-funded Mental Health and Justice Project. The first is an article by Dr Oliver Lewis and Professor Genevra Richardson on "The right to live independently and be included in the community" appearing in the International Journal of Law and Psychiatry, which offers a commentary on article 19 of the UNCRPD, drawing on its drafting history, on the interpretation provided by the responsible UN body and on the efforts by that body to monitor and encourage compliance. It emphasizes the extent of the transformation required to realize the full ambition of the article and the need for cooperation across UN treaty bodies.

The second, also on Article 19 CRPD, and appearing in the same journal, is by Emma Wynne Bannister and Sridhar Venkatapuram, and is entitled "Grounding the right to live in the community (CRPD Article 19) in the capabilities approach to social justice."

SCOTLAND

The DEC:IDES Trial: Developing the supported decision-making evidence base

[*We are pleased to be able to include here an article on this important project, co-written by Amanda Woodrow, Research Assistant for DEC:IDES & Professor Jill Stavert, Co-Investigator for DEC:IDES*]

People who develop a psychotic illness such as schizophrenia can often be faced with the consequences of being judged to lack treatment decision-making capacity. This can leave them vulnerable to the receipt of involuntary psychiatric care, which may be life-changing and traumatic.

Where this capacity is assessed as actually or potentially lacking clinicians are obliged to support its return, so their patients can take part in decision making and avoid involuntary treatment. However in their scrutiny of the English Mental Capacity Act 2005 implementation, the House of Lords concluded: "Our evidence suggests that (supported decision-making) is rare in practice" [5] and the United Nations Committee on the Convention on the Rights of Persons with Disabilities (UNCRPD) makes it clear that having access to appropriate supported decision making is essential if the UK is to be compliant with Article 12 of the UNCRPD. [6] In response, the Scottish Government is devising a national strategy on supported decision-making, legislation in Scotland and England is being reviewed with UNCRPD compliance in mind, including a strengthened emphasis on supporting capacity, and the 2018 NICE Guideline requires all practitioners and organisations to document what they have done to support decision-making capacity.[7]

Despite the importance and legal obligation to support capacity there is a lack of evidence on how to do this effectively in practice, and there is a lack of effective and acceptable psychological interventions to aid this. Recent research indicates that a lack of capacity is likely to stem from interactions between cognitive, emotional and social factors, the effects of which are moderated by a person's awareness of them; suggesting that psychological therapies may particularly relevant to the improvement of these potential causal factors.

The aim of DEC:IDES (DEcision-making Capacity: Intervention Development and Evaluation in Schizophrenia-spectrum disorder) is to address this gap in evidence. It is the first funded randomised controlled trial (RCT) of its kind to focus on supporting decision-making in people with psychosis. DEC:IDES is running as an 'umbrella' trial, comprising three small scale concurrent RCTs, each delivering one of three psychological interventions. The interventions target low self-esteem, high levels of self-stigma, and the 'jumping to conclusions' bias – a

[5] House of Lords Select Committee on the Mental Capacity Act 2005. *Mental Capacity Act 2005: Post-Legislative Scrutiny*.; 2014.
[6] United Nations Committee on the Rights of Persons with Disabilities. *General Comment No. 1; Article 12: Equal Recognition before the Law*.; 2014.
[7] National Institute for Health and Care Excellence. Decision making and mental capacity, NICE Guideline NG108.; 2018.

tendency for patients with psychosis to make decisions quickly, based on reduced or incomplete evidence. Participants in DEC:IDES will have a 50% chance of receiving either 6 weekly 1-hour sessions of therapy to help them with decision-making, or 6 weekly 1-hour sessions of more in-depth assessment of what helps or hinders their decision-making.

This phase of the research is focused primarily on feasibility; gathering information on whether people with psychosis are interested in taking part, and monitoring adherence and attrition rates. The data gathered will help inform the design and acceptability of a full-scale trial in the future.

DEC:IDES is funded by the Chief Scientist Office, sponsored by Edinburgh Napier University and supported by NHS Lothian, Pennine Care NHS Foundation Trust, and Lancashire Care NHS Foundation Trust, with recruitment taking place from March 2020 to March 2021. The Chief Investigator for DEC:IDES is Dr Paul Hutton, Associate Professor of Therapeutic Interventions at Edinburgh Napier University.

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

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Nicola appears regularly in the Court of Protection in health and welfare matters. She is frequently instructed by the Official Solicitor as well as by local authorities, CCGs and care homes. She is a contributor to the 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.

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

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

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

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Conferences

Approaching complex capacity assessments

Alex will be co-leading a day-long masterclass for Maudsley Learning in association with the Mental Health & Justice project on 15 May 2020, in London. For more details, and to book, see here.

2020 World Congress in Argentina

Adrian will be speaking at the 6th World Congress to be held at Buenos Aires University, Argentina, from 29th September to 2nd October 2020, under the full title "Adult Support and Care" and the sub-title "From Adult Guardianship to Personal Autonomy." For more details, see here.

Other conferences and events of interest

Mental Diversity Law Conference

The call for papers is now open for the Third UK and Ireland Mental Diversity Law Conference, to be held at the University of Nottingham on 23 and 24 June. For more details, 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 March 2020. Please email us with any judgments or other news items which you think should be included. If you do not wish to receive this Report in the future please contact: marketing@39essex.com.

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