MENTAL CAPACITY REPORT: COMPENDIUM

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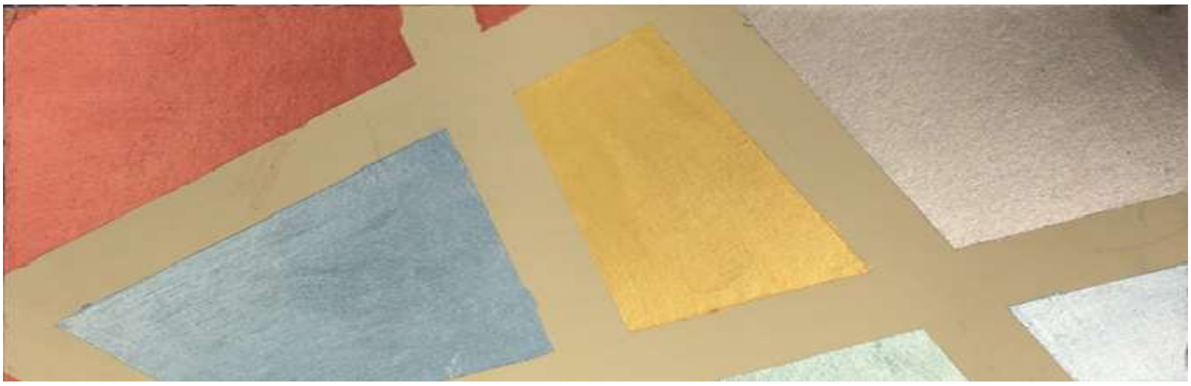

Welcome to the March 2021 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: two cases each on vaccination, how long to keep going with life-sustaining treatment and obstetric arrangements, and important decisions on both family life and sexual relations;

(2) In the Property and Affairs Report: Mostyn J takes on marriage, ademption and foreign law, and updates from the OPG;

(3) In the Practice and Procedure Report: reasonable adjustments for deaf litigants and a new edition of the Equal Treatment Bench book;

(4) In the Wider Context Report: DNACPR guidance from NHS England, NICE safeguarding guidance, reports on law reform proposals of relevance around the world and (an innovation) a film review to accompany book reviews and research corner;

(5) In the Scotland Report: Scottish Parliamentary elections, Child Trust funds and analogies to be drawn from cases involving children.

You can find our past issues, our case summaries, and more on our dedicated sub-site here, where you can also find updated versions of both our capacity and best interests guides. We have taken a deliberate decision not to cover all the host of COVID-19 related matters that might have a tangential impact upon mental capacity in the Report. Chambers has created a dedicated COVID-19 page with resources, seminars, and more, here; Alex maintains a resources page for MCA and COVID-19 here, and Neil a page 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.

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HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

Care home visiting guidance – England

The DHSC has published both guidance for care homes and for visitors, that took effect on 8 March 2021 (as well as a one page summary). It is perhaps worth emphasising that there is no change in the law – visiting people in care homes is not, and has not been, unlawful (save in the exceptional situation where a care home has been closed to visitors at the direction of a Director of Public Health). Alex's summary of the guidance, together with the updated guidance for visiting out of care homes can be found here.

How long can you wait to allow the family to gather around the bedside?

Sandwell And West Birmingham Hospitals NHS Trust v TW & Anor [2021] EWCOP 13 (Hayden J)

Best interests – medical treatment

Summary

In this case Hayden J considered a version of a dilemma that presents itself frequently in clinical settings, although rarely so starkly: should treatment continue solely to allow family the time to be with the patient before they die? The case concerned a man, TW, who had suffered a catastrophic brain injury after a stroke at the age of 50. The view of those caring for him in the intensive care unit was that the interventions that they were carrying out – suctioning his airways and providing every aspect of his personal care – were sustaining the life of his body, but were doing no more than that. Absent ventilatory support, he would be likely to die within minutes, but at most would not survive for long enough to be discharged from hospital, even to a hospice. It is not immediately obvious why his position was brought before the court, but it appears that it must have been a result of the fact his family (in different ways and for different reasons) did not agree that continuation of life-sustaining treatment was no longer in his best interests.

As Hayden J identified, following the medical evidence, the family's views appeared to diverge, but he did not see this as a conflict. TW's wife and his brother "*cling to a hope for recovery which cannot be founded in the evidence.* [His three adult] *daughters acknowledged the force of the medical reasoning and recognise it as irresistible.*" However, TW's daughters, giving evidence together and remotely from Canada:

> *ask*[e]*d only for the chance to say goodbye to a much-loved father. It is the most natural and instinctive request. It is what most families would want. It is what any doctor would want to be able to facilitate, and it is what any judge would want to be able to achieve. I was struck by the way N put it: it was not merely what they wanted, she told me, it is what they knew their father would have wanted. It was, as she described it, a facet of his rights, and his dignity, at the end of his life, that she wanted to be able to deliver. Even in these unbearable circumstances the daughters focused not on their own needs but on what they believe to be their father's needs. I have no doubt that TW would have been immensely proud of his daughters' courage and, if I may add, rightly so.* (paragraph 28)

Hayden J found that this request was "*so powerfully and compellingly advanced*" that he returned to the Trust's Counsel to explore whether this position, which had changed from the case advanced, could be put separately to the doctors. TW's doctors gave further evidence, and Hayden J himself visited TW remotely in the hospital, observing that "[t]*his is an ICU ward in the middle of a pandemic, and it was impossible not to be struck by the exhaustion of all those involved. Their attention to TW, their commitment to their patient, their sensitivity to his welfare and privacy, revealed to me that even in these most distressing of circumstances, they had provided not only for his medical care, but had been vigilant to preserve his dignity as a human being*" (paragraph 30).

When Hayden J heard from Dr A, TW's consultant neurologist:

> *31. [...] Dr A became emotional. It was the emotion, in my view, of a senior, dedicated, Consultant who had been working at an extraordinary rate for many months, in the most difficult of circumstances, and who as a human being was genuinely moved at being unable to facilitate a level of contact at the end of life that would have been his instinct as a doctor as well as a human being. His sympathy to the family was manifest. It was equally clear in the evidence of the other doctors, though expressed in different ways. Dr A impressed upon me the extent to which those working in ICU encounter death on a daily basis and in isolated circumstances. He told me that he had seen more deaths in the last twelve months than in the rest of his career put together. I gave a great deal of thought to N's carefully phrased request and to the equally powerful evidence of M and S. I wondered if it might be possible to achieve that which they desired.*
>
> *32. I cannot imagine a more difficult situation for a doctor than being in the witness box and having to confront this intensely modest and heartfelt request whilst being required to evaluate it against the broader medical context for his patient. The tension between basic human kindness, and professional, ethical responsibility, was exquisitely balanced. Dr B unwaveringly focussed upon his patient, whilst recognising the immensity of the tragedy unfolding. Key for him is the fact that TW has reached a stage where his situation, medically, is properly to be described as "precarious". Despite the best efforts of the team, and the commitment that I have outlined, there have been circumstances, in recent weeks, where even the professionalism and care of this team has not been wholly able to preserve TW's dignity.*

Hayden J noted that increasing medical interventions were being required to maintain TW's life. Although TW was not thought to have felt pain, Hayden J was clear that:

> *33. [...] for it to occur in circumstances where treatment can achieve nothing, I consider that Dr B is right to recognise this as a compromise to his patient's dignity. The precariousness of TW's situation means that it is likely that he will sustain cardiac arrest and other infection which will require invasive treatment. In gentle and sensitive terms both Dr A and Dr B intimated that to require them to provide treatment in these circumstances, which they assess as contrary to TW's interests, comes perilously close to, if not crossing, an ethical boundary.*

TW's daughters lived in Canada, along with his second wife. Because of the pandemic travel restrictions, it was thought impossible to be able to arrange a visit in under three weeks. TW's situation was such that he would likely require invasive intervention in this period. In particular, further cardiac arrest was foreseeable. Hayden J was clear that:

> *34. […] Cardiopulmonary Resuscitation (CPR) to a patient in TW's circumstances has now become inappropriate, in the sense that it serves only to compromise his dignity whilst achieving nothing by way of treatment. I am ultimately satisfied that any plan artificially to sustain TW's situation to enable his daughters or wife to come over from Canada would be inimical to his best interests at the end of his life. Although I have been deeply moved by the evidence of these three impressive young women, I am ultimately unable to yield to their request, whilst fulfilling my obligations to their father. The medical evidence indicates that he would not know of their presence beside him.*

In the circumstances, Hayden J was clear that the continuation of ventilatory support and likely invasive treatment could no longer be reconciled with TW's best interests, and endorsed a palliative plan providing for the withdrawal of ventilator support.

Comment

As noted by Hayden J, in 'ordinary' circumstances, doctors would do all that they could to sustain life so as to allow family to gather to say goodbye. In reality, this is – understandably – as much in the interests of the family as it can properly be said to be in the best interests of the person themselves (save and to the extent it could be identified that the person would wish to be kept alive so that their family could be with them). As with so many other areas, the pandemic is stress-testing ordinary practice almost to its limits, and it was hardly surprising that Dr A found it so challenging to have to confront head on the fact that in this case securing TW's continued life could be seen to be achieving nothing save compromising his dignity. Although, perhaps understandably, Hayden J did not push matters, he would have been very well aware that seeking to require the team to keep treating in such circumstances would have been to cross the line to require the doctors to treat in circumstances which they considered to be clinically inappropriate, a line which the Supreme Court has confirmed should not be crossed (see *Aintree* at paragraph 18). Even if, in very many cases, the line between best interests and clinical appropriateness now seems to be very thin, this case is a reminder that, ultimately there is a line, and clinicians both can – and where appropriate – should make clear when they are being asked to cross it.

When would continuing life-sustaining treatment be unethical?

Re NZ [2021] EWCOP 16 (Hayden J)

Best interests – medical treatment

Summary

In *NZ* Hayden J had to address, in even more acute form, the dilemma that he had addressed in *Sandwell And West Birmingham Hospitals NHS Trust v TW & Anor* [2021] EWCOP 13: the point at which continuing medical treatment can no longer be said to be appropriate. The facts of *NZ* illustrate the cruelty of the COVID-19 pandemic: a Muslim woman in her 30s took all the steps that she could to avoid catching it. She contracted it, however, and was admitted it to hospital. At that point, she was 32 weeks pregnant. Her condition deteriorated rapidly; after her son was delivered by Caesarean section, she was transferred to an intensive care unit, where she was started on extracorporeal membrane oxygenation ('ECMO'), described by the director of ECMO at the Trust as effectively the last resort treatment. ECMO, the court was told, was, until recent times, only really being considered as a viable option for patients who are otherwise regarded as fit, prior to their admission. It is only generally used for patients whose clinical condition places them at a 40% (or lower) chance of survival, despite having received all other intensive care treatments. During the course of the pandemic, the use of ECMO has increased approximately by a third. On average, 25% of patients do not recover. However, those patients who are placed on ECMO in consequence of conditions which are sequelae of symptoms arising from Covid-19 infection, have lower success rates than previously seen with other conditions. The director of ECMO at the Trust gave evidence that fewer than 50% of ECMO patients had been recovering in this second wave of the pandemic.

During the course of NZ's treatment, regular scans showed that NZ's pancreas had ceased to function, part of her left lung had died, and the remaining lung tissue had become 'densely consolidated or collapsed'. In addition to the death of those parts of the left lung and the remaining lung damage, there were signs of pneumothorax and evidence of pooling of blood, caused by the invasiveness of the ECMO procedure. The treating team had started plans for a final visit for the family, but it then became clear that the family did not agree that continued treatment was not in her best interests.

The Trust therefore made an urgent application to court to endorse the plan to stop ECMO and move NZ to a palliative pathway.

The position of the Trust, explained by Dr H, the director of ECMO, was that, whilst there were patients who had stayed longer on the ECMO machine than NZ had yet done, they were all patients in whom a trajectory of improvement is identified relatively quickly, and that:

> 19. […] *having regard to the views of the clinical team and to the second opinion from Professor A, he had come to the conclusion that he had passed a stage where he was seeking to preserve his patient's life, but had reached a point where he was, in reality, 'prolonging her death'. Though he expressed himself in sensitive terms, he signalled, to my mind, unambiguously, that he had reached a threshold beyond which further treatment would be professionally unethical.*

NZ's husband and sister took a different view, as Hayden J explained:

> *20. This is not grounded in any real difference as to the medical situation; it is, for them, a conflict between a religious belief, genuinely and devoutly held, and medical science. It is a conflict which cannot be reconciled. To condone any act that would be seen to bring life to an end would, the family believe, be inconsistent with their faith. They recognise the medical evidence and engage with it. In particular, they accept that continuation*

> *of treatment may cause NZ to suffer but consider that such suffering is the will of God and attracts God's love. MA told me that such suffering is to be welcomed and that NZ would welcome it. It is through suffering that we know God, he explained. This principle echoes not only throughout Islam, but throughout the whole of the Judeo-Christian tradition. It poses real ethical dilemmas for those who understand their faith in these uncompromising and uncompromisable terms. I do not doubt that these are the genuinely held beliefs of NZ's husband. Her sister also articulated them with equal force, though I note she required to be prodded to do so by her brother-in-law. I think it is likely that NZ, had she confronted this dilemma, would, in principle, have expressed the same religious view as her family. I am quite sure that she would have wanted to do all that she could to be with her children.*

Addressing these two positions, Hayden J emphasised that evaluation of best interests

> *21. […] is not confined to medical opinion alone, nor religious beliefs in isolation, nor even an assessment of wishes and feelings. Identifying best interests requires the broad canvas of NZ's life, circumstances and needs to be considered in their totality. Alongside this it must also be recognised that a court will never seek to compel or encourage a medical professional to act in a way that he or she considers unethical. The central imperative in medicine is to do good. Here the medical evidence establishes that continued ECMO treatment would achieve no benefit and cause continuing, potentially escalating, harm. I accept that evidence.*

Hayden J's conclusion was therefore, whilst reached reluctantly, inevitable:

> *29. This is a young woman whose life and hopes have been extinguished by this insidious virus. It is a tragedy of almost unbearable dimension. A young family split apart prematurely; their grief is raw and palpable. It is almost beyond human empathy; the pain is so obvious and visible that there is an instinct to seek to recoil from it. As I have set out, the care plan contemplates that NZ and her family will be together at the end. It is structured to avert further pain and its central premise is to promote NZ's dignity at the end of her life. The objective here is not to shorten her life, but as Mr H has, in my judgment correctly identified, to avoid the prolongation of her death. NZ will have her husband and family with her at the end. That is a right that many have, of necessity, been denied in the last 12 months. Their loss has underscored the importance of this final contact for those for whom it can be achieved. I should like to say finally, that RZ and MA could not have expressed themselves more forcefully, sincerely or with greater eloquence. They could have done no more for their wife and sister and I hope that brings some peace for them.*

Comment

Over and above the personal tragedy at the heart of this case, it shows not just the extraordinary measures (in every sense of the word) being required to meet the needs of patients with COVID-19, and how even those measures cannot guarantee success. It also reinforces the extent to which law and ethics run side by side in intensive care. As in *TW*, Hayden J's decision in this case shines a spotlight on a clinical dilemma that arises very frequently (although normally under less fraught circumstances than at present) – i.e. the point at which continuing treatment is felt by the doctors not just to be doing no good, but actively to be causing harm. In the majority of these cases, a resolution is ultimately reached without the need to come to court – and here is a good place to highlight that mediation can play a hugely important role – but ultimately, a judge may need to be involved. The court can, and will, probe the reasoning of the medical team, and should challenge their decision-making if and to the extent it is based (for instance) upon incorrect assumptions about the patient's wishes and feelings or how the patient would judge the quality of their own life. Ultimately, however, and just as would be the case with a patient able to speak for themselves, the fact that the patient's voice is being relayed by others on their behalf does not mean that the team can be required to act against their clinical conscience.

Vaccination – confirmation of the centrality of the person's wishes and feelings

SD v Royal Borough of Kensington And Chelsea [2021] EWCOP 14 (Hayden J)

Best interests – medical treatment

Summary

In a further judgment concerning vaccination for COVID-19, Hayden J has amplified the approach that he set out in *E (Vaccine)* [2020] EWCOP 14. In this case, the applicant, SD, was the daughter of a woman in her 70s living in a care home in the South-West of England. She brought an application, unrepresented, for a declaration that it would not be lawful to administer her mother, V, with a vaccine against Covid-19, or indeed, any other vaccine, on the basis that to do so would be contrary both to her best interests and to what SD contended would be her wishes. The application was resisted by a London local authority (the judgment does not make clear why it was this local authority, given that V was not resident there). Interestingly, Hayden J was content to appoint SD as her mother's litigation friend, perhaps reflecting the fact that he was sufficiently confident that she was able to relay V's wishes and feelings, central to his determination of her best interests.

Hayden J's judgment contained a succinct pen-picture of V's life which was very relevant to the best interests decision to be made in relation to her. More widely, Hayden J expressed his concern as to how the matter had come to court. On 13 December 2020, SD – who lived in New York – had told the care home that her mother was not to receive any vaccine on the basis that she did not think that the vaccines had undergone sufficiently rigorous safety trials and, in her view, there were unacceptable risks of side effects which contraindicated the taking of the vaccine. On the day the care home was set to vaccinate its residents, V had followed the other residents into the room where the vaccinations were being dispensed. She knew nothing of her daughter's position. Her main carer at the care home had to tell her that she was not to receive the vaccine. She waited for about twenty minutes in the room, and then drifted away. Her general level of functioning meant, it appeared, that the issue had now gone from her mind and she had not returned to consider it. Hayden J considered that there was no question that V did not have the capacity any longer to evaluate the question of receiving the vaccine for herself.

On 14 January 2021 – i.e. a month later, the care home informed the local authority of the situation. The local authority then considered what to do, but does not appear to have made any application – the application brought, nearly a month later, was brought by SD. Hayden J indicated that he considered that the delay was unsatisfactory, noting at paragraph 14 that:

> *When an issue arises as to whether a care home resident should receive the vaccination, the matter should be brought before the court expeditiously, if it is not capable of speedy resolution by agreement. This is not only a question of risk assessment, it is an obligation to protect P's autonomy. In the intervening period, Mr A told me that there was a suspected Covid-19 risk in the care home, which happily came to nothing. It is axiomatic that if Covid-19 had entered the home, V would have been at considerable risk. It is important that I record that every other resident and staff member has now been vaccinated.*

Hayden J identified the specific risks to V as follows (at paragraph 22):

> *i. If V were to become infected with Covid-19, she possesses a number of characteristics which make her particularly vulnerable to severe disease or death. She is 70 years of age, she carries significant excess weight, and she has dementia resulting from her Korsakoff's syndrome;*
>
> *ii. most importantly, she lives in a care home. It is an inescapable fact that in the UK, more than a quarter of the deaths due to Covid-19 have occurred within care home settings;*
>
> *iii. V's particular care home, by virtue of its specialism, deals with a unique category of risk. V has been described as 'a wanderer', though far less frequently of late. In consequence of her short-term memory problems, it is impossible for V to follow the principles of social distancing and preventative hygiene measures. Evidence from Mr A demonstrates that she is very sociable, and it would not be feasible within the setting of this care home for her to self-isolate if she contracted Covid-19;*
>
> *iv. Every member of staff, and every other resident of V's care home, has now been vaccinated. Mr A told me that, while they are not free from the risk of contracting Covid-19 until we are all free from that risk, because no vaccine is 100% effective, this fact nevertheless will result in the care home's residents having greater contact with the outside world in due course. Providing it is safe to do so, he hopes that the residents will be able to venture outside and go for walks, so that they will have something of their basic liberty restored to them. Accordingly, just as the risk to all other residents of the home diminishes, V's risk of contracting the virus will elevate as the outside world gradually returns.*

In terms of V's wishes and feelings, Hayden J rejected the argument advanced by SD that he should place little weight upon the fact that she had received the influenza vaccine every year for the past nine years, because she was simply "following the herd" when she lined up and received her flu vaccine and similarly when she put herself forward for the Covid-19 vaccine. At paragraph 24, Hayden J noted that "*SD suggests this was attributable to her mother's cognitive* *impairments and a facet of her Korsakoff's syndrome*." However, "[p]*aradoxically in the light of the evidence that SD gave, I do not consider that V's compliance should be attributed to her condition. As SD told me, her mother was, while capacitous, readily compliant with the advice of her doctors. Her response both to the flu vaccines and to the Covid-19 is consistent with her earlier capacitous behaviour*."

SD's views, it emerged, were driven in substantial part by her interest in exploring "other solutions." As Hayden J noted at paragraph 29, "[s]*he was, to put it mildly, extremely enthusiastic about the viability and potential for an anti-parasitic drug that she had read about, namely 'ivermectin'. She was in no doubt that this would most effectively protect her mother from the Covid-19 virus*." However, Hayden J continued:

> *30. Ivermectin has not, at least as yet, achieved credibility with any public health authority, as a treatment for Covid-19; oral ivermectin appears to be an unlicensed treatment for some forms of scabies and other parasites. I found it striking that SD rejected the overwhelming view of the public health authorities in relation to the certified vaccines, speculating about the risks of unforeseen side effects or adverse reactions, yet wholeheartedly embraced the unquantifiable risks of an unlicensed and unendorsed drug.*
>
> *31. I explained to SD that it is not the function of the Court of Protection to arbitrate medical controversy or to provide a forum for ventilating speculative theories. My task is to evaluate V's situation in light of the authorised, peer-reviewed research and public health guidelines, and to set those in the context of the wider picture of V's best interests.*

In the circumstances, Hayden J had little hesitation in finding that:

> *32. Though she has argued her case forcefully, I have been left with the impression that SD is unable to disentangle her own anxieties about the vaccines and her personal scepticism relating to the process of endorsement, from her analysis of her mother's best interests. SD's advocacy for the use of ivermectin is both logically unsustainable and entirely inconsistent with her own primary position. I have no doubt that SD's opposition to her mother receiving the vaccine is generated by real concern and distress. This, however, is not shared by her mother and does not reflect V's own authentic view. None of this is to question SD's sincerity, it is simply a reflection of the fact that filial love and concern can sometimes occlude rather than focus objective decision making.*

It will not come as a surprise, therefore, to find that Hayden J concluded that it was in V's best interests to have the vaccine administered. Importantly, perhaps, he made clear that this was the result of a decision on the individual facts of V's case:

> *33. […] In cases such as this, there is a strong draw towards vaccination as likely to be in the best interests of a protected party (P). However, this will not always be the case,* **nor even presumptively** *so. What it is important to emphasise here, as in so many areas of the work of the Court of Protection, is that respect for and promotion of P's autonomy and an objective evaluation of P's best interests*

> *will most effectively inform the ultimate decision. It is P's voice that requires to be heard and which should never be conflated or confused with the voices of others, including family members however unimpeachable their motivations or however eloquently their own objections are advanced.* (emphasis added)

Comment

If the decision in *E* gave helpful guidance as to the (relatively) straightforward issues at stake in considering capacity to consent to the administration of a COVID-19 vaccine, this decision reinforces the centrality of the wishes and feelings of the individual concerned if they do, indeed, lack that capacity.

The decision is also helpful in confirming that situations where agreement cannot be reached cannot be allowed to languish. What the judgment does not address in terms is **who** should bring the application to court in the event that one is required, nor (in this case) why it was the local authority who were the respondent, as opposed to a clinical body. The local authority (at least the local authority for the area) has a statutory 'backstop' responsibility as regards safeguarding obligations, and issues relating to vaccination could, in some circumstances, be seen as a safeguarding matter. However, the normal expectation is that it would be the body with clinical responsibilities towards the person who should bring any application that is required.

Vaccination – considering all the relevant circumstances

Re CR [2021] EWCOP 19 (HHJ Butler)

Best interests – medical treatment

Summary

This COVID-19 vaccination case, decided by HHJ Butler, differed to the previous two (both decided by Hayden J) because it concerned a much younger person, who never – it appears – had the capacity to make their own decisions about vaccination. The person in question, CR, was 31; he had been diagnosed with a lifelong severe learning disability, autism and epilepsy. He was classed as 'clinically vulnerable' as opposed to 'clinically extremely vulnerable' as a result of his epilepsy and severe learning difficulties. He was also overweight, weighing an estimated 22 stone. He fell within the priority group for a vaccination. He was, at that point, in a care home, although it appears that this may only have been a temporary placement.

His father opposed vaccination on a number of bases. The CCG brought an application for a decision that it was in CR's best interests to have the vaccination (supported by his RPR, acting as his litigation friend). In response to questions from HHJ Butler, CR's father

> *1.5.* […] *stated that he had no objections to the vaccination in principle, but that this was not the right time for his son. This was based (mainly) on the lack of data as to the consequences of such a vaccine for those who fell into the same category as his son. He (and his family) did not think that there had been enough testing for those with learning disabilities (and as a result of which the relevant evidence was absent). He was also concerned that the contents of the vaccine itself might interact with the other medication that his son is receiving and in particular those that were used to*

> *control his epilepsy, and treat his ADHD. He agreed that (in part) his concerns were linked to the (now) discredited theories proposed by Dr Andrew Wakefield as regards the link between autism and the MMR vaccine, and which he still believed were accurate.*
>
> *1.6. Thus, it appears that the autism which CR has, is attributed by SR to an MMR vaccination that he received at birth. He has had no vaccinations at all since that time.*

CR could communicate via a limited range of Makaton and will respond to physical cues. It was said that he could be resistant to intervention, including medical intervention, and there was a reference to him having a phobia of hospitals and health interventions. However, in January 2021 he did permit blood samples to be taken from him, and with staff at the care home to provide him with reassurance. The court was informed that at that time CR was sedated (as a result of medication for one of his conditions) but that physical intervention was not needed and nor did CR pull away.

The CCG made clear that it would not administer the vaccination if any form of physical intervention was required.

As there was no suggestion that CR had capacity to make the decision for himself, HHJ Butler identified that the question was purely one of what was in CR's best interests, continuing:

> *3.3. In this instance, it is not possible to determine what CR's views or wishes might be. He is still a young man, but his condition has endured throughout his 31 years. His ability to communicate is compromised, and he is not able to understand the consequences of not having a vaccination, or having a vaccination.*
>
> *3.4. As I have determined that it is not possible to reasonably ascertain his wishes, it seems to me that the position is akin to that proposed by the Law Commission and also referred to by Baroness Hale in* ***Aintree University Hospitals NHS Trust v James*** *[2013] UKSC 67 at [24] 'but the best interests test should also contain 'a strong element of substituted judgment (para 3.25) taking into account both the past and present wishes and feelings of patient as an individual and also the factors which he would consider if able to do so (para 3.28)'.*
>
> *3.5. What factors would he be able to consider if he were able to do so? On the basis of the actual evidence in existence it would be as follows (and as summarised in the helpful skeleton argument provided on behalf of the Applicant and First Respondent):*
>
>> *(a) That the vaccination has MHRA approval in the UK;*
>>
>> *(b) There are no contra-indications for the use of this vaccine which apply to CR;*
>>
>> *(c) Astra Zeneca vaccines significantly reduce the risk of sustaining serious illness requiring hospitalisation (an 80% reduction in those over the age of 80) (cf The Lancet 3.2.21)*
>>
>> *(d) a 75% reduction of asymptomatic infection (University of Cambridge*

> *24th February 2021);*
>
> *(e) that he is living in a care home (albeit covid 19 free at present) and where there have been more than 25% of deaths caused by Covid 19;*
>
> *(f) he has a relevant underlying health condition and which places him in a vulnerable group;*
>
> *(g) he is unable to comply with social distancing and hygiene measures;*
>
> *(h) the UK has one of the highest per capita death rates in the world;*
>
> *(i) he does not appear to have any anxiety about a medical intervention and which has involved the use of something sharp as recently as January 2021 (albeit that this was whilst he was sedated with a medication that is now not being administered as a part of his treatment);*
>
> *(j) the documented common side effects are mild;*
>
> *(k) if he did contract Covid 19 then the consequences for his health due to the health conditions that he does have might be serious illness or death;*
>
> *(l) he is overweight.*

It was accepted that CR fell outside:

> *3.6 […] what might be termed the more conventional cohort of individuals who live in care homes. He is, for example young and other than his epilepsy has no conditions that cause him to be frail. There is no Covid 19 in the care home at present, but as visiting becomes more relaxed then unvaccinated visitors from outside the care home will increase the risk of such contagion. I was also told at the hearing that the vaccination programme for other residents at the care home has started.*

HHJ Butler found that, although CR was not elderly, there was still a risk, and that:

> *3.8. […] the consequences of infection are also still high, and engage his rights pursuant to Article 2 of the ECHR ('Everyone's right to life shall be protected by law'). CR, of course, has the same rights as everybody else who has capacity. So, notwithstanding that CR has the advantage of youth on his side, in my judgment CR still faces a real and significant risk to his safety if the vaccination is not administered. For the avoidance of doubt this applies to both doses. I am also reminded by Mr Wenban-Smith that 'There is a very strong presumption in favour of taking all steps to prolong life, and save in exceptional circumstances …. The best interests of the patient will normally require such steps to be taken. In the case of doubt, that doubt has to be resolved in favour of the preservation of life' (Munby J* ***R (Burke) v GMC*** *[2004] EWHC 1879 (Admin) and which was approved in the Court of Appeal).*

HHJ Butler found that the views of CR's father (which were apparently shared by his mother and twin brother) were genuinely held, were not intrinsically illogical, and certainly not deliberately obstructive:

> *3.10. However, the reasons for opposing the administration of the vaccine have no*

> *clinical evidence base. In particular the objections (and this is* <u>*subjectively*</u> *understandable) are based on objection to this vaccination for his son as a result of what SR believes were the consequences of the MMR injection and the autism of his son.* <u>*Objectively*</u>*, however, this is based upon the discredited theories of Dr Andrew Wakefield (advanced in 1998) and which were (a) found to have no basis in science; (b) were formally retracted by Dr Wakefield in 2020 and (c) resulted in Dr Wakefield being struck off the Medical Register.* (emphasis in the original)

HHJ Butler considered that CR would have been likely to have considered the factors which pointed towards the "*evidence based advantages of having a vaccination*" (paragraph 4.4), and that the "*relevant circumstances*" for purposes of s.4(11) must include "*the specific vulnerability of this man (notwithstanding his relatively young age), together with the overwhelming objective evidence of the magnetic advantage of a vaccination*" (paragraph 4.7).

HHJ Butler therefore found that it was in CR's best interests to have the vaccine, but with the specific caveat that he was not endorsing physical intervention to secure it.

Comment

Of note in this case is the fact that HHJ Butler delved more deeply into the scientific evidence than had Hayden J in either <u>*Re E*</u> or <u>*SD*</u>, in large part because there was not the same evidence as to what CR might have done based upon his own actions in order to guide the decision. Hayden J in *Re E* had made clear that it was "*not the function of the Court of Protection to arbitrate medical controversy or to provide a forum for ventilating speculative theories*" (paragraph 31), but in this case given that such a clear plank of CR's father's objection were the claims of Andrew Wakefield, HHJ Butler was on very sound ground finding that, even if they were subjectively understandable, they were simply ill-founded.

One other point of note is that amongst the factors that HHJ Butler considered CR would have taken into account was the report from the University of Cambridge that the vaccine gave rise to a 75% reduction of asymptomatic infection (University of Cambridge 24th February 2021 (nb, this report actually relates to the Pfizer, not Astra Zeneca vaccine). Questions of the potential of securing against risk of harm to others are likely increasingly to feature in considerations of best interests as matters go forward, which will, as discussed in our <u>guidance note</u>, make matters increasingly challenging to 'house' within ss.5-6 MCA 2005 in the event that any suggestion arises of the use of restraint.

Finally, on a procedural point, this case makes clear that decisions around COVID-19 vaccination are not being viewed by the Court of Protection automatically as serious medical treatment decisions requiring allocation to a Tier 3 (High Court) judge.

A right to family life does not mean an obligation to endure one

ZK (Landau-Kleffner Syndrome: Best Interests) <u>[2021] EWCOP 12</u> (HHJ Burrows)

Best interests – mental capacity – contact – residence

Summary

In this case, the court considered the residence and contact arrangements for a 37 year old man, and the place within those decisions for his wishes and feelings.

ZK had, as a child, developed Landau-Kleffner Syndrome (also known as acquired aphasia with epilepsy). ZK was not deaf but not unable to understand aural language. Until September 2020, he lived with his mother. In 2017, concerns had been expressed about whether he was to be married, leading to a Forced Marriage Protection Order application. This led to proceedings before the Court of Protection, during which it became clear that, despite ZK's profound communication difficulties, it was possible for him to make progress in language development.

By September 2020, ZK was consistently expressing a wish to leave the home he shared with his mother. He expressed the wish to leave quickly. He did not wish his mother or family to have notice of his move. The Local Authority conducted a best interests meeting on 11 September 2020, having assessed ZK as lacking the capacity to make the decision. The decision was to move him out. In his evidence, ZK's nephew, HM, described the shock and sadness it caused to the family when, on the day of the 'removal.' ZK *"just did not return from his community activities."* HHJ Burrows indicated that he understood that,

> *14. […] and I can also see how that has caused ill-feeling towards the local authority and SLP, and its personification, the Managing Director, (MD).*
>
> *15. However, I am not satisfied on the basis of the evidence I have read and heard that the removal was improper, either in the fact that it happened at all, or the in the way it happened. There is clear evidence that ZK wanted to move from his mother's house and into a supported arrangement of some sort. He was assessed as being incapable of making that decision and a best interests decision was made. Consultation with, and notification to, the family would have been ideal as well as compliant with the provisions (and philosophy) of the MCA. However, there were good reasons why that could not and did not happen in this case.*

The separation after removal was sanctioned by the court (it is not clear from the judgment why an application was not made in advance).

The case then returned to HHJ Burrows for him to consider whether it was in ZK's best interests to remain away from his family home and, indeed, to move to a new placement, or for him to return to his family home and their care. By that point, it was clear that there had been a big improvement in ZK's communication skills, a view "*shared by everyone who knows ZK and has known him for some time, except his family. In evidence given by HM, ZK's nephew, he was unable to see the improvement in his uncle's ability to communicate, his engagement with others or his happiness. I do not think HM was being wilfully blind or churlish in what he said. I am quite sure that he and the rest of ZK's core family genuinely believe him to be unchanging, entirely incapable of anything but the most basic communication, and that he will remain the same in the future*" (paragraph 13).

HHJ Burrows was at pains to emphasise that whilst there was before him sufficient evidence to displace the statutory presumption of capacity, capacity was in ZK's case a subject requiring "*serious consideration and scrutiny in view of* [his] *progress*," and the court would be returning to revisit the situation with the benefit of a jointly instructed expert.

HHJ Burrows was able to dispose of the question of deprivation of liberty easily, identifying that the arrangements for him at the placement crossed the line to confinement to which ZK could not consent (but also noting that "*even if he were to reside at home with a package of care provided mostly or entirely by his family, he would also be deprived of his liberty there*" (paragraph 22).

In terms of ZK's best interests, the position was starkly set out. On behalf of the local authority and the Official Solicitor (for ZK) it was argued that "*ZK is doing extremely well where he is, doing what he is, and he wants to remain there. To deny him that wish and send him back to his family would be a serious blow to his confidence and self-esteem, as well as a serious restriction on him continuing to do what he wishes to do*" (paragraph 26).

On behalf of the family, three points were made.

First, that the removal had been illegal. HHJ Burrows did not accept that this was the case:

> *28. An assessment was made of his capacity to make that decision and he was found to be lacking. The Local Authority, with statutory responsibility for ZK's social care then had to decide what was in his best interests. ZK's clearly expressed wishes and feelings were given considerable weight alongside the other factors outlined in the evidence. They then had to decide whether and if so, how they would put into effect what they decided was in his best interests- namely, to leave his mother's home. In the circumstances as I see them, from the evidence, their actions were entirely in keeping with the MCA. There was an element of subterfuge because that was what was demanded by ZK himself. It was regrettable. It caused and continues to cause rancour. However, it was not unlawful.*

Second, the removal was the cause of a lack of trust towards the family towards the statutory body. HHJ Burrows identified that this was right, but that the law was clear:

> *29.* [...] *Where a decision has to be made about care arrangements for a person who is unable to make a choice for himself, that decision must be made in* **his** *best interests. It is plain to me that, objectively viewed, ZK benefits hugely from his engagement with SLP. It is also clear to me that he enjoys that engagement. It would be a significant blow to him if he were suddenly spending considerably less time with the carers and support workers than he presently does. This is not just about recreation or even learning a language. To ZK it is obvious that BSL is the way in which he has been able to engage with and participate in the world. His inquisitiveness, humour and the way he behaves underline the sheer excitement he derives from the world. That should come as no surprise since that was promptly removed from him by his disorder when he was a young child, the MD drew the analogy with a 3-year-old, learning about the world and endlessly asking "why? why? why?" to every new puzzle that experience brings. That seems to me to be an accurate and useful comparison.*

Third, it was submitted that the question to be asked was "why not home?":

> *30.* […] *She referred me to FP v GM & A Health Board [2011] EWHC 2778 (COP) at paragraphs [20] and [25] in support. That case was about an elderly man with dementia who was in hospital. The issue before the Court was whether he should go home or to an EMI Nursing Home. Mr Justice Hedley considered how Article 8 of the European Convention was relevant to the interpretation of the role of the Court of Protection when making best interests decisions about residence. A person is entitled to family life unless the deprivation of family life can be justified under Article 8(2). In that case, the person at the centre wanted to go home. Hedley, J. thought the starting point in that case was "why should [P] not go home?" As I read the judgment, what Hedley, J was doing was to formulate the question he had to answer in that case, on its facts, in a simple and straightforward way. In this case, the situation is very different. ZK has been enabled to leave his family home, at his own request in order to have a more independent life, and he expresses clear wishes to remain where he is. To formulate the question as Ms Jackson suggests serves no practical purpose. To regard it as a legal presumption in this case would be entirely wrong. With regard to Article 8 of the convention, ZK has a right not an obligation to have a family life* (emphasis added)

HHJ Burrows found, in looking at all the relevant factors as required by the best interests test, that he was "*unable to shift the focus of my considerations of ZK's best interests from the fact that his wishes and feelings seem so clear and consistent. Or, put another way- using Ms Jackson's terminology "why not let him do what he wants?"* He continued:

> *32. Mr Karim, Q.C.* [for ZH] *refers me to Article 8 of the European Convention as well as the UNCRPD and the need to maximise individual autonomy. He is right. The whole purpose of the MCA is to enable those whose capacity is absent, seriously inhibited, or just emerging to be a participant in making decisions for themselves as much as possible. In this case, ZK is learning how to communicate with the wider world. He seems to like what he sees. He now has the linguistic tools to comprehend things, to ask questions, to express his views, to reflect, to ruminate, to agree and disagree and to make light of things. He is learning how to be autonomous.*
>
> *33. It is my firm view that if ZK were to be ordered to return home to whatever package of care could be put together for him at his family home at the present time, it would not serve his best interests. There is suspicion and hostility towards the local authority and SLP. I am quite sure that the family does not really comprehend what has happened to ZK, and the extent of his actual and potential abilities. Within a home environment, overseen by family members, the care plan involving SLP (or any equivalent body) would soon turn to conflict.*

HHJ Burrows was at pains to emphasise that this was not to rule out a future move home. Indeed, it might well be that with the development of ZH's communication skills, along with his sense of autonomy, there could come a time when he would be able to make that decision for himself. That was, however, some way down the line.

As regards contact, HHJ Burrows identified that the family's access to ZH should be regulated by what ZH wanted, with regular reviews of the contact plan in light of his wishes and feelings.

A procedural point arose as to expert evidence. HM, a litigant in person, raised the issue of whether he should be required to fund part of the jointly directed expert report, as he asserted he had too little income and capital. HHJ Burrows accepted his evidence, and directed that the cost should not be split so as to include a contribution from him. More fundamentally, however, HHJ Burrows identified that he could not see why he needed to be a party, because he was "*simply another person putting forward the same arguments as his grandmother. I am minded to discharge him as a party, but direct that he be provided with documents in the case, that he be invited to attend future hearings, and to contribute his views on his uncle's best interests by email in advance of the hearing as he has done until now*" (paragraph 37).

Comment

This judgment is of very considerable interest for a number of reasons. The first is that the court was led so squarely by ZH's wishes and feelings which were being asserted, it seems, despite strong familial pressure to the contrary. The second is the neat formulation of a point sometimes forgotten, namely that Article 8 ECHR gives a right to (respect for) family life – it does not impose an obligation upon the person to have a family life with those who they may not wish to. The third is the extent to which the court identified that ZH was on a trajectory towards greater autonomy, and considered it its duty to seek to support that trajectory.

The fourth point is HHJ Burrows' rejection of the argument that ZH had been unlawfully removed from his home. Not least in light of some observations of Sir James Munby faced with one too many situations where the person had been removed against their will without any application to court, there has been a distinct degree of fuzziness as to whether (and when) such applications are required. This fuzziness is discussed here; this case reinforces the point reached in the paper that an application is not required (even if it may well be very advisable if there will otherwise be an impact upon ongoing relationships) if the primary reason for removal is to give effect to the person's wishes and feelings.

The last point which bears highlighting is HHJ Burrows' unfeigned disgust for the fact that at least some of those who had in the past worked with ZK had taken the attitude that a General Practitioner had in March 2017, namely that he wished to confirm that ZK is "*mentally retarded, deaf, dumb, unable to speak and unable to express his feelings due to Landau Kleffner Syndrome*" (paragraph 4). HHJ Burrows was at pains to record his (remote) judicial visit, the detail of which merit reproduction to show just how wrong this was. Whilst ZK might be unable to understand aural language, HHJ Burrows was clear that:

> *5. […] is certainly not unable to express his feelings. With the benefits of learning a non-aural language, ZK has developed a curiosity and inquisitiveness which is matched by his appetite to communicate with others including, on that occasion, me. He seemed to me to derive great pleasure from communicating and to enjoy the company of those who were*

> *with him.*
>
> *6. ZK's communication was, on the face of it, hard work for him. It consists of a combination of methods: he signed (using British Sign Language- BSL); he used a pen on paper to write messages- he is literate. He occasionally referred to the screen of his mobile phone, where he would display a relevant image. All of this was relayed to me by his intermediary and a signer. When I met him I wondered how frustrating it must be to have to go through all that just to communicate. On reflection, however, I realise that for someone who for many years, before he was introduced to sign-language, was unable to communicate very effectively at all, this process is intensely liberating.*
>
> *7. Having discussed a number of subjects with ZK for around 30 minutes I was, and remain, entirely unconvinced that the term "mentally retarded", ignoring its offensiveness, applies to him.*

Capacity and sex – the Court of Protection grapples with the move from 'consent to' to 'engaging in' sexual relations

HD (Capacity to Engage in Sexual Relations)[2021] EWCOP 15 (Cobb J)

Mental capacity – sexual relations

Summary

In *HD* Cobb J has grappled with the impact of the Court of Appeal's decision in *Re JB* [2020] EWCA Civ 735, in which the Court of Appeal had made clear that the question of capacity with regard to sexual relations should normally be assessed by reference to the question of whether the person has capacity to decide to engage in sexual relations, rather than (as had previously been understood) to consent. The Court of Appeal in *JB* identified (at paragraph 100) that the relevant information for purposes of deciding to engage in sexual relations may include "*the fact that the other person must have the capacity to consent to the sexual activity and must in fact consent before and throughout the sexual activity*."

In the case before him, concerning a 29 year old woman with what was described as a mildly severe learning disability, Cobb J found that:

> *27. [...] on the ultimately undisputed evidence and on the application of the test propounded in Re JB, I am driven to the conclusion that while HD understands the need for a sexual partner to consent to engage in sexual relations, it is clear from the evidence that she cannot currently understand the need for a sexual partner to have capacity, to consent to sexual relations. I might add that had the question of HD's capacity to engage in sexual relations been listed before me several months earlier, i.e., prior to the Court of Appeal's decision in Re JB, I would probably have reached the opposite conclusion (i.e., that HD had capacity).*

Cobb J identified that Leading Counsel for HD (via the Official Solicitor) had reflected more widely upon whether it was possible to tailor, or disapply any of, the relevant information contained at paragraph 100 of *Re JB*, in an assessment of capacity to engage in sexual relations. However, at paragraph 28, Cobb J noted that:

> *[n]otwithstanding the inevitably distressing implications for HD of the*

> *conclusion to which the parties were drawn on the evidence, Mr McKendrick accepted that the circumstances did not exist here for the court to tailor or disapply the application of any of the relevant Re JB information. I agree. In short, there is no proper basis for distinguishing HD's case from the ordinary run of cases which it seems to me were contemplated by Baker LJ, and I could not therefore but conclude that the information relevant to HD's decision should be those set out in [100] of Re JB.*

One of the experts before him was of the view that it would not be possible to enable HD to learn how to assess the capacity of her sexual partner to consent to sexual relations. Another was more optimistic, and Cobb J considered that "*there is nothing to be lost, and possibly much to be gained, by providing HD with a package of further education to see if she can so learn. In view of Dr. Carritt-Baker's pessimism about the outcome, I do not propose to adjourn these proceedings now to await the outcome of any such education offered; I would however be very willing to reserve any further application for determination of this issue to myself*" (paragraph 29).

Cobb J noted that he had been asked to consider the analogous position of 'consent' under the criminal law:

> *31.* [Leading Counsel for HD] *drew attention to the commission of the offence of rape if the alleged perpetrator "does not reasonably believe [their partner] consents" – see section 1(2)and 3(1)(d) of the Sexual Offences Act 2003 (the 'reasonable belief' defence). He argued that an anomaly may well arise where the capacitous may lawfully reasonably believe their partner has capacity to consent to sex, and does consent, as a matter of criminal law, whereas in the context of welfare proceedings in the Court of Protection P must understand, retain, weigh up and use the fact her partner must have capacity to engage in sex. He submitted that the Court of Appeal in Re JB does not explain why a heightened civil test is required beyond that needed by the criminal law. His submission in this regard chimed with the observations of Macur LJ in R v GA [2014] EWCA Crim 299 in which she said this:*
>
>> *"The judgment of the Court of Appeal recognises and adopts the principle of the obvious desirability that civil and criminal jurisdictions should adopt the same test for capacity to consent to sexual relations by reference to various first instance judgments, amongst others Re MM (Local Authority X v MM and KM) [2007] EWHC 2003.*
>>
>> *We agree. ……"*

Cobb J gracefully declined to decide these points, however, as they did not arise on the case before him. He did though, note that Baker LJ in *Re JB* was clear that the jurisdiction of the Court of Protection has a distinctly different focus from the criminal law and that it was not "*appropriate to view these issues through 'the prism of the criminal law'*" (paragraph 106). On the contrary:

> *What is needed, in my view, is an understanding that you should only have sex with someone who is able to consent and gives and maintains consent throughout. The protection given by such a requirement is not confined to the*

> *criminal legal consequences. It protects both participants from serious harm.* (paragraph 107)

Cobb J was well aware of the interference in the life of HD that he was going to flow from his declaration that she lacked capacity to engage in sexual relations.

> *33.* [She] *is soon to be 30 years old and for the first time in her life will be living in her own apartment. She is at a crucial stage in her future development and has much to look forward to. She has met a partner (Z) with whom she appears happy. No assumptions can be made about the strength of her feelings for Z, or his for her, simply because they are both learning disabled; I value his and her achievements in finding happiness in a relationship in the same way as capacitous non-learning-disabled couples.*

Comment

It should be noted that the Supreme Court may yet pronounce further in *JB*'s case, the Official Solicitor's application for permission to appeal not yet having been determined.

Cobb J was clearly driven to the conclusion that he reached in this case reluctantly, and it is difficult to avoid the thought that, yet again, the tension between potentially incompatible public policy aims: (1) the securing of the importance of consent as meaning consent; and (2) the securing of the right of those with cognitive impairments to express themselves sexually is singularly poorly-served by the statutory law in this area.

One further, unrelated, point is of note – Cobb J observes, in passing, the fact that there was some uncertainty about how HD had been fitted with a contraceptive implant given her apparent lack of capacity to be able to consent to the procedure. One can see the judicial eyebrows being raised in the footnote where he noted that it appeared that her father had signed the relevant document – in 2018…

The Court of Protection and obstetric decisions – two contrasting stories

X NHS Foundation Trust & Anor v Ms A [2021] EWCOP 17 (Cohen J) and *East Lancashire Hospitals NHS Trust v GH* [2021] EWCOP 18 (MacDonald J)

Best interests – medical treatment

Summary

In two decisions which came out simultaneously, the Court of Protection had to consider how to approach obstetric decisions, in both a planned (albeit relatively compressed) fashion and an unplanned emergency.

In *X NHS Foundation Trust & Anor v Ms A* [2021] EWCOP 17, Cohen J was concerned with Ms A, a woman in her 30s, who was 38 weeks pregnant, and who suffered from paranoid schizophrenia. She had been in hospital on at least 5 occasions in 2007, 2011, on two occasions in 2015 and now. The admissions in 2007 and 2011 were respectively after the birth of her two children. It appeared that those admissions might have been after she ceased taking medication. There have been other referrals to mental health services not requiring hospitalisation. In September 2019, Ms A stopped taking medication as she was well and wanted to try for another child. Various concerns about her mental health and functioning were raised in

2020, particularly in the last few months of the year. In early 2021, at her appointment with Dr B, her consultant obstetrician, she formed the view that Ms A lacked capacity with regard to her mental health care and treatment as she was demonstrating no insight into her previous illness. Ms A stated then that she was hoping for a normal vaginal birth at home.

In early 2021, Ms A's mental health deteriorated, and she was detained, first under s.2 and then s.3 MHA 1983. Simultaneously, it became clear that her baby was breech, which, if not corrected, meant that the risks in a vaginal delivery were significantly greater, and potentially fatal. Attempts to undertake a procedure to turn the baby were stymied, in part by Ms A's anxieties which initially led her to decline it. The choice was therefore between a vaginal breech birth or a planned caesarean section.

The Trusts responsible for Ms A's physical and mental health applied to the court for declarations and decisions about her birth arrangements. The solicitor instructed by the Official Solicitor as Ms A's litigation friend saw Ms A. Ms A said she would not be happy and would want to have it under any circumstances, the material part of the note being set out at paragraph 12 as follows:

> *When asked what she would say if there were signs of distress during labour from the baby, and the medical team said that they needed to move to an emergency caesarean section, Ms A said she didn't like thinking of the worst scenario, and didn't like to say anything about that. Her position was summarised helpfully in the Official Solicitor's agent's note in these terms:*
>
> *i) You don't agree that you are unwell;*
>
> *ii) You think you do have capacity to decide yourself how to give birth;*
>
> *iii) It is important to have a vaginal birth;*
>
> *iv) You don't feel like you have been listened to;*
>
> *v) You don't feel like everything has been done to exhaust the option of a vaginal birth;*
>
> *vi) You think that, for you, the cons of a C-section outweigh the pros.*

On the evidence before him, Cohen J was in no doubt that Ms A: (a) lacked capacity to conduct the proceedings and make decisions regarding her obstetric care and treatment and (b) that she was not able to retain and weigh up the information, including the risk that the course of action that she wished presented both to herself and the foetus, and also the increased risks engaged by an emergency caesarean section rather than a planned caesarean section.

As regards her wishes, Cohen J identified (at paragraph 18) that:

> *There is no doubt that in her more rational moments, Ms A wants the best for her child. It is why she came off medication in 2019. At a different point of her interview with the Official Solicitor's agent she says that "I would just like us to be healthy and well and return home safely". She stated that the single most important thing to her is "for me and baby to be healthy, well and safe". And indeed, it was in this sense, her being able to put the fetus first, that she presented until her relapse at the end of 2020. I am in no*

> *doubt that if she regained capacity, that it would be her wish to have a safe delivery of her child.*

Cohen J made clear that he considered that Ms A's expressed views were of great significance. However, at paragraph 22, he made clear that he was "*in no doubt that the views expressed by Ms A are not in her best interests, and it is the test of her best interests which I must apply*."

Cohen J therefore endorsed the plan for transfer, including by restraint if required, to the maternity unit at the physical health hospital to undergo the planned caesarean section (although he also authorised an emergency one in the event that Ms A went into labour before the date for the planned procedure).

In *East Lancashire Hospitals NHS Trust v GH* [2021] EWCOP 18, MacDonald J was concerned with an evolving emergency – an application made in the case of GH, a 26 year old woman who suffered from anxiety, depression and acute agoraphobia and who had gone into labour at home nearly 72 hours earlier but who had thereafter suffered an obstructed labour. Within this context, it became apparent that GH required urgent in-patient obstetric treatment and a possible emergency caesarean section. GH was, however, refusing to agree to that course of action. An urgent application was made, the hearing starting at 22:00. The Official Solicitor, herself, acted as GH's litigation friend, under her (relatively new) out of hours scheme, and MacDonald J was at pains to express his gratitude to her for testing the evidence of the Trust by way of cross-examination and making, by way of closing submissions, a considered recommendation to the court regarding GH's best interests.

MacDonald J identified at the outset of his judgment that:

> *As Mr Wenban-Smith fairly acknowledged in his opening, in An NHS Trust and Anor v FG (By Her Litigation Friend, the Official Solicitor)* [2014] EWCOP 30 *Keehan J made clear the heavy burden on Trusts to engage in early and thorough planning in cases of this nature in order to prevent the need for urgent applications to the out of hours judge. However, I accept Mr Wenban-Smith's submission that this case is distinguished by the fact that up until late yesterday afternoon GH was assessed to have capacity with respect to decisions concerning the management of her pregnancy and birth and indeed had agreed to admission to hospital in the event that admission was required during the course of her labour. It was only during the latter part of the day yesterday that it became clear that GH's anxiety and agoraphobia had become the dominant feature in her decision making and that a subsequent capacity assessment revealed that she lacked capacity to decide whether to agree to be admitted to hospital for obstetric treatment and a possible emergency caesarean section. Within this context, and as the Official Solicitor pointed out, there were options that might have been considered in order to endeavour to avoid the need for an urgent hearing following that assessment, I was satisfied that this case met the criteria for the urgent out of hours service. I make clear however, that nothing said in this judgment should detract from what should be the ordinary approach in cases of this nature as set out by Keehan J in An NHS Trust and Anor v FG (By Her Litigation Friend, the Official Solicitor).*

In his judgment, given after the event (having indicated his decision at the end of the out of hours hearing), MacDonald J was clear that:

> *30.* […] *GH's current agoraphobia and anxiety is preventing her from using or weighing information in deciding whether to agree to be admitted to hospital for obstetric treatment and a possible emergency caesarean section.*
>
> *31. Despite clearly and carefully presented information that unless she is now admitted to hospital both her and her baby are at increasing risk of serious injury or even death, GH has chosen, without acknowledging and considering the reality of those risks, to stay in what she considers her "safe space", which she considers will allow her to give birth in a manner safe for both herself and her unborn child. Within this context, this is not a case in which GH has acknowledged the risk of serious injury or death, weighed that risk and then rejected that risk it in favour of an unwise course of action but rather a case in which GH simply does not acknowledge the risk of serious injury or death or accept that the risk of serious injury or death is relevant to her as long as she remains in her "safe space". I am satisfied that this demonstrates that GH's agoraphobia and anxiety has overwhelmed her ability to use and weigh the information required to decide whether to agree to be admitted to hospital for obstetric treatment and a possible emergency caesarean section. Within this context, I am further satisfied GH's inability to use and weight information is clearly the result of an impairment of, or a disturbance in the functioning of, GH's mind or brain.*
>
> *32. I am also satisfied that in her current circumstances there is no evidence before the court that GH is likely to regain capacity to make the decision regarding admission to hospital before it becomes necessary for her safety and the safety of her unborn child for that admission to take place.*

As regards her best interests, MacDonald J held that it was in GH's best interests to be conveyed from her home to hospital by ambulance, with use of reasonable force if necessary, and for the medical and midwifery practitioners attending GH to carry out such treatment as may in their opinion be necessary for the management of GH's pregnancy and delivery, as outlined in the Obstetric Management Plan. In this, he gave

> *34.* […] *significant weight to the fact that, at a time when all involved accept that GH had capacity, she had indicated that whilst she wished for a home birth, she agreed to be admitted to hospital should that be required. I am satisfied that this is cogent evidence regarding her wishes and feelings at a time when she had capacity with respect to the decision in issue. Further, I have also weighed in the balance in assessing GH's best interests the fact that she was clearly looking forward to the birth of the child and wished for the birth to go smoothly and safely. If GH had retained capacity with respect to the decision in issue, I am satisfied that it is likely she would have remained in agreement with being admitted to hospital should that admission have become necessary during the course of her labour, which it now has.*

He noted the risks attendant on admission to hospital, particular in circumstances where one of the options contemplated is a caesarean section under a general anaesthetic. A caesarean section carries with it the risks associated with a general anaesthetic and an increased risk of bleeding. As he observed, "[t]*he transportation of GH to hospital will also inevitably increase her levels of anxiety at a time when her body is already stressed by her pregnancy and obstructed labour, particularly if it is necessary to use reasonable force to facilitate the transfer*" (paragraph 35). Those risks were, however, outweighed by the risks to GH (and to the health of her unborn baby) by a home birth in her particular circumstances.

MacDonald J sought to consider the position from GH's point of view:

> *38.* […] *In this regard, I am once again assisted by fact of GH's consent to admission when she had capacity to consent to that course and before she was overborne by her agoraphobia and anxiety. As I have stated, for the reasons I have given I am satisfied that this would remain her position if she had capacity in light of the fact this this view was taken by her as recently as a few days ago. I am further satisfied that GH would also take counsel of relatives and family who seek for her to go to hospital and would likely place weight on that counsel, particularly in circumstances where it is plain that GH was desirous of a safe birth for her second child. Within this context, I have of course also borne in mind that, having heard the evidence in this case, the considered recommendation of the Official Solicitor, as litigation friend for GH, that it is in GH's best interests now to be admitted to hospital for obstetric and postnatal care.*

The order was therefore made. MacDonald J noted that:

> *40.* […] *it is a very grave step indeed to declare lawful medical treatment that a patient has stated she does not wish to undergo. It is a graver step still compel, possibly by means of the use of sedation and reasonable force if further gentle persuasion fails, the removal of a person from their home to ensure their attendance at hospital for such medical treatment. Parliament has conferred upon the court jurisdiction to make a declaration of such gravity only where it is satisfied that the patient lacks the capacity to decide whether to undergo the treatment in question and where it is satisfied that such treatment is in that patient's best interests.*
>
> *41. In this case I am satisfied that the Trust has discharged the heavy burden resting upon it in demonstrating that GH lacks capacity to decide whether to agree to be admitted to hospital for obstetric treatment and a possible emergency caesarean section and that the course of action proposed by the Trust is in GH's best interests. Within this context, I make the order in the terms appended to this judgment.*

In light of the foregoing, it may come as a (happy) surprise to discover the postscript to the judgment that:

> *43. Ahead of this judgment being formally handed down, the court was informed that GH had given birth to a healthy baby boy. In the event, following the out of hours hearing and the decision of the court, GH's labour began to progress quickly and she delivered her son at home before it was possible to execute the arrangements authorised by the court*

> *regarding her transport to hospital for obstetric and postnatal treatment.*

Comment

Cases concerning birth arrangements are always – and rightly – ones which cause concern, both to the courts, and to practitioners. In both of these cases, it is striking the extent to which the court founded themselves on what they understood to be evidence that the woman in question in fact would have wished to have been delivered safely of their baby, even if the means now being proposed were ones that they were objecting to. Their will, in other words, was being prioritised over their preferences. These cases are a crucial reminder of the importance in this setting (above almost all others) of ensuring that proper steps are taken by way of advance care planning to ensure the recording of the evidence required to determine that will.

GH's case is also a reminder of how quickly the Court of Protection can be summoned to help where required (and also of the importance of the fact that the Official Solicitor is now able to offer an out of hours service so as to ensure that the person in question is represented). As MacDonald J reminded us, the power to go out of hours should only be used as a last resort, especially in circumstances where contingency planning is possible. But it is very important that it is there. The decision is also, thankfully, another reminder of the fact that planning for the worst is quite often the best guarantor that the best will in fact occur.

Human Rights in Care Homes Survey

The Essex Autonomy Project wants you (if you are a professional working in or with care homes in England and Wales!) for a survey, which you reach via here, details of which are below:

- *Human Rights in Care Homes: A Survey-Based Study*
- *We are inviting you to participate in this survey so we can learn about the experiences of professionals working in or with care homes during the Covid-19 pandemic.*
- *This survey is part of a larger research project, "Human Rights in Care Homes", focusing on the impact of the Covid-19 pandemic on respect for human rights in care homes. Our goal is to help care professionals and policy makers protect human rights in care homes going forward. By completing this survey, you will help us understand the situation on the ground and what support may be needed.*
- *Though the survey is primarily targeted at people working in England or Wales, we welcome responses from professionals working elsewhere.*

The survey closes at midnight on 3 April 2021.

LPS steering group meeting – February 2021

The minutes of the most recent LPS steering group meeting are now available. The discussion focused upon the impact assessment published in January 2021, key points of feedback being:

- The training strategy and plans for 'workforce readiness' have moved on significantly

- since the Act, and the next IA needs to reflect that.
- Plans for LPS, and assessment of its impact on the sectors who will implement it need to take account of the short- and long-term impacts of Covid-19.
- The IA should assess the impact of the transition year between the Deprivation of Liberty Safeguards and LPS.
- Data on deprivations for the 16 and 17-year old group and in unregulated settings is limited. This could be improved for future updates of the IA.
- Future assessments could say more on how central Government will support sectors who will implement LPS, for example on workforce readiness and training.
- The estimated costs of assessments under LPS may need to be refined.

X – permission refused

The Court of Appeal has refused permission to X to appeal the decision of Sir James Munby ([2020] EWHC 65 (Fam)) that the decision of a competent (pre-16) or capacitous (16- or 17-) year old child to refuse life-sustaining medical treatment will not be determinative. Refusing permission, Peter Jackson LJ held that an appeal from the conclusions of Sir James:

> *would not have a real prospect of success. The arguments were thoroughly analysed by the Judge and his conclusions were correct. It is settled law, before and since the HRA 1998, that the court may countermand the decisions of mature minors in their best interests. Section 8 FLRA 1969 cannot be interpreted so as to confer upon mature minors an absolute right to refuse treatment. The ECHR does not suggest or mandate that conclusion either. The Canadian authorities do not have the effect contended for. Indeed paragraph [2] of **AC** (incompletely cited at paragraph 39 of the applicant's skeleton argument) arises from the fact that the Canadian legislation expressly creates a presumption in favour of the decision of a mature minor over 16: that state of affairs, which falls short of the absolute autonomy argued for in this case, supports the conclusion that such a radical change in the law must be a matter for Parliament.*
>
> *There is no compelling reason for this court to hear an appeal. The arguments have been exhaustively considered at first instance. They make a case for a change in the law: they do not sustain a case about what the law is.*
>
> *Lawful medical treatment decisions in relation to mature minors already require very great weight to be given to the view of the patient. Allowing for differences of expression, there is much common ground between the approach identified in **AC** and that explained by Balcombe LJ in **Re W** at 88. The fact that there is some divergence in academic opinion in a matter of this kind is not surprising. Even if this court was entitled to revisit its earlier decisions, there is no indication that there is any uncertainty in the settled law, nor that any subsequent developments (including the HRA and the passage of time) require it to be revisited by the courts.*

PROPERTY AND AFFAIRS

Short note: ademption, foreign law and the MCA 2005

In *Rokkan v Rokkan and Harris* [2021] EWHC 481(Ch), the court had to decide whether a gift in a will adeemed (failed) by virtue of a transfer between bank accounts at a time when the testator lacked mental capacity.

The facts were that the testator held monies in 2 Norwegian bank accounts and in her will made specific bequests of the balances therein. Later and at a time when, for the purposes of a preliminary issue, it was assumed that the testator lacked capacity so to do, she transferred those balances to an English bank.

Section 24 Wills Act 1837 requires a will to be read as if made immediately before death and, therefore, if property specified in a gift has ceased to exist by that point, the gift fails, see paragraph 72. The bank balances in question had ceased to exist, so, unless there was a relevant exception to the rule, the gift in question failed.

The beneficiary relied on the MCA 2005, Sch. 2, para 8, which provides that if a deputy appointed on behalf of a person without capacity (P) makes a disposition of property, and under P's will or intestacy any person would have taken an interest in the property but for the disposal, that person takes the same interest in any property representing the original property as circumstances allow. This re-enacts s.101 of the Mental Health Act 1983.

He also relied on *Jenkins v Jones* (1866) LR 2 Eq. 323 where the testator made a specific gift of farm stock to his son; after he had lost capacity his wife and son (without the authority of the testator) sold farm stock and kept the proceeds in a separate account. The court held that as the conversion of the property was not the act of the testator the gift did not adeem and that it attached to the proceeds.

The court distinguished the latter on the analysis that the transfer had been made without authority (paragraph 85) and held that the former did not assist as, if the beneficiary's argument was right, then the section would not be necessary (paragraph 87).

The court upheld the orthodox position that ademption is not based on intention and the issue is simply one of looking at the fact of what has happened (paragraph 89) and found that the gift had indeed adeemed and therefore failed.

The major part of the case considered conflict of laws in relation to succession and is an interesting read from that point of view too.

Marriage – the components of capacity revisited

NB v MI [2021] EWHC 224 (Fam) (High Court (Family Division)) (Mostyn J)

Mental capacity – marriage

Summary

In this case Mostyn J considered – and refused – an application for a declaration under the inherent jurisdiction that NB's Pakistani marriage to her husband MI was not valid as a marriage in this jurisdiction and thus, with the court's grant of a necessary extension of time, annulled.

The judgment is effectively in two parts. The first is an analysis and determination of NB's case. The second, from paragraphs 43 to 100, following which the court returns, briefly, to NB's case, is more of a treatise on the law of marriage and the power of the court – or lack thereof - to declare that a marriage was void at inception.

As to the first half, NB was, at the time of the hearing, a young woman in her early thirties of a "*Pakistani family, resident in England.*" In 1995 aged 6 she was involved in a car accident as a result of which she suffered a "*catastrophic brain injury*" resulting in mental health difficulties and an impairment of cognitive functioning. A damages claim was settled for a large sum, and the money managed by a Deputy.

Interestingly – and very encouragingly – by 2019 NB was considered to have regained capacity such that her Deputyship was discharged: she was considered able to manage her property and affairs.

The application concerned NB's marriage which she had entered into in 2013 in Pakistan with MI. MI, having consummated the marriage and spent a number of weeks with NB in Pakistan shortly thereafter had otherwise been entirely absent from the marriage, living in Dubai, and apparently demonstrating little interest in pursuing a "married life" with his wife.

Mindful of her significant assets as a result of her personal injury award, NB brought an application to court for a declaration either that the foreign marriage should not be recognised or that it should be annulled. MI did not respond to the application. The court set out the nature of the application thus:

> *These are the questions that fall for determination:*
>
> *i) Did the applicant lack capacity to consent to marry on 1 June 2013?*
>
> *If yes:*
>
> *ii) Does the court have power under its inherent jurisdiction to declare that the marriage between the applicant and the respondent, valid according to the law of Pakistan, is not recognised as a valid marriage in this jurisdiction, and if so, should the power be exercised?*
>
> *iii) Should time be extended under s.13(4) of the Matrimonial Causes Act 1973 to permit the applicant's nullity petition to be heard?* (paragraph 9)

What follows in the judgment is a consideration and clarification of the – somewhat out of date – case law on marriage, much of which still derives from Munby J's *Sheffield City Council v E* [2004] EWHC 2808 (Fam), [2005] Fam 326 which is now of course almost 20 years old. Mostyn J considers the evolution of modern marriage, the fact that many marriages, both historically and now, do not concern either procreation or indeed sex, and that many do not involve cohabitation. He specifically doubts the judgment of Parker J in *London Borough of Southwark v KA and Others* [2016] EWCOP 20 at paragraph 76, suggesting that capacity to enter into sexual relations is a requirement for capacity to marry, observing at paragraph 15:

> *It is possible to envisage a person lacking the mental and physical capacity to choose to engage in sexual relations, perhaps as a result of traumatic injury, but who nonetheless has full capacity to take a wife. Similarly, a couple may marry and live together tanquam soror vel tanquam frater (as sister and brother -*

> *see below). In X City Council v MB, NM and MAB Munby J at [62] helpfully reminded us of Briggs v Morgan (1820) 3 Phill Ecc 325 at 331-332, where Sir William Scott said it may be that a marriage "at a time of life when the passions are subdued" is "contracted only for comfortable society", the spouses being "fairly left to just reflection and more placid gratifications". Needless to say, these are all perfectly valid marriages.*

Gathering together the existing case law, Mostyn J set down a set of "straightforward propositions", namely:

> *i) The contract of marriage is a very simple one, which does not take a high degree of intelligence to comprehend.*
>
> *ii) Marriage is status-specific not spouse-specific.*
>
> *iii) While capacity to choose to engage in sexual relations and capacity to marry normally function at an equivalent level, they do not stand and fall together; the one is not conditional on the other.*
>
> *iv) A sexual relationship is not necessary for a valid marriage.*
>
> *v) The procreation of children is not an end of the institution of marriage.*
>
> *vi) Marriage bestows on the spouses a particular status. It creates a union of mutual and reciprocal expectations of which the foremost is the enjoyment of each other's society, comfort and assistance. The general end of the institution of marriage is the solace and satisfaction of man and woman.*
> *vii) There may be financial consequences to a marriage and following its dissolution. But it is not of the essence of the marriage contract for the spouses to know of, let alone understand, those consequences.*
>
> *viii) Although most married couples live together and love one another this is not of the essence of the marriage contract.*
>
> *ix) The wisdom of a marriage is irrelevant."*

Accordingly, while two out of the three capacity reports considered that NB lacked the requisite capacity to enter into a marriage in 2013, Mostyn J preferred the evidence of the sole expert who concluded that she possessed it.

Mostyn J observed that NB was asked what ramifications of the marriage she did not understand and her reply was she did not understand their financial differences; how the respondent would live here; what work he would do; or whether he would be prepared to sign a prenuptial agreement. However, he determined (at paragraph 35):

> *In my judgment the law does not impose on this applicant a requirement to be able to understand the full ramifications of marriage and specifically the question of where her husband might choose to live, or his involvement in the management of her damages. The fact that she might find it distressing to spend less time with her family while her husband to come to England says nothing at all about her capacity to consent to marriage…..*
>
> *39. The evidence given by the applicant satisfies me fully that she had capacity to marry. She was fully aware of the simple nature of the contract and that*

> *by an exchange of vows a union was created with mutual expectations of comfort, society and assistance. That she was not aware, and may not have been capable of being made aware, of the potential financial ramifications of marriage; of her husband's intentions as to residence and work; of whether he would sign a prenuptial agreement; or of any potential claim he may have against her on divorce is nothing to the point. None of these things tell me anything about her capacity to marry in June 2013. Again, they may tell me quite a lot about the wisdom of the marriage she entered into, but that is quite another matter.*

Accordingly, he refused to grant the applications sought albeit that he sought to give some comfort to the applicant by concluding his judgment with observations to the effect that, in the event she were to pursue divorce proceedings,

> *the prospects of the respondent succeeding in a claim for ancillary relief is vanishingly remote. The award of damages to the applicant was calibrated by reference to her needs, and compensation for her pain and suffering. This marriage never functioned as a marriage and accordingly I find it impossible to conceive of any circumstances, even were the respondent to suffer grave hardship, where he could mount a plausible claim against the applicant* (paragraph 112).

In the second half, provided in the event "a higher court disagrees with my primary finding" (paragraph 42) and therefore and strictly obiter, Mostyn J goes on to provide a fascinating history of the evolution of the law of marriage throughout the twentieth and early twenty-first century – dipping back to the seventeenth century as necessary.

Mostyn J's key concern was the practice of the court in seeking to avoid the statutory prohibition s.58(5)(a) of the Family Law Act 1986 that "No declaration may be made by any court, whether under this Part or otherwise - that a marriage was at its inception void." The judgments in *KC & Anor v City of Westminster Social & Community Services Dept. & Anor* [2008] EWCA Civ 198 and *Re RS (Capacity to Consent to Sexual Intercourse and Marriage)* [2015] EWHC 3534 (Fam) both come for criticism in this regard: only Holman J in *A Local Authority v X & Anor (Children)* [2013] EWHC 3274 (Fam) is applauded for his refusal to grant the application sought – as Mostyn J observes (at paragraph 79):

> *A different, and to my mind more principled, approach was taken by Holman J in A Local Authority v X & Anor (Children) [2013] EWHC 3274 (Fam). This was a similar case where a local authority sought, pursuant to the inherent jurisdiction, a declaration of non-recognition of the marriage in Pakistan of X, a girl then aged 14. Although that marriage was valid under the laws of Pakistan, it was completely invalid, and void ab initio under English law on the ground of non-age: s.11(a)(ii) Matrimonial Causes Act 1973. Holman J refused the application stating: "I would be bypassing and flouting the statutory prohibition in section 58(5) of the 1986 Act by a mere device. I cannot do that and I am not prepared to do that." He held that there was nothing to prevent X petitioning for a decree of nullity.*

Hayden J, in contrast, is criticised for the approach adopted in *Re RS (Capacity to Consent to Sexual Intercourse and Marriage)* [2015] EWHC 3534 (Fam), a case concerning a 24-year-old man, who suffered from intellectual disability and autism spectrum disorder, who was married in Pakistan. The marriage was valid under the laws of Pakistan. The evidence was that he could not validly consent to the marriage in consequence of unsoundness of mind. Accordingly, it was an invalid, albeit voidable, marriage under s.12(1)(c) Matrimonial Causes Act 1973. Hayden J, however, accepted submissions made on behalf of the local authority that as a marriage that could not lawfully have been conducted in England, it could be declared void at the time of its inception on the grounds of public policy and in "*the interests of justice, fairness and respect for different aspects of individual autonomy*" (paragraph 52). Mostyn J, deprecating this approach, held:

> *84. For my part I must respectfully part company with this reasoning. I cannot shrink from the conclusion that the statutory prohibition in s.58(5)(a) of the Family Law Act 1986 has been, to use the words of Holman J, bypassed and flouted. I can see the temptation of a judge to find some kind of loophole where nullity proceedings are impossible, whether in consequence of want of jurisdiction, or because they are out of time. But this scenario was expressly considered by the Law Commission, and therefore impliedly by Parliament, which decided that the statutory prohibition should be unyielding even in those circumstances. Parliament could have inserted an exception on the ground of public policy but it chose not to do so.*

Even Sir James Munby does not escape criticism. The decision in *X City Council v MB, NM and MAB* [2006] EWHC 168 (Fam), [2006] 2 FLR 96, again concerning a marriage of a 25 year old who undoubtedly lacked capacity to marry but whose parents wished him to marry in Pakistan. In that case Munby J (as he then was) made two declarations:

> *1. MAB does not have the capacity to marry.*
>
> *2. Any purported marriage by MAB whether celebrated inside or outside England and Wales will not be recognised in English law.*

Mostyn J observed:

> *87. There is no reference in the judgment to ss. 55 and 58 of the Family Law Act 1986. Nor is there any reference to the public policy power of non-recognition of an unconscionable foreign legal construct.*
>
> *88. In circumstances where no ceremony of marriage has taken place the statutory code does not directly apply. It only applies where a ceremony of marriage has taken place. Therefore it is not in direct violation of s.58(5)(a) for anticipatory declarations of this nature to be made. The first declaration only speaks to MAB's capacity at the time it was made and it is a truism that capacity can and does fluctuate. Therefore if MAB were to go through a ceremony of marriage at a later date his capacity at that point would have to be reassessed. However, the declaration is a useful record of the judicial finding of MAB's capacity to marry at that point in time.*

> *89. With respect, I cannot agree with the second declaration. It addresses a marriage at some point in the future. If MAB had recovered his capacity to marry at that point then it would be valid under English law. But if he had not, and his incapacity to consent to marriage endured, the declaration would be in conflict with the statutory prohibition. It could only be granted by application of the stringently exceptional public policy power which I have set out above. That is not referred to in [36] where the grant of the declaration is explained.*
>
> *I do not dispute the existence of the general power not to recognise, exceptionally, an unconscionable right, power, capacity, disability or legal relationship arising under the law of a foreign country. However, in a case where the statutory prohibition applies, the exercise of this power, if not in fact blocked by the prohibition (see above), must be very highly exceptional…*

Comment

In the second half of the judgment which, as we noted, is obiter, Mostyn J was ultimately primarily concerned less with the conclusions the courts reached in the majority of these cases rather, the manner in which they reached them. Much of this (lengthy) judgment might therefore be of academic rather than practical interest. It is, however, extremely helpful in its elucidation and updating of the position with regard to capacity to marry, and the issue as to whether capacity to enter into sexual relations is a requirement for capacity to marry is an issue where there is now a frank (live) dispute between different High Court judges.

Modernising lasting powers of attorney

In a blog on 16 February 2021, the OPG introduced the project the Ministry of Justice (MoJ) and the Office of the Public Guardian (OPG) are working on to modernise lasting powers of attorney.

The project aims to:

- increase safeguards for the donor
- improve the process of making and registering a lasting power of attorney (LPA), for donors, attorneys and third parties
- Keep LPAs as affordable as possible whilst ensuring OPG is working sustainably
- In the spring of 2021, the Ministry of Justice intends to launch a public consultation on changes to the legal framework for LPAs.

For more information, details and updates on the modernising LPA work visit this new site.

If you would like to register your interest in assisting with our research and engagement, please fill in this contact form.

Use a lasting power of attorney – more LPAs are now eligible

In a blog on 4 March 2021, the OPG announced that the Use an LPA online service would be extended for use in relation to LPAs registered on or after 1 September 2019 (the cut-off date having been 17 July 2020).

The service enables users to share details of their LPA with third party organisations. The service has proven to be successful and saved many attorneys time and hassle by reducing the need to post out an LPA for validating with an organisation.

Getting started as an attorney or deputy

In a blog on 9 March 2021, the OPG sought to give some useful tips and ideas on how to make sure that attorneys and deputies getting started get off on the right foot.

PRACTICE AND PROCEDURE

New edition of Equal Treatment Bench Book

The 2021 edition of the Equal Treatment Bench Book was published on 24 February 2021.

There is new and expanded content on:

- The impact of the COVID-19 pandemic on different groups and how to conduct remote hearings (on audio or video platforms) fairly;
- Welsh/English bilingualism and the right to speak Welsh in courts and tribunals in Wales;
- Reducing jargon and legalese;
- Assisting a litigant who has difficulty reading or writing;
- Extended guidance in relation to litigants-in-person;
- New entries in the disability glossary;
- Confidence in the courts of minority ethnic communities;
- Sensitivity if a witness is experiencing menopausal symptoms.

It should be noted that the book maintains (at p.357) the error of previous editions of stating that the:

> *The United Nations Convention on the Rights of Persons with Disabilities is directly applicable in the UK and provides that 'persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others'*

The correct status of the CRPD was best described by Cobb J in *Re A (Capacity: Social Media and Internet Use: Best Interests)* [2019] EWCOP 2 as follows

> *While the UNCRPD remains currently an undomesticated international instrument, and therefore of no direct effect (see Lord Bingham in A v Secretary of State for the Home Department* [2005] UKHL 71*;* [2006] 2 AC 221 *at [27]), it nonetheless provides a useful framework to address the rights of persons with disabilities. By ratifying the UNCRPD (as the UK has done) this jurisdiction has undertaken that, wherever possible, its laws will conform to the norms and values which the UNCRPD enshrines: AH v West London MHT* [2011] UKUT 74 (AAC)*; [16] (See R(Davey) v Oxfordshire CC & others* [2017] EWCA Civ 1308 *at [62], and Mathieson v SS for Work and Pensions* [2015] UKSC 47*,* [2015] 1 WLR 3250 *at [32]). I am satisfied that I should interpret and apply the domestic mental capacity legislation in a way which is consistent with the obligations undertaken by the UK under the UNCRPD.*

Short note: reasonable adjustment for a deaf party to proceedings

A Local Authority v M, F, A and B [2021] EWFC 10 is a judgment given in family proceedings considering whether two young children should be placed in long-term foster care or for adoption. We cover the judgment because useful lessons were identified which can be carried across to ensuring effective participation in

Court of Protection proceedings. The mother ('M') was profoundly deaf and had previously been assessed as having a learning disability, with extremely low cognitive ability, and lacking capacity to conduct care proceedings. However, subsequent expert evidence established that this was wrong on both counts. Moreover, there was no evidence that the professionals conducting the pre-birth assessment of M's parenting ability had the skills suitable to her needs as a deaf parent.

The judgment provides guidance on the type of reasonable adjustments to be considered where a party to proceedings is deaf. The judge observed that deafness was a disability for Equality Act 2010 purposes, section 20 of which requires public authorities (including the courts) to make reasonable adjustments to provisions, criteria or practices that place the disabled person at a substantial disadvantage. This can include providing information in an accessible format and securing effective and fair participation in proceedings, as expanded upon in the Equal Treatment Bench Book. In this case, the mother was supported by a lip-speaker and an intermediary, there were regular breaks, and the judge prepared a simplified version of the judgment which was read aloud to the mother with their assistance.

The main lessons learnt, potentially applicable to the Court of Protection are:

1. Professionals working with a deaf person must be aware of their obligations under the Equality Act 2010 and the need for reasonable adjustments. They (including those supervising contact arrangements) should receive adequate and timely deaf awareness training, to include information about how to provide information in a clear and appropriate way to a deaf person who also has communication difficulties.
2. The person's needs must be identified, with expert advice as necessary, and corresponding support be made available, provided by professionals with suitable skills. A cognitive and capacity assessment undertaken by a suitable specialist at the outset of proceedings can prove instrumental, both in terms of determining the person's mental capacity but also for reasonable adjustment purposes.

We commend the relevant Advocate's Gateway Toolkit which informed the judgment. More broadly, the court's Equal Treatment Bench Book is an incredibly helpful resource when considering how to promote a person's participation in proceedings (whether that is P or a party to proceedings). Appendix B provides useful examples of reasonable adjustments for a whole range of protected characteristics which COP practitioners can draw from to promote participation.

We also commend the post about this case by Abigail Bond on the Transparency Project, which also links to a recent but more unusual care case involving a deaf parent, see *A* Local *Authority v X & others* [2020] EWFC 36, where the mother had neither litigation capacity nor the capacity to give evidence in court but was assisted to participate as fully as possible in the proceedings by a bespoke DVD 'interview' process devised and undertaken by Dr Austen.

THE WIDER CONTEXT

A reminder – respond to the White Paper!

A reminder that the consultation contained in the White Paper on reforming the Mental Health Act 1983 closes on 21 April 2021. It poses significant, and wide-ranging questions – including many as to the place of capacity in any future legislation (as to which see further Alex's shedinar here). The consultation can be found here, and Neil's analysis of the White Paper here.

DNACPR decisions – new guidance and letter

Responding to a judicial review claim compromised in the summer of 2020, new guidance on DNACPR decisions has now been published on the NHS website. It addresses a range of scenarios, including:

- Where the person wishes to refuse CPR, making clear that whilst the doctor can complete a DNACPR form to indicate this, it will only be legally binding if it is made as an Advance Decision to Refuse Treatment;
- Where the doctor decides in advance. The guidance emphasises, importantly, that this a medical treatment decisions that can be made even if the patient does not agree. Doctors must tell patients that the form has been completed (unless doing so would cause the patient physical or psychological harm, the test set out in *Tracey*), but the doctor does not need consent to complete one;
- Where the person does not have capacity to make decisions about CPR, at which point it is said that a health and welfare attorney with the correct authority has the power to refuse CPR on the same basis that the person might do themselves,[1] otherwise (unless an ADRT is in place), the decision is a best interests one.[2]

The guidance emphasises that:

> *DNACPR decisions should not be made for a group of people at once. For example, DNACPR decisions should not be made for everyone living in a care home or for a group of people over a certain age. This is unlawful, irrespective of medical condition, age, disability, race or language.*

The guidance also has a useful section on what you should do if you are concerned about a DNACPR form in your medical record or someone else's.

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[1] It is suggested that this is in fact, not the case. An attorney has the power to make a decision **at the time** that CPR is not to be carried out. It is not obviously the case that an attorney has the power to decide, **in advance**, that CPR should not be carried out. Rather, the attorney's indication that the donor would not wish CPR is a factor that should carry very significant weight in the decision whether to make a DNACPR recommendation.

[2] Whilst this follows the decision in *Winspear* case, it should be noted that it is not, in fact, obviously a best interests decision because as the guidance has already made clear, the decision whether or not to recommend CPR is a decision of the doctor's not the patient's, and best interests decisions are decisions that the person themselves can take. In any event, it is undoubtedly a decision which should be taken in the spirit of a best interests decision, in particular involving consultation with those interested in the person's welfare.

The importance of DNACPR decisions being made on an individual, not a blanket basis, is also emphasised The importance of good practice in Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and people with a learning disability and or autism was emphasised in the letter from the NHS National Medical Director and others dated 4 March 2021, including this key message:

> The NHS is clear that people should not have a DNACPR on their record just because they have a learning disability, autism or both. This is unacceptable. The terms "learning disability" and "Down's syndrome" should never be a reason for issuing a DNACPR order or be used to describe the underlying, or only, cause of death. Learning disabilities are not fatal conditions. Every person has individual needs and preferences which must be taken account of and they should always get good standards and quality of care

Specific recommendations for care homes directed at identifying abuse and neglect

On 26 February 2021, NICE published a guideline document on keeping adults in care homes safe from abuse and neglect in order to make a number of recommendations to improve safeguarding residents in care homes. It is targeted principally at care home providers, managers, staff and volunteers because safeguarding practices and procedures vary significantly at the local level notwithstanding the legal framework and associated statutory guidance. It is noted, in particular, that care homes often struggle to understand: (i) the difference between safeguarding issues and poor practice; and (ii) when and how to make safeguarding referrals to the local authority.

The recommendations are specific and clear, covering the following topics:

- *Safeguarding policy and procedure;*
- *Whistleblowing policy and procedure;*
- *The respective roles of care home providers, local authorities, clinical commissioning groups and other commissioners;*
- *Staff training;*
- *Care home culture, learning and management;*
- *Identifying abuse and neglect;*
- *Steps to take if abuse and/or neglect is identified (including immediate protective measures, investigations, reporting and responding to reports, as well as providing the necessary support).*

The guidelines consider, in a helpful level of detail, the indicators of different types of abuse and neglect at both an individual and organisational level. It is necessary reading not just for care home providers (and their staff), but also those involved in safeguarding investigations as well as adults living in care homes, their family, friends and advocates.

Supporting people who have eating and drinking difficulties: new guidance from the Royal College of Physicians

The Royal College of Physicians has published (10 March 2021) a guide to practical care and clinical assistance. Its particular focus is on the complexities that can arise around nutrition and hydration towards the end of life.

The guidance, applying the law within England & Wales but offering clinical principles which will also be applicable within different legal frameworks in Scotland and Northern Ireland, updates the previous *Oral feeding difficulties and dilemmas* published in 2010, particularly in relation to recent changes in the law governing procedures for the withdrawal of clinically assisted nutrition and hydration (CANH) and other life-sustaining treatments.

It was developed by a working party with representation from a wide range of specialties, including neurology, dietetics, speech and language, gastroenterology, law, ethics, and care of older people. (Alex was one of the two lawyers involved)

Eating and drinking are essential for maintenance of nutrition and hydration but are also important for pleasure and social interactions. The ability to eat and drink hinges on a complex and coordinated system, resulting in significant potential for things to go wrong.

Decisions about nutrition and hydration and when to start, continue or stop treatment are some of the most challenging to make in medical practice. The newly updated guidance aims to support healthcare professionals to work together with patients, their families and carers to make decisions around nutrition and hydration that are in the best interests of the patient. It covers the factors affecting our ability to eat and drink, strategies to support oral nutrition and hydration, techniques of clinically assisted nutrition and hydration, and the legal and ethical framework to guide decisions about giving and withholding treatment.

The guidance is primarily for medical and healthcare professionals, particularly those involved in caring for people who have eating and drinking difficulties, including gastroenterologists, ward nurses, geriatricians, dietitians, speech and language therapists, neurologists, palliative care teams, care home and community nurses.

Updated throughout, it includes a new chapter on dietary modifications and a series of illustrative examples of patients to help guide practice. From Alex's perspective, one of its most important innovations is that it includes practical guidance to address one of the most difficult areas that other guidance in this area has all too often shied away from: what to do where the patient's wishes (either capacitous or incapacitous) are to be provided with food and drink in a way which professionals feel that they cannot accommodate because of the risk. The framework proposed seeks to assist in securing against undue risk aversion on the one hand whilst on the other hand recognising that professionals have their own rights.

Film review

In a first for us, but keeping up with the times, Simon Edwards reviews I Care a Lot (2020), now streaming on Amazon Prime (in the UK)

Rosamund Pike puts in a stellar performance as the malevolent court appointed guardian who looks after the affairs of helpless elderly "inmates" of conniving care homes in Massachusetts.

She relies on falsified doctors' reports and a rather negligent judge to take over and fleece her victims, picked for their isolation from friends and relatives. Unfortunately for her, one of her victims has rather unsavoury connections.

The court room scenes will strike a chord to the initiated with a desperate son pleading that the guardian has prevented all contact with his mother and sold her home to pay care fees with the retort that the son has behaved in a disruptive manner abusing and assaulting care home staff and represents the type of relative whose only interest is preserving their inheritance.

Direction, by Jonathan Blakeson, is taut, time never drags and there is a thrill, and a laugh, coming round every corner. He also wrote the script and shows a keen eye for the detail of the process.

Pike steals every scene and there is a terrific twist at the end.

Short note: ordinary residence, deeming and deputyship

R (Lancashire County Council) v JM & Anor [2021] EWHC 268 (Admin) concerns a dispute between two local authorities as to which one was responsible for funding P's accommodation at a Transitional Rehabilitation Unit ("TRU") under the National Assistance Act 1948 ("1948 Act"). The authorities had referred their dispute to the Secretary of State for determination – the challenge was brought to his decision that P was ordinarily resident in Lancashire County Council ("Lancashire") and therefore that authority was responsible for funding his accommodation.

P had sustained a serious brain injury as child and received a personal injury damages award in the sum of £3.1million. Part of that sum was used by his deputy to purchase a property in Edenfield in Lancashire. P came to the attention of Lancashire due to allegations of financial and emotional abuse as well as self-neglect in 2010. It was agreed that P would move to the TRU with a view to finding another residential placement (his house was in a poor condition).

HHJ Eyre QC considered the legislative framework, pursuant to the National Health Service and Community Care Act 1990 ("1990 Act") and the 1948 Act, in respect of assessing P's needs for the provision of community care services and providing for those needs. He observed that the effect of, the National Assistance (Assessment of Resources) Regulations 1992 and of the National Assistance (Residential Accommodation) (Disregarding of Resources) (England) Regulations 2001, meant that the funds derived from personal injury damages were to be disregarded when considering the duty to provide residential accommodation, particularly as to whether such accommodation would otherwise be available to the individual.

He noted that it was common ground that, but for the potential effect of section 24(5) of the 1948 Act, P would fall to be ordinarily resident in St Helens (the other authority) while living at the TRU. That statutory ("deeming") provision provided that:

> *Where a person is provided with residential accommodation under this Part of this Act, he shall be deemed for the purposes of this Act to continue to be ordinarily resident in the area in which he was ordinarily resident immediately before the residential accommodation was provided for him*

In analysing the deeming provision and ordinary residence, HHJ Eyre QC considered the cases of

R (London Borough of Greenwich) v Secretary of State for Health [2006] EWHC 2576 (Admin) and *R (Barking & Dagenham LBC) v Secretary of State for Health* [2017] EWHC 2449 (Admin). The two main principles were that:

1. If arrangement should have been made pursuant to s 21 of the 1948 (following the relevant assessment), then the deeming provision should be applied and interpreted on the basis that those arrangements had actually been put in place by the appropriate LA ("*Greenwich* principle"); and,
2. If the deeming provision does not apply, then, if the individual has capacity, the question of ordinary residence falls be determined on the principles laid down in the leading case of *R v LB Barnet, ex parte Shah* [1983] 2 AC 309, namely *"abode in a particular place …which he has adopted voluntarily and for settled purposes as part of the regular order of his life for the time being …"*

The key question on the facts was whether the s 24(5) came into operation by virtue of the application of the Greenwich Principle. The Secretary of State had decided that Lancashire should have assessed P's needs pursuant to s 47 of the 1990 Act. The *Greenwich* principle applied, which meant that for the purposes of invoking s 24(5), Lancashire should be treated as having undertaken that assessment. If they had done so, they would have found that he was in need of care and accommodation in a residential setting; and that such care was not '*otherwise available*'. Accordingly, Lancashire would have been required to fund a placement for P.

HHJ Eyre QC was satisfied that the Secretary of State approached the determination in the correct manner, which had been summarised on behalf of the Secretary of State as follows:

> *By definition, application of the Greenwich principle requires the [Secretary of State] to engage in what [Lancashire] characterises as an exercise of 'speculation'. It is impossible for the [Secretary of State] to apply the deeming provision to the arrangements that 'should have' been made, without reaching a view on the facts as to what arrangements would have been made if the local authority had complied with its duties at the 'trigger date'.*

HHJ Eyre QC was satisfied that the conclusions reached by the Secretary of State were those that he was properly entitled to reach on the material before him. The claim was therefore dismissed.

This case further emphasises the importance of local authorities ensuring that they properly discharge their statutory obligations with regards to assessing needs and putting arrangements in place in accordance with their community care duties. If they fail to do so, and are found at a later date to have acted unlawfully, then the application of the *Greenwich* principle could mean they have a much larger bill to foot by virtue, most obviously, of interest. The case should be considered alongside the judgment of Thornton J in *Surrey County Council v NHS Lincolnshire CCG* [2020] EWHC 3550 (QB) (on which we have previously reported) where it was found that the CCG had been unjustly enriched to the extent of the care fees paid by the LA to the care home.

Controlling or coercive behaviour – review and amendment to the Domestic Abuse Bill

Following a review of the Controlling or Coercive Behaviour Offence Research Report 122 March 2021, the offence in s.76 Serious Crime Act 2015 is to be amended (by the Domestic Abuse Bill) so that it is no longer a requirement for the abuser and victim to live together, where they have previously been an intimate personal relationship. The review highlighted that those who leave abusive ex-partners can often be subjected to sustained or increased controlling or coercive behaviour post-separation. This is a very welcome development, but the offence still will not include the situation where the abuser and victim are not in either family members or (currently or previously) in an intimate relationship, so it will still not be a tool which can be used in situations of what Alex has called 'proximity abuse,' a phenomenon often encountered in the case of those on the cusp of capacity who all too often fall between the cracks in safeguarding terms.

Autonomy does not always equate to a 'good' outcome

In a (short) report, the Prisons and Probation Ombudsman considered the care given to a prisoner, Brian Daniels, who died of a stroke aged 74 at HMP Durham.

> *13. Throughout his time in prison, Mr Daniels regularly refused food and medical treatments, including going to hospital. This was sometimes a form of protest, but more frequently he said it was because he wanted to hasten his death. He said on many occasions that he wanted to die in prison.*
>
> *14. In 2020, Mr Daniels' health deteriorated. A significant contributory factor was his increasing resistance to all forms of treatments, including refusals to go to hospital on several occasions. On 12 August, he agreed to go to hospital after falling ill. However, once there he refused treatment and said once more that he wanted to die. On 21 August, prison and healthcare staff met with hospital staff, including palliative care consultants at the hospital. Mr Daniels had requested that all care should stop, and his carers agreed that he had the mental capacity to make that decision. He returned to prison on 24 August, under a palliative care treatment plan (care with the focus on optimising the quality of life and reducing suffering).*

The PPO's independent clinical reviewer concluded that, overall the clinical care Mr Daniels received at Durham was equivalent to that which he could have expected to receive in the community. We note this report to make the short point that accepting treatment refusal – where such refusal is properly considered to be capacitous – does not amount to clinical failing, even for those detained in prison.

Distinguishing capacity and autonomy – the criminal law perspective

R v Rebelo [2021] EWCA Crim 306 (Court of Appeal (Criminal Division) (Dame Victoria Sharp P, Davis and Picken JJ)

Other proceedings – criminal

Summary

In a very unusual criminal case, fascinating –

essentially existential – questions arose as to the interrelationship between capacity and autonomy. Mr Rebelo ran a business selling a chemical, DNP, as a food supplement which was claimed to promote weight loss. On 4 April 2015, a 21-year-old student, Eloise Aimee Parry, purchased a quantity of DNP capsules from the appellant's business via the internet. On 12 April 2015, after taking eight of the capsules, tragically, she died. DNP was not licensed as a medicinal drug, and ingestion by a human is to be regarded as hazardous and its toxic effects various and serious, including, inter alia, kidney failure, liver failure and cardiac arrest.

Ms Parry was a woman with a complex mental health history. When she encountered the DNP on Mr Rebelo's website, she described (in emails and messages to university friends) what she had taken and how she could not control her use of DNP. Despite appreciating that DNP was causing her harm, she continued to order further supplies from the appellant's business. She was repeatedly warned by her GP, social worker and friends of the danger from taking DNP, including the potentially fatal consequences. On 10 April 2015 a friend of Ms Parry, warned her that she was going to die if she did not stop taking DNP to which Ms Parry replied: *"I wish I wouldn't too but the psychological desperation to take the pills is so hard to fight. They make everything feel okay. They give me control. Which I know is delusional but I feel it so overwhelmingly!"*

At trial, the prosecution case was that the supply of these tablets for human consumption constituted an unlawful act which was dangerous and led to death (unlawful act manslaughter); it also constituted a gross breach of the duty of care owed to Ms Parry, crossing the criminal threshold, in circumstances which created an obvious and serious risk of death (gross negligence manslaughter).

Mr Rebelo's defence was that, whilst he accepted placing DNP on the market, he did not so do with the intent or reasonable expectation alleged by the prosecution. Rather, he contended that:

> *Ms Parry was an autonomous woman who decided to make a foolish decision in the exercise of her free will and killed herself, as she was entitled to do. The appellant's act of placing DNP on the market was too remote. Putting DNP on to the market did not cause her death and he bore no responsibility for Ms Parry ingesting it. It was not possible for him to have foreseen the possibility that she would take a handful of the capsules.*

In 2018 Mr Rebelo was convicted of both unlawful act manslaughter and gross negligence manslaughter, together with the offence of placing an unsafe food on the market contrary to Article 14 of Regulation (EC) 178/2002 and Regulation 19 of the Food Safety and Hygiene (England) Regulations 2017. He appealed against his manslaughter convictions. In April 2019, the Court of Appeal quashed the conviction for unlawful act manslaughter because it concluded, by analogy with the approach taken to the supply of heroin in *R v Kennedy (No 2)* [2007] UKHL 38, [2008] 1 Cr App R 19, that placing unsafe food on the market, of itself, was not a dangerous act; and that to place DNP on the market could not, therefore, amount to a dangerous act sufficient to amount to an unlawful act for the purposes of unlawful act manslaughter. The Court of Appeal rejected the submission that the trial judge ought to have acceded to a submission of 'no case to answer' in respect of gross negligence manslaughter. In that connection, the appellant had argued that there was insufficient evidence that DNP created an obvious and serious risk of death, the only risk being when there was an overdose; alternatively, because there was "*a break in the chain of causation as a consequence of the voluntary (that is to say free, informed and deliberate) act of the deceased herself*." In rejecting that submission, the Court of Appeal said, that there was "*clearly enough material to justify leaving the issue of serious and obvious risk of death to the jury*." The conviction for gross negligence manslaughter was quashed, however, because the Court of Appeal concluded that the direction given by the judge to the jury on the issue of causation was defective:

> *74. In that part of the route to verdict dealing with autonomy the judge asked whether the prosecution had proved that Eloise Parry lacked capacity or was vulnerable and unable to exercise her free will when making the decision to take DNP. The reference to capacity came from the evidence of Dr Rogers applying the criteria set out in s. 3 of the Mental Capacity Act 2005. Thus, the question posed in the route to verdict in relation to gross negligence manslaughter did not reflect sufficiently clearly the issue that arose which was not merely whether it was <u>not</u> so unreasonable that it eclipsed the defendant's acts or omissions but which also depended on whether Eloise Parry's decision to take DNP may have been free, deliberate and informed decision, as Ms Gerry argued. Her capacity would be relevant to that issue.*
>
> *75. In that regard, it is important to underline that capacity is not the same as autonomy. To direct the jury that provable lack of capacity as defined in the 2005 Act would be sufficient to demonstrate lack of autonomy was a misdirection particularly given the emphasis thereafter placed on the evidence of Dr Rogers. The second limb of the direction – the reference to Eloise Parry being 'vulnerable and unable to exercise her free will' – failed to assist the jury with what was meant in that context by the word vulnerable and how it interacted with any exercise of free will. Admittedly the judge was only using the term adopted in Kennedy (No 2). But in that case the issue of capacity did not arise on the facts and there was no suggestion that the victim was suffering from a mental disorder that might deprive him of capacity. Further, the use of the word vulnerable was not discussed further. The direction should have required the jury to consider only the question of Eloise Parry's free, deliberate and informed decision.*

Mr Rebelo was retried in February 2020. His case, again, was that "*Ms Parry was an adult woman suffering from an emotionally unstable personality disorder and an eating disorder who made a fully free, voluntary and informed decision to take the DNP; she was not acting under any compulsion, nor was she vulnerable to feeling compelled. She was someone who wanted to take the DNP and so did. She was a bright and able university student who had conducted internet research and was well informed about the risks of DNP*." He did not give evidence, his sole witness being Dr Richard Latham, a consultant psychiatrist. His evidence was given "back to back" with that of the prosecution experts. Dr Latham said that, in his opinion, there was insufficient evidence to displace the presumption under section 23 of the Mental Health Act,[3] that Ms Parry had capacity. At paragraph 22, his evidence is recorded as follows:

> *In his opinion, Ms Parry's mental health issues influenced the way in which she made decisions, but she retained capacity. He explained that, where capacity is an issue, people can fluctuate from hour to hour. In the present case, Ms Parry was capable of understanding the information on DNP. When she took DNP for the last time, she was repeating something that she had done on previous occasions. However, Dr Latham also said:*
>
>> *"The decision every time she took DNP; that was likely to be because of the cycle of behaviour associated with her mental disorder. She was bingeing, purging and using DNP. These were compensatory behaviours. I don't believe you could ever describe the situation of her taking DNP as fully free because this was part of her disorder and was driven by the symptoms of her disorder. Similarly with voluntariness, I do believe that her mental symptoms meant that her decision was not fully voluntary. The mental symptoms that she had; they do have an impact on her ability to resist the compulsion, so whilst I said before there is still likely to have been some degree of choice … that choice was very significantly impaired by her mental disorder."*

After this evidence, the appellant apparently lost confidence in his legal team and dispensed with their services. A newly instructed legal team sought an adjournment to prepare but were only granted a short time so as not to derail the trial. They also sought permission for an adjournment to accommodate the holiday commitments of a new expert as to Ms Parry's capacity, which the judge refused on the basis that, in effect, it was very unlikely that the expert would add anything.

The judge gave written directions to the jury on causation, as follows, the material parts of which are as follows:

> *21. In relation to the question of causation, the Prosecution must make you sure that Eloise Parry did not make a fully free, voluntary and informed decision to risk death by taking the 8 tablets of DNP on the morning of 12 April 2015: this is the 'decision' you must think about. If this was a fully free, voluntary and informed decision, or may have been, that means that as a matter of law, her death was caused by her free choice, because in those circumstances, the Defendant only set the scene for her to make that decision, but he did not cause her death.*
>
> *22. What does a fully free, voluntary and informed decision mean? Lawyers sometimes refer to a person's ability to make a fully free, voluntary and informed decision as 'autonomy'. Whether a decision is fully free, voluntary and*

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[3] This must be a typographical error in the judgment (rather than Dr Latham's report) for ss.2-3 Mental Capacity Act 2005.

> *informed will be a matter of degree. It will be for you to judge whether all the relevant factors in this case, including her eating disorder and her mental health generally, were such that you can be sure that her decision to take the DNP was not fully free, voluntary and informed, as the Prosecution alleges.*
>
> *23. It is important that you look at each element separately although there is likely to be some overlap between 'fully free' and 'voluntary'.*
>
> *24. You will appreciate that a state of mind may fluctuate and just because some decisions Eloise Parry made at some times in her life may not seem to be fully free, voluntary and informed, it could still be the case that when she made the decision to take DNP on 12 April 2015, that decision was fully free, voluntary and informed. It is that decision you must think about.*
>
> *25. When considering whether it was 'fully free' you will want to consider in particular the effect of any mental health condition. In ordinary language, you might talk about someone being vulnerable because of their mental health issues. This might include, as the Prosecution say, that the person's ability to protect themselves from significant harm was impaired. The Prosecution say that Eloise Parry was vulnerable because of her mental health problems and her psychological addiction to DNP, because those problems stifled her ability to make a fully free decision. The Defence say that she was able to protect herself; they say that an adult woman suffering from an emotionally unstable personality disorder and an eating disorder can, and in this case did, make a fully free, voluntary and informed decision to take the DNP.*
>
> *26. When considering whether the decision was 'fully voluntary' you will want to consider whether she was acting under any compulsion, whether caused by her mental health problems or any psychological addiction she may have had to DNP. Here too, you will consider whether she was vulnerable, which in this context would mean that her ability to resist feeling compelled to take the DNP was impaired. The Prosecution say that there is clear evidence that she was acting under an element of compulsion because of her psychological dependence on DNP combined with her mental health problems. The Defence say she was not acting under compulsion, nor was she vulnerable to feeling compelled; she wanted to take the DNP and so she did.*
>
> *27. When considering whether she was 'fully informed' you will want to consider whether she knew the risks that she was taking. The Prosecution say that she was not fully informed as the references she makes to 'safe' doses are nonsense and not supported by science. The Defence say that she had conducted substantial research so knew full well what risks she was taking."*

As to capacity, the judge directed the jury:

> *33. You should ask yourselves whether taking account of all the evidence in the case, Eloise Parry made a fully free, voluntary and informed decision to take the DNP? If you conclude that her decision was, or may have been, fully free, voluntary and informed, then that decision was the cause of her death, because as a matter of law, that decision supersedes or overtakes any grossly negligent act by the Defendant in*

> *supplying the DNP in the first place. The Defendant is not guilty of manslaughter.*
>
> *34. If, on the other hand, you are sure that Eloise Parry did not make a fully free or fully voluntary or fully informed decision to take the DNP, then, if the defendant was in gross breach of his duty of care owed to her, his negligence remains a substantial and operative cause of her death, even if it was not the sole cause of her death. He is guilty of manslaughter.*

Mr Rebelo appealed on a number of grounds. For present purpose, the materially interesting one is the assertion that the judge had misdirected the jury on the question of causation. Specifically, he asserted that the judge had failed to direct the jury that that even if they concluded Ms Parry's decision was not fully free and voluntary, they still had to assess whether the decision to take the amount of DNP that she did was such that it could be said "to eclipse" the appellant's gross negligence. It was said that, in light of the decision given on the first appeal in 2019, this further step was required in order to establish the necessary link between the appellant's supply of DNP and Ms Parry's death, and that Ms Parry's action in taking the amount of drugs that she did, did not break the chain of causation.

Dame Victoria Sharp P, giving the judgment of the Court of Appeal, held that this was misconceived. On a proper interpretation of the first appeal judgment, the requirement that Mr Rebelo sought to add did not exist:

> *34. [...] the key issue was whether Ms Parry had or might have made a fully free voluntary and informed decision to take DNP; if that was the case, the jury could not be sure that the appellant's breach of duty was a cause of her death. We repeat the following passage from the Court of Appeal's judgment:*
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> > *"In relation to the question of causation, the prosecution must make you sure that the victim did not make a fully free, voluntary and informed decision to risk death by taking the quantity of drug that she ingested. If she did make such a decision, or may have done so, her death flows from her decision and defendant only set the scene for her to make that decision. In those circumstances, he is not guilty of gross negligence manslaughter."*
>
> *35. What followed was an explanation of what is meant by "fully free, voluntary and informed"("What does a fully informed and voluntary decision mean?"). It is in that context, that the "starting point" taken is "the capacity of the victim to assess the risk and understand the consequences"; and then of her "ability to assess the risk and understand the consequences relating to the toxicity of the substance and her appreciation of the risk to her health or even grossly negligent breach of the duty of care". As Sir Brian Leveson P said at para 77, what is required is a "balancing exercise" in order to decide whether the prosecution has established that a defendant's breach of duty is a substantial and operative cause of death, even if it is not the sole such cause, bearing in mind, of course, that the jury would only be considering the causation issue at all if they have already concluded that the appellant's conduct amounted to gross negligence and required criminal sanction.*

Dame Victoria Sharp P noted that the trial judge had given a much fuller direction than had been suggested by Sir Brian Leveson P in the first appeal, but that was not surprising because she had to relate the legal direction given to the evidence called in the trial. She commended the judge's direction as a model of clarity, and held that the jury were accurately directed on the issue of causation and their approach to the core issue of "*free, voluntary and informed consent*." Further, the word 'eclipsed' had, in fact, been used when taken the jury through her written directions in the course of her summing up. It followed that the appeal against conviction on this ground had to be dismissed.

In the course of dismissing the other grounds of appeal, Dame Victoria Sharp P noted that the final report of the new expert upon which the defence wished to rely had been internally contradictory in stating that "*whilst* [Ms Parry's] *urge to take the drug at times overcame her decision not to take the drug, this decision was in my view still under her control*."

Comment

Questions of self-control arise often in the context of addiction, and are discussed (and compared to the approach taken to anorexia) in this fascinating article by Jill Craigie and Ailsa Davies. They pose deep questions as to the meaning of autonomy and its interaction with capacity. This case shows how this interaction is not merely of theoretical interest, but has real consequences – and the reality of those consequences (in this case criminal liability on the part of Mr Rebelo) mean that the courts, and indeed two juries, had to roll their sleeves up and try actually to disentangle the different elements.

Legal capacity and decision-making: the ethical implications of lack of legal capacity on the lives of people with dementia

The latest Alzheimer Europe Ethics Report is a fascinating, nuanced and significant report on legal capacity and decision-making. Its focus on the ethical implications of the issues (including the ethical implications of the 'hard-line' approach advocated by the (former) UNCPRD Committee) is very welcome. It also does not shy away from the complexities of the issues involved in the following areas: (1) guardianship; (2) treatment, care and support; (3) advanced care planning and advance directives; (4) participation in research; (5) coercive measures; and (6) civil and political life.

Book reviews

Clustered Injustice and the level green (Luke Clements, Legal Action Group, 2020, ebook/paperback, £20)

In some ways, it is ironic that this book is published by the (wonderful) Legal Action Group, because one reading of its 124 pages of densely argued and righteously furious central text is that many of LAG's most dedicated readers could be seen as part of the problem for peoples whose lives are disadvantaged. By working within a legal system that focuses on legal problems as divisible, personal issues, and by mounting judicial reviews against specific decisions, or discrimination actions against particular policies, lawyers could be seen as reinforcing the fundamental clustered injustices that the system as a whole inflicts upon individuals whose lives are disadvantaged.

Indeed, Luke Clements, the Cerebra Professor of Law & Social Justice at Leeds University and a solicitor himself, in his concluding chapter expressly makes a strong case (in the context of creating the sort of problem-solving organisational cultures he sees as necessary) for less "heavy lifting" to be done by lawyers – and more by social care professionals, at least within administrative systems that are non-managerialist. That the final substantive chapter does seek to offer solutions is welcome, as the tenor of the first 6 are so unremittingly (and groundedly) grim in their delineation of the problem that it is difficult to see any possible light at the end of the tunnel.

It is very much to LAG's credit that they should be publishing this book, which serves as so important a reminder that legal action (two of the three words within the publisher's very title) is not, and should not just be, limited to taking action **within** the law as it stands, but also taking action **about** the law. And to do that requires precisely the sort of detailed, careful, and empirical analysis of and challenge to the wider system within the law sits that this book offers.

Power of Attorney: All you need to know: granting, it, using it or relying on it (Sandra McDonald, Souvenir Press, 2021, paperback/Kindle: £10.99)

In this book, the former Public Guardian for Scotland, Sandra McDonald, brings a huge weight of expertise to bear in the lightest touch way possible upon almost all issues that might be relevant for those thinking about granting/making a power of attorney, being an attorney, or working with an attorney. Drawing, in part, upon her own experiences as attorney for her father, she seeks (as she puts it in the introduction) to empower people to make and use powers of attorney as effective instruments. In this, I would suggest she succeeds magnificently.

The book is avowedly not a legal textbook, but rather a practical guide. Nonetheless, it does a masterful job of bringing the law home – including a particularly elegant chapter 7 on (in effect) implementing the UN Convention on the Rights of Persons with Disabilities as an attorney through supporting decision-making and respecting the person's rights, will and preferences. Even if a pedant might quibble as to whether attorneys are, in fact, bound by the UNCRPD, this chapter represents a model of how the sometimes rather abstract discussions about the right to legal capacity in Article 12 CRPD can be brought down to earth in practical, grounded, and principled fashion.

One very striking – and important – feature of the book is that it is not limited to one of the three different jurisdictions within the UK, but rather seeks to cover Scotland, England & Wales and the (future) regime in Northern Ireland. This has several advantages, not least because it allows for commonalities in approach to be identified underneath differences in language (I particularly appreciated the way in which the differences between the English concept of 'best interests' and the Scottish concept of 'benefit' are dismissed as, ultimately irrelevant "as long as you place the individual at the centre of your consideration, when acting under either law.").

Seeking to cover all three regimes in one book does, however, mean that there are a few bits where this English lawyer twitched for fear that a reader in England & Wales might be led astray, and which I'll list here so that in the next edition – as I hope this book will be regularly updated given its value – they can be addressed. The first is that, sadly, there is no prospect in England & Wales that you could get legal aid to assist in making an LPA, as this is specifically excluded by the relevant legislation. The second is even if (which I have to say I find challenging as a concept) you could empower your attorney in Scotland to authorise the deprivation of your liberty, you definitely cannot in England & Wales. The third is that an attorney cannot instruct an IMCA, as is suggested might be possible as one way of resolving a dispute: only an NHS body or a local authority can instruct an IMCA – an attorney could potentially instruct (if this was within the scope of their powers) someone who was independent and was an advocate, but this would not be an IMCA. The fourth is that, whilst the book makes clear that it is giving only a very light touch discussion of advance decisions, it is important to emphasise that in England & Wales the 'sequencing' of advance decisions to refuse treatment and the making of LPAs governing medical decision-making has to be got right so as not to get into real difficulties.

Lastly, and whilst this book follows the Code of Practice to the MCA in suggesting that the test for capacity is a two stage test starting with a diagnostic element, it is clear from subsequent case-law that, at least in England and Wales, the test starts with asking whether the person is able to make their own decision. Only if they cannot does consideration progress further. An ironic feature of this book is that it reinforces why the test should be approached in this fashion (over and above the fact that the MCA provides this): if they follow the advice set down here, which does not focus on the impairment, but on the ability of the person, attorneys should find themselves more often in the zone of supporting the person to make their own decisions than stepping into their shoes.

As the book makes clear, it is not intended to be a legal textbook, and provides at the back all the resources that could be hoped for to direct those who are going to be actually making / granting and using powers of attorney in the different jurisdictions. So the points of detail noted above do not detract materially from the importance or utility of this book, nor the achievement of bringing so much wisdom home to bear in 328 pages without a single footnote!

Alex Ruck Keene

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

Irish Mental Health Act reform

A public consultation on the ongoing review of the Mental Health Act 2001 is now open (until 31 March 2021), details of which can be found here.

Australian Royal Commissions

Two Royal Commissions have reported in the past month in Australia on areas which will be of interest to readers of the Report, both for what they say (and recommend) in relation to the Australian position, and for potential wider implications for other jurisdictions:

- The Royal Commission into Victoria's Mental Health System, of particular wider interest being Volume 4: "the fundamentals for enduring reform," and the proposals in Chapter 26 for a new Mental Health and Wellbeing Act which goes beyond legislation which simply relates to compulsory treatment and assessment.
- The Royal Commission on Aged Care Quality and Safety: of particular interest more broadly may be the section in Volume 3A at 1.3.1 discussing the success (or otherwise) Charter of Aged Care Rights that has been in force since 2014, and the discussion at 1.3.2 of the proposed rights of people both seeking and receiving aged care.

Research corner

This month we highlight two articles which report upon trials which produced results perhaps opposite to those which were hoped for.

The first is an article in PLOS Medicine: Advance care planning in patients with advanced cancer: A 6-country, cluster-randomised clinical trial. The trial involved 23 hospitals across Belgium, Denmark, Italy, Netherlands, Slovenia, and United Kingdom in 2015–2018. Somewhat depressingly, the authors report that:

> *Our results show that quality of life effects were not different between patients who had ACP conversations and those who received usual care. The increased use of specialist palliative care and AD inclusion in hospital files of intervention patients is meaningful and requires further study. Our findings suggest that alternative approaches to support patient-centred end-of-life care in this population are needed.*

The second is an article in Age and Ageing, *The effectiveness and cost-effectiveness of assistive technology and telecare for independent living in dementia: a randomised controlled trial*. As the authors note, the use of assistive technology and telecare (ATT) has been promoted to manage risks associated with independent living in people with dementia but with little evidence for effectiveness. Their randomised study (in England, between 2013 and 2016, suggested that time living independently outside a care home was not significantly longer in participants who received full ATT and ATT was not cost-effective in terms of days lived in the community or securing quality of life. The researchers conclude that

> *Our data suggest that it would be premature to conclude that more extensive ATT systems to support independent home living for people with dementia are clinically important or cost-effective compared to more basic systems. This may be because basic ATT such as carbon*

> *monoxide and pendant alarms are themselves effective in preventing harms, or because more extensive ATT systems are inadequately supported by providers, or inadequately tailored to the needs of people with dementia and their caregivers.*

SCOTLAND

Scottish Parliament Elections

It is still anticipated that the elections for the 6th session of the Scottish Parliament will take place on 6th May 2021. Normally the Parliament would have been dissolved six weeks before that, on 25th March 2021. However, it is understood that on this occasion the Parliament will go into recess, rather than being dissolved, so that it can be re-convened if required for urgent purposes related to the pandemic.

As is customary, the Law Society of Scotland has issued its priorities for the elections. The overarching principle of the Society's submission is respect for the rule of law. Under "Priority areas for law reform" and addressing "incapacity, mental health and adult support and protection", the Society has written:

> *"The Scottish Parliament established Scotland as a world leader in adult incapacity, mental health, and adult support and protection law and practice with its legislation of 2000, 2003 and 2007. Excellent work is currently being undertaken on reviewing and updating these areas of law in light of human rights and other developments, including emerging needs highlighted by the pandemic such as reform of deprivation of liberty situations. We are in danger of falling behind other jurisdictions in an area in which Scotland has recently led the way.*
>
> *"We urge parties to:*
>
> - *Commit to the delivery and implementation of coordinated and updated legislation across adult incapacity, mental health, and adult support and protection law and practice in the next Session."*

Adrian D Ward

Child Trust Funds

There are tendencies in some quarters to see guardianship as the only available response where an involuntary measure is shown to be required. In fact, it is a last resort. Under section 58(1)(b) of the Adults with Incapacity (Scotland) Act 2000, a sheriff may not grant a guardianship order unless "no other means provided by or under [the 2000 Act] would be sufficient to enable the adult's interests in his property, financial affairs or personal welfare to be safeguarded or promoted". Section 1(3) of the Act casts the net beyond the scope of the Act to encompass all options: guardianship, as with any other intervention under the Act, must be "the least restrictive option in relation to the freedom of the adult, consistent with the purpose of the intervention".

In the November Report I explained my conclusion that there is a culture of institutional ageism and disability discrimination, revealed by the pandemic. There have however been many other manifestations, including the tendency of legislatures to legislate without regard to the position of people with mental or intellectual disabilities. Thus, unfortunately, provision by the UK Parliament for Child Trust Funds ("CTFs") did not appear to have addressed the question of how the funds could be accessed by young persons with impairments of relevant capabilities. In response to concerns quoted in the media, the UK Ministry of Justice announced that court fees to access the funds would be waived. That however was limited to court fees for applications to the Court of Protection in England & Wales, ignoring the need for similar access in Scotland. Enquiries as to whether the Public Guardian's fee of £91 for an Access to Funds ("ATF") application in Scotland would be waived were met initially with an assertion that ATF was not available because CTFs are not held in current accounts. However, section 26(3) of the 2000 Act applies a specialised definition of "current account" for the purpose of the ATF provisions in Part 3 of that Act. The words "current account" mean any account within the provisions of section 26(1) and 26(2), that is to say, "an account held by a fundholder in the adult's sole name". A "fundholder" is defined in section 33(2) as "a bank, building society or other similar body which holds funds on behalf of another person". Thus ATF would appear to be applicable to all CTFs provided that, where the funds are invested and the account categorised as a "stakeholder or shares-based" account, the fundholder is authorised by the terms of the arrangement establishing the CTF to realise investments, so that they can then be accessed as a fund in terms of ATF provisions.

Scottish Government have now confirmed that "with the combination of the Legal Aid system and the ATF fee waiver" there are no financial barriers to an adult being able to access CTFs.

Adrian D Ward

The meaning of "personally seen" and "personally examined"

Concerns were initially caused in Scotland, particularly to medical practitioners, by the decision in *Devon Partnership NHS Trust v Essex HC* [2021] EWHC 101 (Admin), that the phrases "personally seen" and "personally examined" in the requirements for recommendations by medical practitioners for detention of patients suffering from mental disorders, under the (England & Wales) Mental Health Act 1983, required physical presence and that guidance from NHS England that doctors might lawfully use video assessments during the pandemic was wrong (see the February Report for an account of the case as it applies to England & Wales). The case could only potentially have persuasive effect in Scotland, and even that only if relevant legislation in Scotland employs the same phrases "personally seen" or "personally examined", or perhaps some other use of "personally". In fact, such phrases do not appear in relation to any procedures under either the Adults with Incapacity (Scotland) Act 2000 or the Mental Health (Care and Treatment) (Scotland) Act 2003.

Beyond the scope of those Acts, concerns have been expressed in relation to "presence" in section 9 of the Requirements of Writing (Scotland) Act 1995. However, the requirement is not "personal presence" or "physical presence", simply "presence", and one would doubt whether two persons interacting by electronic means, seeing each other, and simultaneously applying their minds to the same subject, are not in each other's "presence" (compare, for example, phrases such as "presence of mind"). The Coronavirus (Scotland) (No 2) Act 2020, in Schedule 4, Part 7, does in paragraph 9(1) disapply any requirement "for a relevant person to be physically in the same place as another person when that person" signs or subscribes a document, takes an oath, or makes an affirmation or declaration. It would be interesting to know whether anywhere across the entire range of Scots law there is any requirement to "be physically in the same place" for any such purposes, and whether in such event there is any definition of what is "the same place": the same enclosed space, the same unenclosed space and if so of what maximum dimensions, the same building, the same town, or what?

The Minutes of the Meeting on 10th February 2021 of Scottish Government's Short Life Mental Health Legislation Commencement Consideration Group include a note that does not mention the *Devon* case but clearly refers to it. It concludes that "Scottish legislation is not affected by this ruling".

Adrian D Ward

"16 going on 17" – or going back to childhood?

"You need someone older and wiser, telling you what to do". *L* was 17 years old. In her case, the complications of being a "young person" between her 16th and 18th birthdays were not improved by rather many people in her life seeking to tell her what to do, and in dispute if not as to who was oldest, certainly as to who was wisest. Her case ended up before the First Division of the Inner House of the Court of Session, presided over by the Lord President, and is reported as *L v Principal Reporter* [2021] CSIH 4; 2021 SLT 173. Whether she will benefit – if "benefit" is the right word – from the even more elevated wisdom of the Supreme Court is not yet known.

At age 17 she was of course in matters of private law an adult. That was her status, for example, under the Age of Legal Capacity (Scotland) Act 1991 and the Adults with Incapacity (Scotland) Act 2000; and, more significantly for present purposes she was no longer a child in accordance with the definition in section 199 ("a person who is under 16 years of age") in the Children's Hearings (Scotland) Act 2011. Unfortunately, a question arose as to whether her position was governed by Regulation 9 of the Secure Accommodation (Scotland) Regulations 2013, which deals with the placement in secure accommodation of looked after "children", and whether that Regulation could apply to someone up to age 18. *L* was a "looked after" "child". Social workers had concerns for her welfare. She was placed in secure accommodation and referred to a Children's Hearing, which made an interim compulsory supervision order (ICSO), including an authorisation that she be placed in secure accommodation. She appealed against the ICSO to the sheriff, who refused her appeal. The sheriff held that the procedure under which she had been placed under the ICSO was lawful. She petitioned for Judicial Review, seeking declarator that she had been unlawfully deprived of her liberty. She sought reduction or suspension of the ICSO on the basis that referral of her to the Children's Hearing, the ICSO, and implementation of the ICSO, were all unlawful because, for the purposes of the relevant legislation, she was not a "child". The Lord Ordinary refused her application. She appealed to the Inner House.

The Opinion of the Inner House was delivered by Lord Malcolm. The court noted that section 75 of the Children (Scotland) Act 1995 enables Scottish Ministers to promulgate regulations making provision for placing in secure accommodation "looked after children" who have not been involved in the Children's Hearing system. A child in terms of section 75 is "a person under the age of 18 years", as defined in section 93(2)(b)(i) of the 1995 Act. The 1995 Act is one of the enabling provisions cited in the preamble to the 2013 Regulations. Also cited, among others, are sections 152 and 153 of the Children's Hearings (Scotland) Act 2011. There is no intrinsic definition of "child" in the 2013 Regulations.

It is well known that under section 199 of the 2011 Act "child" means a person who is under 16 years of age, but the exceptions to that definition include a person who is 16 or over in respect of whom information in terms of section 66 of the 2011 Act had been passed to the Principal Reporter before the person's 16th birthday. *L* did not fall within that exception.

The Inner House determined the matter by reference to Rule of Court 58.3(1), which provides that a Petition for Judicial Review may not be lodged if the application "could be made by appeal or review under or by virtue of any enactment". The court held that the mechanisms for challenging decisions of a Children's Hearing are as set down in the 2011 Act. Such challenges can include issues as to competency or jurisdiction. The court was not persuaded by *L*'s submission that she could not invoke those procedures because she is not a child. She had in fact already invoked those procedures in respect of a previous ICSO.

Notwithstanding that determination, the court proceeded to express a view on the legal issue raised as to whether *L* was subject to the statutory provisions under which the chief social work officer and other parties had proceeded. *L*'s central argument was that the definition of "a child" in section 199 of the 2011 Act is exhaustive and applied to the circumstances under consideration. As she was not a child, she could not be referred to the Children's Hearing. The Hearing had no power to impose compulsory measures depriving her of her liberty. It was argued that she was in no different position from someone aged 25.

The view expressed by the Inner House was that section 75 of the 1995 Act was the enabling provision. It envisaged someone such as *L* being referred to the Children's Hearing system. That did not import the definition of a child contained in section 199 of the 2011 Act. That definition "is not exhaustive for all proceedings before a Children's Hearing".

One is left to speculate about the potential effect on *L*'s circumstances of relevant provisions of Part 1 of the Adult Support and Protection (Scotland) Act 2007. It is clear from section 53(1) of that Act that in Part 1 childhood ends at the age of 16, beyond which – without any exceptions – a person is an "adult" for the purposes of Part 1. The "general principle" in section 1 of the 2007 Act is of similar effect to the "benefit" principle in sections 1(2) and (3) of the 2000 Act. A person may intervene, or authorise an intervention only if satisfied that the intervention "will provide benefit to the adult which could not reasonably be provided without intervening in the adult's affairs" and "is, of the range of options likely to fulfil the object of the intervention, the least restrictive to the adult's freedom". Section 4 of the 2007 Act brings within the scope of the provisions of Part 1 a situation where a Council believes that a person is an adult at risk and that it might need to intervene by performing functions under Part 1 "or otherwise". It is not possible to ascertain from the report of *L*'s case whether relevant principles of the 2007 Act were applied, and in particular what options were considered in order to comply with section 1.

Adrian D Ward

Two more children's cases with implications for adults

The whole ethos of the Adults with Incapacity (Scotland) Act 2000 is predicated upon the explanation by Scottish Law Commission in paragraph 2.50 in its "Incapable Adults" Report of 1995 that adults with impairments of their capabilities are not children. However, the greater volume of reporting of children's cases, compared with reported decisions under the 2000 Act, does mean that from time to time points of principle in a children's case can reasonably be "read across" to adult law requirements, as we did with the case of "The girl who did not want to return to Poland" in the February Report. We briefly note two further such cases here.

M v C [2021] CSIH 14 contained criticism by the Inner House of a sheriff at first instance for not adequately addressing the requirements to seek the views of the child at the centre of that case. In allowing an appeal against the sheriff's decision, the Inner House relied substantially on the Convention on the Rights of the Child ("CRC"). The decision would certainly be of potential relevance to the requirement under section 1(4)(b) of the 2000 Act to take account of the present and past wishes of an adult. It might also be a pointer towards the extent to which the courts would be prepared to take guidance from the UN Convention on the Rights of Persons with Disabilities ("CRPD"). Legislation to incorporate CRC in Scots law is proceeding through the Parliament. The National Task Force for Human Rights Leadership has now established a Reference Group to consider similar incorporation of CRPD. CRPD is perhaps less easily to be converted into statute than CRC, as it contains principles which require to be balanced: in several cases, blinkered adherence to one principle would violate another. Nevertheless, it is the business of the courts to balance the application of relevant principles to particular factual circumstances, and it would be unsurprising if we were to see increasing reference by the judiciary to CRPD.

The other potentially relevant case is *MB v Principal Reporter* [2021] CSOH 19. A pandemic-related series of four successive Interim Compulsory Supervision Orders by a Children's Hearing was held by the Court of Session to amount to a failure to act compatibly with the procedural aspects of Article 8 (the right to private and family life) of the European Convention on Human Rights.

Adrian D Ward

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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

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

Alex is also doing a regular series of 'shedinars,' including capacity fundamentals and 'in conversation with' those who can bring light to bear upon capacity in practice. They can be found on his website.

Adrian is speaking at a webinar organised by RFPG on 25 May at 17:30 on Adults with Incapacity. For details, and to book, see here.

Advertising conferences and training events

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

Our next edition will be out in April. 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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