Essex CHAMBERS

MENTAL CAPACITY REPORT: COMPENDIUM

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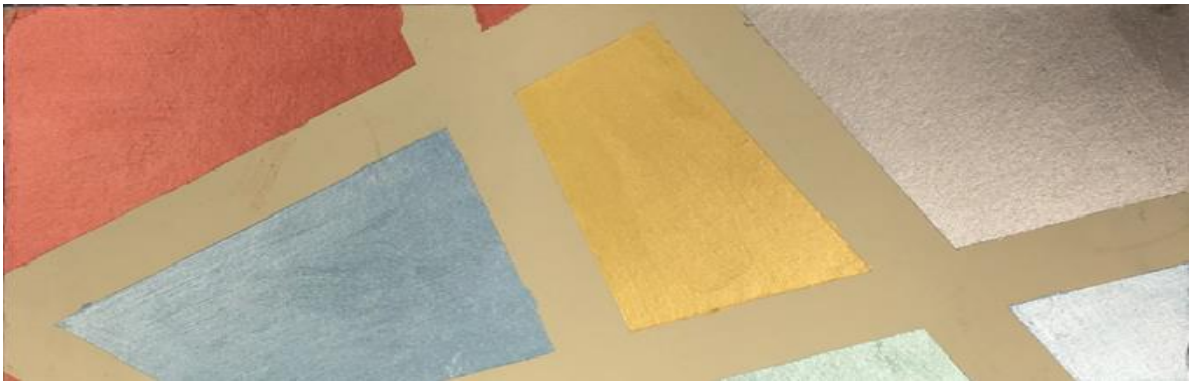

Welcome to the November 2019 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: two deprivation of liberty cases making clear what should (and should not) happen before the court; two important cases about reproductive rights and capacity, and capacity under stress in different contexts;

(2) In the Property and Affairs Report: welcome clarity as to how to make foreign powers of representation effective; and capacity and the financial implications of marriage;

(3) In the Practice and Procedure Report: two important judgments from the Vice-President highlighting different aspects of case management and confirmation as to the procedural rules governing inherent jurisdiction applications in relation to adults;

(4) In the Wider Context Report: news from the National Mental Capacity Forum (and a survey they need completing); an important case about the intersection of capacity, the inherent jurisdiction and the Mental Health Act 1983 in the context of force-feeding; and when you can rely upon your own incapacity to your benefit.

(5) In the Scotland Report: four important publications from the Mental Welfare Commission.

You can find all our past issues, our case summaries, and more on our dedicated sub-site here. If you want more information on the Convention on the Rights of Persons with Disabilities, which we frequently refer to in this Report, we suggest you go to the Small Places website run by Lucy Series of Cardiff University, where you can also find clear guidance as to the (non) place of mental capacity in relation to voting, ahead of the deadline for registration in the General Election of 26 November.

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

Contents

HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

Deprivation of liberty and proper scrutiny

DL v LB Enfield [2019] EWCOP B1 (Senior Judge Hilder)

Article 5 ECHR – DoLS authorisations

In this case, a local authority respondent sought to challenge the jurisdiction of the Court of Protection in relation to s.21A applications, "*to challenge what might colloquially be called 'a gravy train'. Mr Holbrook* [Counsel for the local authority] *said today, 'I am challenging the accepted wisdom of what goes on in the Court of Protection.'*" It appears that the local authority sought, in essence, to limit the circumstances under which an application could be brought and the case management directions that the Court of Protection should make before determining it. The argument was based upon a partial selection of passages from the judgment of King LJ in *Director of Legal Aid Casework & Ors v Briggs* [2017] EWCA Civ 1169 (concerning the scope of legal aid in s.21A proceedings).

Senior Judge Hilder rejected the arguments advanced by the local authority, and observed that:

> *39. However large the numbers of a local authority caseload of persons being provided with care in the circumstances of their liberty being deprived it is imperative that those responsible for such conditions are never allowed to become cavalier about the significance of deprivation of liberty to the individual concerned and to society as a whole. In my judgment Article 5 rights do not become less precious because of the administrative burden of cases reliant on them.*
>
> *40. Mr McKendrick QC has reminded the court of the generous ambit of Article 5.4 which entitles a person to speedy consideration by a court and in particular has referred to the case of Waite v the United Kingdom ECHR 2002. Article 5.4 is first and foremost a guarantee of a fair procedure for reviewing the lawfulness of detention. An applicant is not required as a precondition to enjoying that protection to show that on the facts of his case he stands any particular chance of success in obtaining his release. When I put that to Mr Holbrook he also, and I quote, "entirely endorsed this" proposition.*
> *41. Closer to home, the Court of Protection's own Vice-President has recently had cause to restate this approach in the case of CB v Medway Council [2019] EWCOP 5 at paragraph 33. He said:*
>
> > *"What is involved here is nothing less than CB's liberty. Curtailing, restricting or depriving any adult of such a fundamental freedom will always require cogent evidence and proper enquiry.*

> *I cannot envisage any circumstances where it would be right to determine such issues on the basis of speculation and general experience in other cases."*

> *42. So, bearing in mind that these proceedings are brought pursuant to section 21A and that it is very clear from the paperwork that the qualifying requirements being scrutinised may include capacity and definitely include best interests, I have no doubt that it is appropriate for the court to go on to consider now* […] *what are the appropriate case management decisions to progress this matter.*

Perhaps not very surprisingly in light of this, Senior Judge Hilder departed from the general rule in welfare cases, to order that all the costs incurred by the applicant detained person should be paid by the local authority to reflect that they had been incurred because the local authority had failed to take a "*sensible and appropriate approach to these proceedings*."

Comment

It is clearly important that cases before the Court of Protection are managed proportionately, but the approach taken by the local authority in this case was – to put it mildly – striking. It is welcome that Senior Judge Hilder took the opportunity to make clear that it was simply wrong to seek to prevent proper consideration of the question of whether the standard authorisation in DL's case should be upheld.

As a secondary – but important – point, it should be noted that Senior Judge Hilder had cause to consider the proper use of s.49 reports. As she noted (at paragraph 44), they are:

> *a vital tool in the armoury of the Court of Protection but the court is also aware that the very usefulness of that tool comes as a burden to other public services, in this case the NHS. Practice Direction 14E sets out the circumstances to consider when the court is being invited to make a section 49 order and I emphasise that it is important that the court and the parties follows those requirements.*

How not to make an application to authorise deprivation of liberty

LB Barnet v JDO & Ors [2019] EWCOP 47 (Senior Judge Hilder)

Article 5 ECHR – Deprivation of Liberty

Summary

This frankly astonishing case reads as an object lesson in how **not** to make an application to the Court of Protection to authorise deprivation of liberty.

It concerns a young man, JDO, with diagnoses of cerebral palsy, autism, learning disability and epilepsy. He had been living at supported living placement in arrangements amounting to deprivation of liberty. There were ongoing civil proceedings claiming damages for JDO on the basis of clinical negligence. The Official Solicitor acted as JDO's litigation friend in those proceedings. In June 2017, a

Re X order was made under the streamlined procedure, authorising the deprivation of his liberty at the placement, and requiring the London Borough of Barnet to make an application to the court 'no less than one month before the expiry of the review period', in accordance with any Rules or Practice Directions then in effect. The local authority did not make an application (on a COPDOL 11 form) until November 2018, some six months late.

The COPDOL 11 form has a box on the first page which tells the applicant to "Give any factors that ought to be brought specially to the court's attention (the applicant being under a specific duty to make full and frank disclosure to the court of all facts and matters that might have an impact upon the court's decision)." The local authority wrote 15 lines of text, including the following:

> *"The Local Authority is aware that [JDO] has separate clinical negligence proceedings in which the Official Solicitor is instructed. The Official Solicitor, who is not instructed in relation to [JDO's] care and placement, has shared its view that, going forward, renting a flat with a private package of care might work for [JDO] with a view of a flat purchase in the future. No firm proposal has been seen and in any event none of the parties consider that this is in [JDO's] best interests at the present time (certainly for the duration of this order) and all parties consider that the current supported living and care package remain in [JDO's] best interests."*

The application was supported by a statement apparently by his mother, OD, "*typed and couched in formal language*," including the following provisions:

> *"4. I have been advised about and I am in agreement with the London Borough of Barnet making an application to the Court of Protection to authorise the deprivation of liberty in the supported housing for my son. This includes the fact that there is no less restrictive option for my son other than to continue to reside in his current accommodation….and the restrictions in place are a proportionate response to the significant risks and harms he would be subject to if he were anywhere less restrictive….*
>
> *9. I can confirm that I do not consider there is a need for an oral hearing as I am in full agreement of the proposed arrangements under the Deprivation of Liberty Safeguards for my son [JDO]."*

In January 2019, the court received a handwritten letter from JDO's parents raising concerns about the care being provided to him. On 1 February 2019, solicitors instructed by the Official Solicitor rang the court to ask whether it had received an application from the Local Authority in respect of JDO, whether a hearing had been listed, and whether letters from the Official Solicitor had been put before the court. The call was followed up by a letter from the solicitors. Two weeks later, the court received a COP9 application from the local authority asking for further time to submit the requested statement and that the court "*consider the local authority's view that an independent person be appointed as litigation friend in this case*" because "*The local authority is concerned about the Official Solicitor having a potential conflict between* [JDO's] best *interests in the clinical negligence claim and taking a view on the level and type of care and support that he currently requires*." The matter then left the streamlined procedure, and was listed for a case management conference, the Official Solicitor being invited to act as litigation friend. The local authority made a further

application for an independent person to be appointed as JDO's litigation friend, rather than the Official Solicitor, again citing the potential conflict of interest that it asserted that arose from the fact that "*already acts as litigation friend for JDO in his clinical negligence claim and the level and cost of care and support JDO receives is of direct consequence to the amount of award JDO would receive in his clinical negligence case*."

That application was dismissed, and matters finally reached a hearing before Senior Judge Hilder. Before Senior Judge Hilder, the local authority set out three propositions:

(1) That the streamlined procedure set out in PD11A only required persons with *immediate* concern about P fall within the categories of persons to be consulted, and from those categories it was up to the applicant to choose whom it wishes to consult;

(2) That the duty of full and frank disclosure was a limited one, not requiring "*the Applicant to disclose different opinions when those opinions are not, in the Applicant's view, based on fact. The Applicant only has to highlight paragraph 33(b)* [suggesting that the arrangements in relation to which authorisation is sought may not in fact be in the best interests of the person the application is about, or the least restrictive option] *if it considers the DOL is not 'in fact' in P's best interests.*"

(3) The consultation requirement in PD11A was limited to the persons who offer an alternative to the Applicant's proposal.

The local authority accepted that: "*a lot of the initial confusion in this application could have been avoided" if letters from the Official Solicitor had been annexed to the application*;" and that the Applicant "*was distracted by considering whether or not the Official Solicitor, as litigation friend to P in other proceedings, had the status of a party for the Re X application*." The local authority argued that there was no reason to state in the application paperwork that its proposed placement may not in fact be in JDO's best interests "*because there were no other available options at the time of the application to call that into question*" and "[t]*here was no prospect that in the period of the DOL authorisation sought in the application, up to November 2019, that there was any other available option for JDO…*"; and that the Official Solicitor was not listed as a person to be consulted because "*it did not appear to the Council that the Official Solicitor was interested in JDO's current welfare*."

Senior Judge Hilder, it was fair to say, was not overly impressed with either the arguments as to the construction of PD11A or the explanations given by the local authority as to its approach. As she noted:

> *44. The streamlined procedure was conceived and implemented with full acknowledgment of its dependence on the conduct of the party who makes the application – as demonstrated by the express inclusion of the duty of full and frank disclosure in the Practice Direction. This duty is foundational to ensuring the 'reliability and completeness' of information put before the court, and therefore foundational to compliance with Article 5. It must be understood as such by any person or public body who avails themselves of this procedure.*

> *45. The duty of full and frank disclosure is a serious and onerous obligation that applies to litigants and their legal advisers alike. As far as I am aware, this duty has not previously been the subject of judicial scrutiny in the context of deprivation of liberty authorisations but in other contexts the applicable principles are well settled.*

Having set out the principles in an extract from *Fundo Soberano de Angola & Ors v. Jose Filomen dos Santos & Ors* [2018] EWHC 2199 (Comm), she continued:

> *Paragraph 33 of PD11A reflects these principles in simpler terms. In particular:*
>
> *it specifies that the duty extends to "all facts and matters that may have an impact on the court's decision whether to authorise the deprivation of liberty";*
> *it directs the applicant to "scrutinise the circumstances of the case" and "clearly identify" factors needing particular judicial scrutiny or suggestive that proposed arrangements may not be in P's best interests or the least restrictive option or otherwise indicative that the order should not be made; and*
> *it specifically includes a requirement to explain why persons of a relevant category have not been consulted.*

Senior Judge Hilder found nothing in *N v ACCG* that justified the submission that the requirement for full disclosure is limited to circumstances where there are "*other actual competing alternatives available*." "*If anything*," she noted:

> *the recognition of the "creative" possibility of proceedings (also at paragraph 35 of the judgment) goes against it. In my view, cases which considered authorisations of deprivation of liberty (albeit not by the streamlined procedure) offer more insight into the approach to be adopted to the duty of full and frank disclosure:*
>
> *a. in Re Briggs (Incapacitated Person) [2017] EWCA Civ 1169 at paragraphs 94 – 95 King LJ was clear that*
>
> > *"… Proper consideration of those cases by the assessor in compliance with the guidance in the DOLS Code, requires far more of an extensive consideration of the relevant circumstances than that which is suggested by Mr Nicholls, namely simply ensuring a care plan and needs assessment is in place without further consideration as to the content.*
> >
> > *95. Contact, for example, is an issue capable of going to the heart of whether being detained is in a person's best interests; it may be that in an ideal world P's best interests would be served by a deprivation of liberty in the form of her living in a care home properly looked after, where the appropriate medication regime will be adhered to and P will have a proper balanced diet. Desirable as that may be, and such a regime may well provide the optimum care outcome for P, but it may also be the case that unless, regular contact can be facilitated to a particular family member, the distress and confusion caused to P would be such that it would be no longer in her best interests to be detained, and that what might amount to sub optimum physical care would ultimately be preferable to no, or insufficient contact…."*

b. in CB v. Medway Council [2019] EWCOP 5 at paragraph 33, Hayden J Vice-President of the Court of Protection emphasised that

> *"what is involved here is nothing less than CB's liberty. Curtailing, restricting or depriving any adult of such a fundamental freedom will always require cogent evidence and* ***proper enquiry.*** *" (emphasis added)*

As to the local authority's arguments upon the law:

> *48. Dealing with the legal submissions first, in my judgment the Applicant's scope of consultation argument is misconceived. Paragraph 39(d) of PD11A is expressed in ordinary plain language and should be understood accordingly. The description of "anyone engaged in caring for the person" is plainly not limited to primary carers but is wide enough to include those who give care only for part of P's living arrangements, including care during contact periods; and the description of anyone "interested in his or her welfare" does not import any limitation only to concerns about "P's immediate welfare or near-future welfare." I agree with Mr. Hallin that Mr. Paget's suggestion otherwise artificially denies the obvious link between P's long-term and immediate interests. Moreover there is nothing in paragraph 39 which limits the consultation to three people – "if possible, at least three" people in categories (c) and (d) should be consulted. It would clearly not meet either the letter or the spirit of paragraph 39 for the Applicant to "decide" whom to consult in such a way as to "bypass" those most obviously within the required categories. Mr Paget's exposition of "apparent tensions" in paragraph 39(d) and how its requirements can be met in practice is, in my judgment, a strangulation of the plain language of the Practice Direction.*
>
> *49. I further agree with Mr. Hallin that the Applicant's subjective view argument is a fundamental misunderstanding of the duty of full and frank disclosure. If it were to be up to the Applicant to determine whether a view which differs from its own is valid and therefore to be brought to the attention of the court or not, the duty of disclosure would be neither full nor frank. As set out in paragraph 46(2) above, it is a well-established principle of a duty of full and frank disclosure that the materiality of relevant information is to be determined by the court. If a person sensibly within the categories of person who ought to be consulted holds a view which is contrary to the Applicant's, the Applicant must make that clear in the application, irrespective of its own view of the merits of that other view. In the context of a procedure designed for non-contentious applications, such factors clearly include indications that the proposal is in fact disputed, irrespective of the applicant's view of the merits of that dispute. If explanation is needed as to why this is so, the Court of Appeal has set it out: the validity of the streamlined procedure as a mechanism for compliance with the obligations of Article 5 depends upon it.*
>
> *50. The Applicant's alternatives-only argument overstates the ordinary meaning of the Practice Direction and the import of N. v ACCG . The suggestion of a literal meaning which requires consultation with "anyone, except the most insensitive person, who has met P" is an unattractive resort to reductio ad absurdum which fails to give credit to the professionalism, experience and judgment which may reasonably be expected of social workers and best interest assessors. If the duty of disclosure extended only to concerns where alternative options were already identified, inactivity on the part of person under the duty would be rewarded and opportunity for proper enquiry*

> *denied. There is no threshold for bringing a challenge to a deprivation of liberty and any applicant for authorisation under the streamlined procedure must proactively inform the court of contrary views.*

When it came to the facts of the case before her, Senior Judge Hilder was scathing as to the conduct of the local authority, finding (inter alia) that the placement, at the time of filing the COPDOL could not reasonably have been considered by the local authority to be non-contentious, that it was in breach of its duty of its full and frank disclosure in relation to the Official Solicitor's position because:

> *in fact the Applicant did recognise that the Official Solicitor was an appropriate person to consult about the application in this case – as demonstrated by the fact that the Applicant did actually consult her (paragraph 3(g) of* [the social worker]*'s statement). However, having received a response which was not to the Applicant's liking, the Applicant then failed to put the result of the consultation before the court fully or indeed at all. Such as was included in the COPDOL11 form reflects the Applicant's position, not the Official Solicitor's. Thereafter, the Applicant went to extraordinary lengths to seek to avoid the Official Solicitor's participation in proceedings, including apparently choosing an alternative solicitor for JDO.*

Senior Judge Hilder also emphasised that:

> *it is not appropriate for the body with consultation obligations to "present" OD (or any person in her position in the proceedings) with a pre-prepared statement. The purpose of consulting with OD is to ascertain her views, so that they can be relayed to the court. It is not to put words into her mouth, or to persuade her to adopt the Applicant's views. The contrast between the statement ostensibly made by OD and the letter written by DD is stark. There is significant distance between assisting a lay person to write their statement, and presenting them with a pre-prepared document for signing. The latter approach is highly unlikely to elicit genuine views. In this matter it amounts to a breach of the duty of full and frank disclosure.*

Importantly, Senior Judge Hilder highlighted that:

> *the period spent working out whether the application had appropriately been made represents a delay in the progress towards final judicial determination. I have no doubt that had the application in November 2018 been made on form COP1 as a disputed welfare issue, it would have been put before the Urgent Business Judge (as is usual procedure at the central registry) and would have been listed for Case Management Conference within something like 28 days of issue. Instead, its first listed hearing was not until 21 st March 2019. The very real consequence of the Applicant's approach was delay and a longer period of unauthorised deprivation of JDO's liberty.*

Senior Judge Hilder will consider any applications arising out of her conclusions, and it is not difficult to anticipate what those will be.

Comment

Senior Judge Hilder noted that the fact that the serious deficiencies in the local authority's application had been identified was "*some testament to the robustness of the streamlined procedure itself*." However,

the fact remains that the approach taken by the local authority was extremely troubling – and one anticipates that the court may of its own motion be examining some of the other "*50 assessments*" which the social worker in question said in her witness statement had "*passed through the court of protection without any issues*." If any silver lining is to be found in this otherwise very grim cloud, it is that any shred of doubt as to the nature of both (1) the consultation requirement under COPDOL11; and (2) the duty of full and frank disclosure has been comprehensively dispelled.

Practical guidance on how to make COPDOL11 applications can be found here, and how to comply with the duty of full and frank disclosure here.

Best interests and contraception

An NHS Foundation Trust v AB and [2019] EWCOP 45 (MacDonald J)

Best interests – contraception

Summary

This is the latest chapter in the long running case of AB, first heard before Lieven J on whether or not a termination was in AB's best interests (see *Re An NHS Trust v AB* [2019] EWCOP 26). The first instance decision was then overturned by the Court of Appeal (see *Re AB (Termination of Pregnancy)* [2019] EWCA Civ 1215).

The question for the court at this hearing was whether it was in AB's best interests to be fitted with an intrauterine contraceptive device (IUD) at the same time as she underwent a caesarean section under spinal anesthetic.

At the start of the hearing both the local authority and the Official Solicitor opposed the application. By the end of the hearing neither actively opposed the application but nor did they consent to it. CD, AB's adoptive mother, remained opposed.

AB is a 25 year old woman who has been diagnosed with moderate learning disabilities and who is 38 weeks pregnant. She was the adopted daughter of CD, a midwife and native of Nigeria. AB came to the United Kingdom when she was 13 years old, having previously been raised by relatives in Nigeria. AB speaks both English and Igbo. AB had been assessed as lacking capacity to consent to sexual intercourse.

The local authority had not been able to ascertain the circumstances in which AB had become pregnant, but the dates of her pregnancy suggested that it had happened while she was on a trip to Nigeria.

It was agreed by all parties that AB currently lacked the capacity to consent to and/or use contraception.

The local authority and the Official Solicitor's position was that (i) AB could gain capacity with appropriate education and (ii) the risk of AB getting pregnant in the future was virtually nil because the local authority now had in place a complete, comprehensive and effective support plan[1] to safeguard AB from the risk of unplanned pregnancy. This plan, it was argued negated the need for contraception and would allow for a further period of work to be done with AB to increase her ability to participate in decisions concerning contraception.

The court was particularly concerned about what it termed "the purported safeguarding plan" because it had been formulated in a situation of continuing uncertainty as to the care plan for the new born child. The most that could be said by the local authority in evidence was that the learning disability team were *hoping* that CD would be the carer for AB's daughter and AB following the birth.

The following factors weighed heavily with the court:

- It remained unclear how AB had got pregnant in the first place.
- It was likely that she was at the time in the care of one of her three female relations who the local authority were proposing as the primary supervisors who would safeguard AB from risk of further unplanned pregnancy.
- There was evidence from a number of sources that suggested that AB had been involved in other sexual activity and may have been the victim of sexual abuse or sexual exploitation.
- The supervision plan contained no information at all regarding how the risk of unplanned pregnancy would be managed for AB if and when she returns to visit Nigeria.
- Neither the local authority nor the police had completed their investigations into the circumstances of AB's pregnancy and so the local authority was unable to state definitively the precise nature and extent of the risk to AB of further unplanned pregnancies.

MacDonald J rejected the local authority and Official Solicitor's submission that the risk of AB becoming pregnant in the future as being virtually nil and held that '*it is plain that in the short term there is an appreciable risk that AB will be sexually active or exposed to sexual activity whilst she remains in the United Kingdom, or indeed if and when she visits her family in Nigeria. Further, as a young women, the chances of AB conceiving are high and, accordingly, the risk of AB being sexually active or exposed to sexual activity translates to a concomitant appreciable continuing risk of unplanned pregnancy. In the medium to longer term, given AB's age this appreciable level of risk will continue for at least a further ten years, during which time I am satisfied that it is likely that AB will return to Nigeria to visit her family*.'

On the issue of AB's capacity to make decisions about contraception the Judge accepted the evidence from the Trust that it was extremely unlikely that AB would ever gain capacity, particularly as she had

[1] The plan was that AB would never be left at home alone, would never be left unsupervised with a male, would be accompanied in the community and would be with CD, a trusted family member or support worker at all times.

already had 15 educational sessions on mode of delivery of her baby and made no progress towards capacity at all.

The judge also accepted the evidence from the Trust that the most appropriate method of contraception for AB was an IUD, and that to insert it at the same time as the cesarean was performed would mean that it could be inserted painlessly with minimum risk of infection and minimum risk of perforation of the uterus. By contrast the insertion of an IUD at a later date would be extremely painful for AB.

With respect to best interests the court concluded that it was not possible to ascertain AB's wishes on the issue of contraception and no cogent direct evidence of AB's beliefs and values regarding the use of contraception.

It is worth setting out in full what the Judge said about best interests (at paragraph 42):

> *In the assessment of best interests, the question of risk must be weighed, including the risk of future pregnancy and the risks to mental and physical health associated with pregnancy, childbirth and/or the removal of the child. For the reasons set out above, I am satisfied that there is an appreciable risk that AB will have a further unplanned pregnancy unless steps are taken to prevent this. The history of litigation in this matter demonstrates eloquently the devastating impact that a failure to protect AB from the appreciable risk of further unplanned pregnancy that I am satisfied subsists in respect of AB. Further, I have given weight to the opinion of Dr N, endorsed by Professor X, that in light the features of a mood disorder displayed by AB, she is at greater risk of mental health difficulties, including puerperal psychosis following the delivery of a child. There is no reason to believe that this risk would cease to pertain in respect of a further unplanned pregnancy. Finally, I have born in mind the careful evidence of Ms T regarding the upset and distress that AB has experienced as the "dry run" for the upcoming caesarean section has been completed.*

The judge therefore concluded that it was in AB's best interests to have an IUD fitted and the least restrictive and proportionate method of doing this was to do it after her cesarean section when it would cause her no pain and would negate the need for a further separate, distressing procedure to be undertaken.

On the issue of Article 8 ECHR, MacDonald J said this (at paragraph 47):

> *Finally, in circumstances where the insertion of an IUD will prevent AB from having children and making a significant choice regarding her own body, AB's Art 8 rights are engaged. As I have noted above, proper consideration of P's Art 8 rights is achieved through the best interests appraisal under s 4 of the Mental Capacity Act 2005. Within this context, I have had regard to the fact that, whilst it is the case that for the duration of its insertion the IUD will prevent AB from conceiving, the evidence before the IUD can be removed at any time should AB's position change in terms of capacity to consent to sexual relations. Having regard to the risks I have identified, and to the consequences for AB of those risks becoming manifest, I am satisfied that the interference in AB's Art 8 rights*

constituted by the court decision to authorise the insertion of an IUD as being in AB's best interests is one that is necessary and proportionate for the purposes of Art 8(2).

Comment

This careful and clear judgment emphasizes the importance of public bodies considering the issue of future contraception while P is still pregnant so as to be able to protect P from future pregnancies if this is in P's best interests, in the least restrictive and proportionate way. Anecdotally this does not often happen because while local authorities are responsible for putting in place a care plan that guards against the risk of P having sex if she lacks capacity to consent to it, they do not consider themselves the decision maker on decisions about contraception. This is considered to be the GP's domain.

Sex (revisited)

A Local Authority v H [2019] EWCOP 51 (Sir Mark Hedley)

Mental capacity – contact – sex

Summary

This is the latest judgment concerning the life of H, for whom protective orders were previously made when she was 29 years old: *A LA v H* [2012] EWHC 49. Seven years later, H had moved from a care home to a supported living arrangement which the court had been authorising. She had made considerable progress. She lived in her own flat inside a large house subdivided into flats, one of which was given aside to care and support staff, one of whom slept there at night. She was able, effectively, to organise her own life within that flat. She worked two days a week and was able to go out from time to time, but the reality was that there were still significant restrictions on her liberty engaging Article 5 ECHR.

Sir Mark Hedley was asked to reconsider the previous declarations of incapacity in light of H's progress. The court agreed with the parties following an expert's reassessment that H had capacity to engage in sexual relationships and to deal with issues of contraception, but lacked capacity as to residence, care and contact. Accordingly, his Lordship observed, "*the court has no jurisdiction whatever to determine matters relating to consenting to sexual relations or contraception because H has capacity and she is entitled, as any citizen of this country is entitled, to make her own decisions for good or ill in relation to those matters*" (para 17).

H met the judge in his chambers, accompanied by a care assistant, and her counsel and solicitor. She was keen for the restrictions to be withdrawn in due course but wanted "*to take it slow*", and appreciated the security and support from her accommodation and care arrangements. In particular, she wanted to be able to choose with whom she had relationships and who became guests to her property. The judge focused therefore on the contact arrangements and made five general observations.

1. The court was being asked to grant to the local authority coercive powers: "*granting certain coercive powers in respect of some incapacity may well involve those powers trespassing into areas in which the person does have capacity. This case will be a classic illustration of that. It is very difficult to devise powers in relation to those with whom H is to have contact that do not intrude on her ability to practice the freedom of consenting to sexual relations*" (paras 25-26). She should have the maximum freedom that consenting to sexual relations is intended to bestow but, at the same time, the court was obliged to remember its protective role (para 28).

2. Any restrictions must be necessary and proportionate "*because they involve significant inroads into the Article 8 rights of H and, therefore, put her in a less favourable position than other people in the community would be in*" (para 30).

3. The court should confine its focus to those areas where compulsory powers are needed: "[a]*lthough of course the court must approve the whole of the care plan, it is not the function of a Judge to tell the social worker how to do their job nor is it usually remotely helpful if they try to do so*" (para 31).

4. Any coercive powers should always be framed within the limitations of the area where P lacks capacity. So, in this case, "*the coercive powers must not make any mention of the question of how sexual relations or anything else are exercised. They are simply not the court's business. The court's business is simply to deal with best interests arising out of the fact that H lacks capacity to decide with whom she should come into contact*" (para 32).

5. The intention of the MCA is not to dress P in forensic cotton wool but to allow them as far as possible to make the same mistakes that others are at liberty to make. So "[i]*t is not the function of the court, it is not the function of the local authority to ensure that H lives a moral life. That is her business. It is only the function of the court and the local authority to regulate who it is she comes into contact with*" (para 33).

It followed from the course of action endorsed by Sir Mark Hedley the local authority has the power to maintain or monitor the list of welcomed visitors to H's flat. They may provide for those times when a visitor should be in and out of the flat, but "*once that visitor lawfully enters the flat and the front door is shut, the local authority have no further responsibilities for what then takes place. Those are matters entirely for H and the person who is in the flat with her*" (para 34), unless of course H demonstrated distress. As for contact outside the flat:

> *Again, it is important to say that the local authority may decide whether that is a person with whom H should have contact and they may decide where it is appropriate for H to have contact with such a person. What they may not decide is how H then behaves once that contact is authorised. That is for her and it is for her to make her own decisions for good or ill as to how she then conducts herself*." (para 37)

Comment

This is a useful, practical illustration how of things might work on the ground when carers and public bodies are faced with a situation where someone has capacity to consent to sex but lacks capacity to make decisions in relation to contact. The court rightly calls a spade a spade in terms of coercive powers. After all, the law provides a defence to legal liability when acting in a person's best interests. His Lordship stated: "[t]*here is a great tendency in social work terms to hide coercion behind the façade of encouragement and, whilst that is no doubt very sensible in terms of talking to clients, in terms of the actual powers that the local authority have, coercive powers should be specified as such and identified as such and authorised as such"* (para 39).

There was an issue as to whether the measures that cut across areas of capacity ought to be considered under the inherent jurisdiction (para 29). But it seems the decisions in this case were taken very much in the Court of Protection. That seems sensible as incapacitated best interests arrangements often cut across areas where the person has capacity. Having the capacity to manage day to day finances but lacking capacity as to contact with others is but one example. In this case, the judge was open as to whether the case should continue before a District Judge or otherwise (para 41).

Capacity, the inherent jurisdiction and self-neglect

London Borough of Croydon v CD [2019] EWHC 2943 (Fam) (Cobb J)

CoP jurisdiction and powers – interface with inherent jurisdiction – mental capacity – care

Summary

The local authority brought a case before the court seeking orders to enable them to provide care to CD for his own protection. CD was not present at the hearing and nor was he represented, but the Official Solicitor accepted the invitation to act as Advocate to the Court.

Cobb J set out the dire situation in which CD was in, finding unsurprisingly that it was quite proper for the matter to be brought before the court:

> *CD is diabetic and also epileptic and has poor mobility, incontinent of urine and faeces and unable to maintain his home environment. CD's condition is further complicated by excess alcohol use and he is mostly inebriated at home. This has led to frequent incidents of falling in his flat, non-concordant with medication, severe self neglect, inability to manage his personal care, activities of daily living, his health and wellbeing. Recently his home environment deteriorated to a stage that a care agency commissioned via Croydon Council were unable to access the flat to support him with his care needs for fear of cross contamination and infection. Due to this lack of support occasioned by his poor and unhealthy home environment, CD frequently called the London Ambulance and Police… he attended the Accident and Emergency [department] of the Princess Royal Hospital in Bromley and Croydon University Hospital in Croydon regularly. CD lives alone and he has limited positive support network, he socialises with friends in the same block of flats who equally have alcohol misuse problems.*

> *CD is unable to safely complete most activities of daily living without help and support from his carer. Due to his restricted mobility he is unable to manage his living environment and his personal care or complete most activities of daily living. His flat has been 'blitz cleaned' on many occasions and support care package commissioned but this has failed on all occasions. All professionals working with CD are of the view that community care has failed and te housing department is not able to meet his needs.*

By the time the matter came before the Court CD's flat was soiled with human waste, putting him and anyone who accesses his flat at high risk of infectious diseases. He was continuing to drink alcohol and soil himself. His entire house from the hallway, lounge, bedroom and kitchen, including all his furniture, had faecal and urinal stains making it odorous and uninhabitable to live and preventing carers from going to his flat to provide the personal care CD required.

Cobb J found that CD was disinclined to change his ways and was not willing to be moved to a safe environment where he could be supported with his personal care.

The applicant local authority commended a twenty point care plan to the court which allowed its staff to gain access to CD's accommodation in order, first of all to provide appropriate care for CD himself and secondly to make his accommodation safe for human habitation.

The Official Solicitor, acting as Advocate to the Court, accepted that this plan appropriately met the needs of the case.

There was disagreement however as to the jurisdictional basis upon which the Court was being invited to impose care on CD against his will as being in his best interests. The local authority sought orders pursuant to the court's inherent jurisdiction, while the Official Solicitor submitted that the court should take the safer jurisdictional route of the MCA by making the orders pursuant to s.48 MCA 2005.

Cobb J held that CD was both a vulnerable adult within the meaning of *Re: SA* [2005] EWHC 2942 and therefore amenable to the inherent jurisdiction, and also someone whom there was reason to believe lacked capacity to make decisions about this care. Cobb J therefore made the order pursuant to the MCA 2005 (on the basis that where there is a statutory route it is more appropriate to use it it), while recording in the order the finding that CD was a vulnerable individual so the inherent jurisdiction route was an alternative available to the local authority on the particular facts of this case.

Cobb J sounded a note of caution in relation to the question of deprivation of liberty. Whilst he identified that Munby J had, in *Re PS* [2007] EWHC 623 held that the court had the power under the inherent jurisdiction to direct that an adult could be placed at a specified place and deprive them of their liberty there, he noted that: "[t]*his was, importantly qualified by what he goes onto say at [23] namely that (i) the detention must be authorised by the court on application made by the local authority and before the detention commences and (ii) subject to the exigencies of urgency or emergency the evidence must establish unsoundness of mind of a kind or degree warranting compulsory confinement, in other words there must be evidence establishing at least a prime facie case that the individual lacks capacity and that*

confinement of the nature proposed is appropriate." Cobb J noted that he was not being asked to consider the question of deprivation of liberty on the facts of the case before him, but alerted the local authority and the Official Solicitor to his provisional view on the subject.

Comment

It is entirely understandable that the local authority brought this case to the court, and entirely understandable why Cobb J granted the relief that he did. We suggest that Cobb J was well-advised to proceed down the route of s.48 MCA 2005, because to use the inherent jurisdiction in this situation would appear to us to have been problematic. There was no suggestion that CD's will was being overborne by another, such that the inherent jurisdiction could be used to secure his autonomy by removing that other person's influence – i.e. the approach that the Court of Appeal commended in ***Re DL*** as "*facilitative, rather than dictatorial, approach of the court* [aimed at] *the re-establishment of the individual's autonomy of decision making in a manner which enhances, rather than breaches, their ECHR Article 8 rights*." Although we do not have the precise order that Cobb J made, its effect is clear, as it would enable the local authority lawfully to effect entry to CD's house even in the face of his refusal. If that refusal is capacitous within the meaning of the MCA 2005, then it would be difficult to see why (in the words of Lieven J in *JK*, handed down subsequently to CD, and discussed elsewhere in this report) this would not be a situation in which the inherent jurisdiction would be being used to reverse the outcome under the statutory scheme of that Act. Further, what would be the consequence if CD refused entry – would he be in contempt of court for frustrating the effect of the order? Cobb J had previously in *Re PR* sounded a note of caution in relation to the use of injunctive relief against a vulnerable adult; we suggest that this note would equally sound in relation to CD's position under the inherent jurisdiction.

Finally, we note that Cobb J again reiterated his view that the inherent jurisdiction can only be used to deprive a person of their liberty if they **both** are 'of unsound mind' of a nature and degree warranting confinement **and** lack the relevant decision-making capacity. Baker LJ in *Re BF* had expressed the view (in refusing permission before the Court of Appeal, so therefore, strictly, not in a decision with precedent value) that the inherent jurisdiction could be used to deprive a person **with** capacity of their liberty so long as they satisfied the criteria of 'unsoundness of mind,' at least on an interim basis whilst investigations are being undertaken. Baker LJ was undoubtedly correct that, for purposes of Article 5(1)(e) ECHR, deprivation of liberty does not require proof of incapacity (as otherwise the MHA 1983 would be incompatible with the ECHR). But insofar as recourse is being had to the inherent jurisdiction as an extra-statutory detention mechanism, we would respectfully suggest that its use should be as limited as possible, and that it would be intensely problematic were it to be routinely used in relation to those with unimpaired decision-making capacity.

Capacity and palliative care

University Hospitals Bristol NHS Foundation Trust v RR [2019] EWCOP 46 (Cobb J)

Mental capacity – best interests – medical treatment

Summary

RR was a 20 year old man who had been afflicted by aplastic anaemia for five years, and treatment, including a bone marrow transplant, had not been successful – partly due to RR not following the recommended care and treatment plan. The Trust applied to the court for a declaration that RR lacked capacity to make decisions about palliative care provision, and to approve a palliative care plan for him. At the time of the court hearing, RR was thought likely to die within days or weeks. The basis for the application was that the Trust did not consider it was in RR's best interests for a further bone marrow transplant to be attempted primarily on the basis that he would not comply with the treatment plan, and as RR was thought to lack capacity to make relevant decisions for himself, the Trust wanted a court to confirm that its decision was correct.

RR was said to have been diagnosed with a range of conditions – autism, Asperger's syndrome, dyspraxia and traits of an emotionally unstable personality disorder. He had been subjected to significant harm while in the care of his birth parents as a young child, prior to being adopted at the age of 7 or 8. The court found that he lacked capacity to make decisions about his medical care, noting that the issue of his capacity had only been raised within recent days or weeks, as it became apparent that RR was nearing the end of his life. Cobb J relied in particular on an assessment by a court-appointed independent psychiatrist, who concluded that RR did meet the diagnostic criteria in s.2 MCA 2005 due to "major problems of emotional dysregulation due to childhood trauma, compounded by Asperger's syndrome". This made it difficult for RR to weigh information and communicate a decision, as his poor ability to manage his emotions, his maladaptive coping strategies and his inability to think about aspects of the past would prevent him from reflecting on aspects of his treatment that cause him particular distress. In particular, he could take into account information about the previous failed bone marrow transplant. However, Cobb J noted that it had not been an easy decision, not least as there was evidence of RR apparently making informed and reasoned decisions previously, and since the fear and anxiety about his state of ill health might have affected his decision-making irrespective of his mental disorder.

Cobb J approved the palliative care plan, noting that there was no real prospect of a second bone marrow transplant, in view of the recent deterioration in his health, the standard risks accompanying that treatment and the low prospect of success generally (around 1%), and the need for RR to remain in isolation for 4 weeks after the transplant, which RR had said he could not do and to comply with an ongoing programme of monitoring.

RR had previously expressed the wish to have a second transplant, but on discussion with the court-appointed psychiatrist, appeared to consider that there were no options available for him, and he said that he could not cope with a further period of inpatient treatment. His father and girlfriend wished him to have a bone marrow transplant. RR died 48 hours after the court hearing.

Comment

It must be assumed from the fact that the Trust issued these proceedings in the Court of Protection, that the doctors were willing to attempt a second bone marrow transplant despite the risks and the very low prospects of success. In those circumstances, and given RR's previous wish to receive such treatment against the views of the treating doctors, it is not surprising that proceedings were brought. This is precisely the scenario encompassed by the Supreme Court's edict in *NHS Trust v Y* [2018] UKSC 46 that life-sustaining treatment decisions (including best interests decisions not to treat) require the sanction of the court if at the end of the process of decision-making, "*the way forward is finely balanced, or there is a difference of medical opinion, or a lack of agreement to a proposed course of action from those with an interest in the patient's welfare*" – which must, self-evidently, include from the person themselves, either at the time, or at the point when they had capacity to make the relevant decision.

The judgment also illustrates the difficulty of assessing capacity in people who have diagnoses such as autism and personality disorder, and where queries about their capacity are only raised in the context of a treatment dispute with clinicians. Whether or not RR lacked capacity at the time of the court hearing, however, it seems the outcome would have been the same, as RR was too ill to undergo further treatment and was not willing to agree to a long admission to hospital.

Capacity, diabetes and refusal of treatment

The Hospital vs JJ [2019] EWCOP 41 (Cobb J)

Mental capacity – best interests – medical treatment – deprivation of liberty

Summary

JJ was 23 and lived with his parents. Months earlier he had been diagnosed with type 1 insulin dependent diabetes which he was struggling to come to terms with. Not taking daily injections, he collapsed in a GP surgery and was admitted to hospital. Close to requiring intensive care, the hospital sought authorisation from the court to, as a last resort, use physical restraint to administer the insulin in his best interests. Shortly before the hearing, he accepted a subcutaneous injection of rapid acting insulin which helped to avert a crisis. But without continued treatment, he would die within a week or so from diabetic ketoacidosis.

One of the issues was whether he had the necessary mental impairment for the purposes of the MCA 2005. Previous compulsory treatment had probably led to longer-term psychological consequences and made JJ quite distrustful of some of the staff. A consultant liaison psychiatrist confirmed that JJ had experienced "*a psychological reaction*" and another healthcare professional said he was "*so medically unwell that there is a clear clouding of his thinking*" and he was barely able to engage in conversation. On an interim basis, Cobb J was satisfied that there was reason to believe JJ lacked

capacity to refuse the treatment and that the injections were in his best interests. Physical restraint to administer the insulin was very much to be a last resort, and the deprivation of liberty was authorised. Finally:

> *26. As JJ's father pointed out, (and if I may say so, I am sure he is right about this), JJ desperately needs help to come to terms with this condition. JJ is obviously a bright, thoughtful, engaging, loving young man who his mother said wanted to look top to bottom of the diagnosis of dyslexia when he was a younger person and he will, for his part, want to fully understand, investigate, and familiarise himself, and significantly and perhaps most difficulty accept this condition of diabetes if he is to maintain stable life in the community. That is a longer-term project, long beyond the remit of today's hearing or the immediate issues that confront us all, but I give voice to them because IJ having articulated them, they resonate very loudly and clearly with me.*

Comment

This case illustrates the elasticity of the concept of 'impairment of, or disturbance in the functioning of, the mind or brain', particularly in urgent matters. It resonates with the argument that the key issue ought to be whether someone is proven to be unable to decide. That is what matters. Whether it is because of a mental impairment or for some other reason is, one might argue, increasingly irrelevant in practice, although critical of course at present in terms of whether the MCA is available. Perhaps a Capacity Act rather than Mental Capacity Act is the way forward – and we will watch with interest to see how the Assisted Decision-Making (Capacity) Act 2015 in Ireland operates in practice when it comes into force, dispensing as it does with the 'diagnostic' element.

Capacity assessment research – help wanted

As part of the Wellcome-funded Mental Health and Justice Project, a metacognition workstream is looking at the interfaces between mental capacity and cognitive science. One of their main goals is to understand how capacity is assessed in practice and how best to support assessors from various backgrounds. To look further into this, they are surveying legal, health and social care professionals in England & Wales. It is a short, 2-page online document which should take between 2 and 10 minutes to complete. The results will help the group and the wider MHJ project to tailor their future research to the concerns raised. If you would like to take part or share, please click here. The researchers are particularly interested to hear from lawyers as to their perspectives as they are currently under-represented amongst respondents.

Medical treatment and 16/17 year olds – joining the dots

Prompted by work done for the case of Re D, which highlighted the disconnection of the courts (and indeed commentators) in relation to the position of medical treatment in relation to 16-17 year olds, Alex has written a working paper highlighting some key questions that seem to require consideration and resolution. It is deliberately (if pompously) described as a working paper because it contains thoughts that are still in train; Alex very much welcomes comments upon its contents, and reserves

the right entirely to change his mind about anything contained within it upon the basis of further reflection and/or in the light of observations received.

PROPERTY AND AFFAIRS

Capacity, marriage and financial consequences

Mr Adrian Stuart Mundell v (Name 1) [2019] EWCOP 50 (Mostyn J)

Mental capacity – marriage

Summary

In this case, Mostyn J was asked to consider at some speed (the proposed marriage being three days hence) whether Name 1 ("X") lacked capacity to marry Name 2 ("Y") in circumstances where X's property and affairs deputy was concerned that X did not understand the financial implications of marriage.

X was born in Christmas Eve in 1990 and was 28 years old. From childhood he has suffered from learning difficulties. A property and affairs deputy was appointed to act, in particular because he had been awarded a substantial sum by way of compensation by virtue of a road traffic accident when he lost a leg while working as a refuse collector. The award of damages was carefully calculated to meet his needs, and his needs alone. Part of the award had been used to purchase a home and the remainder has been invested on his behalf.

X and Y began their relationship approximately three years previously, since when she had moved into his home with her two children, now aged seven and sixteen. In so doing, she relinquished a council property, of which she had been a tenant for about 12 years.

X was considered to have testamentary capacity to make a will, and in October 2017 he had made a will leaving his estate to his parents and he specifically indicated he did not want to benefit Y. That will would be revoked if he were to marry, although Mostyn J noted that it would be open to him before the marriage, to execute a codicil to his will which provided that the will shall survive his marriage and be effective thereafter. Mostyn J noted (at paragraph 7) that:

> *One of the immediate counterintuitive problems that I have to face is that I am being asked to declare today that I have, on an interim basis, reason to believe that* [Y] *does not have the capacity to marry whilst, at the same time, to accept that he had the capacity to make a will in 2017 and has the capacity today to execute the codicil that I have mentioned. It would be surprising if the degree of mental capacity that is needed to execute a will is in fact less than the degree of mental capacity that is needed validly to contract a marriage.*

Mostyn J suggested that it was in his interests, although it was not part of the decision he had to make, that X should execute a codicil to his will to that effect prior to the wedding, if Mostyn J permitted the marriage to proceed.

In accordance with the relevant case law on capacity to marry, Mostyn J considered whether X understood: (a) the nature of the marriage contract and (b) the duties and responsibilities that normally attach to marriage. In respect of (b), Mostyn J disagreed with Munby J in *Sheffield City Council v E and S* [2005] 2 WLR 953 that the essence of marriage is for two people to live together and love one another. While recognising that this is a common expectation, Mostyn J observed (at paragraph 14) that:

> *There are plenty of examples, both in the distant past and more recently, of marriage being created where the parties like each other could not be said to love each other: where their relationship is one of platonic friendship rather than one of passion. Moreover, there are plenty of examples in this modern age of parties marrying where they do not share a common home or a common domestic life but, nonetheless, their marriage is well and truly a marriage.*

Instead, Mostyn J focussed on whether X understood that his marriage could have financial consequences. In this regard he observed (at paragraph 31) that:

> *it would be inappropriate and, indeed, arguably dangerous to introduce into the test for capacity to marry a requirement that there should be anything more than a knowledge that divorce may bring about a financial claim. This,* [X] *plainly understands. However, what the extent of that claim should be is a mystery to even the most sophisticated and well educated of lay, as well as legal, persons and to suggest that there is needed an appreciation of what the result of a financial remedy claim might be, would be to set the test for capacity far too high.*

On this basis, Mostyn J did not hesitate to find that X had capacity to marry. He noted, however, that:

> *if this marriage happens and then later breaks down and a financial claim is made, then the scope of any claim by (name 2) is necessarily going to be extremely limited, given that the entirety of* [X]*'s means derive from a personal injury compensation payment which will have been calibrated by reference to his needs. There are numerous authorities in the books which have effectively emphasised the near-immunity of personal injury awards from a financial claim. So, the extent of any claim that were to be made on the breakdown of this marriage, were it to happen, would be limited, in my provisional prognostication at this point, to alleviating serious financial hardship and no more.*

Making foreign powers of representation effective in England & Wales

Re Various applications concerning foreign representative powers [2019] EWCOP 52 (Senior Judge Hilder)

CoP jurisdiction and powers – international jurisdiction

Summary

In this case, Senior Judge Hilder has returned to the somewhat complex issues that arise where an attorney seeks to use a power of representation granted in a foreign jurisdiction. She had previously considered these issues in *Re JMK* [2018] EWCOP 5, a decision which attracted a certain amount of comment. In this case, concerning five separate powers, she had the benefit of the Official Solicitor as

Advocate to the Court. In each of the applications, the applicant was asking Court of Protection to make orders to give effect in England and Wales to representative powers originating in a foreign jurisdiction.

Senior Judge Hilder started by giving a useful overview of the provisions of Schedule 3 to the MCA 2005, and the way in which they implement (albeit with some differences) the provisions of the 2000 Hague Convention on the International Protection of Adults, notwithstanding the fact that the UK has not, in fact, ratified that Convention in respect of England & Wales. Within that framework, Senior Judge Hilder noted, there were five options for the holder of a foreign power of representation ("R") to ensure that they have necessary powers of management in relation to the property of an adult in England & Wales:

(1) R may simply rely on the power, using it directly to demonstrate their authority

Although this is, in principle, how Schedule 3 should operate (see paragraphs 13 and 14), Senior Judge Hilder noted that "[i] *practice, this approach is generally not found to be effective because, as* [three of the cases before her] *each demonstrate, financial institutions in England and Wales usually seek some domestic confirmation of authority*."

(2) R may obtain an order from the country where the donor is habitually resident permitting him to manage the donor's property (essentially the equivalent of a deputyship order); and then seek recognition of that order under Schedule 3 Part 4 / Rule 23.4.

As Senior Judge Hilder noted: "[g]*iven that powers of attorney are typically granted with a view to avoiding any need for court proceedings, it is not difficult to see why this approach – which requires proceedings in two courts – is not commonly favoured*."

(3) R may seek a declaration under s15(1)(c) MCA 2005 and Rule 23.6 that he or she will be acting lawfully when exercising authority under the power in England and Wales.

As Senior Judge Hilder noted: "[t]*here is some suggestion from commentators that this should be R's application of choice.*" She then went on to note the requirements that would have to be satisfied before the Court of Protection could grant that declaration. Importantly, she noted that:

> *Mr. Rees* [on behalf of the Official Solicitor] *has posed a question as to whether there is a "threshold" for the exercise of the court's jurisdiction to make this type of declaration: is it exercisable in respect of any foreign power of attorney, or must the donor be an "adult" within the meaning of Schedule 3 paragraph 4, or must the donor lack capacity within the meaning of section 2 of the Act? The question is significant because, if there is no threshold of capacity within the meaning of section 2 of the Act, the Court may be making declarations in respect of persons who would otherwise be outside its jurisdiction.*
>
> *Mr. Rees suggests that for the court's jurisdiction to make this type of declaration to arise, the donor of the power must be an "adult" within the meaning of Schedule 3 paragraph 4. I agree. That seems to have been the approach taken by Baker J in HSE v. PA & Ors* ***[2015] EWCOP 38*** *at paragraph 44, and is consistent with the 'scope of jurisdiction' provisions on paragraph 7(1) of Schedule 3 - "The*

court may exercise its functions under this Act (in so far as it cannot otherwise do so) in relation to" "adults" in various circumstances.

(4) R may seek an order of the court under s.16 MCA 2005

Senior Judge Hilder noted that it would be possible for to court to make an order under s.16 even if an application asking it to do so was not formally before the court, and that

There are two ways in which the exercise of the full, original jurisdiction may assist:
(a) by making an order which appoints R as the adult's deputy for property and affairs; or
(b) where the adult's property in England and Wales is limited and R is simply seeking to remit such property to the state where the adult is habitually resident, by making a "one-off" order authorising R to make the transfer.

In either case, the court would need evidence that the adult lacked relevant capacity within the meaning of section 2 of the Act, and to be satisfied that the appointment/ authority to transfer is in the best interests of the adult.

If the court is considering making such an application, Senior Judge agreed with the submission of the Official Solicitor that the existence of a valid foreign power of attorney is a material consideration when considering what is in the best interests of the adult in question, but it is not a bar to the exercise of the full, original jurisdiction of the court.

(5) R may apply for orders of recognition of the power of representation as a 'protective measure.'

This appeared to be the application intended by the applicants in each of the five cases before the court. This meant that Senior Judge Hilder had to consider further what constitutes a 'protective measure' for the purposes of the recognition provisions of Schedule 3 paragraph 19. Whilst she noted that she was persuaded that she had been too narrow in her understanding of the position in *Re JMK* (in which she had held that a 'protective measure' could only be a measure made or approved by a court), she ultimately found that she did not have to decide the 'interesting' question of precisely when and under what circumstances a foreign power of representation would become a protective measure upon registration by an administrative body (such as the Office of the Public Guardian). Senior Judge Hilder noted that:

If, when an appropriate application is made, the court were minded to take the view that a power of attorney can be transformed into a protective measure through a process of registration linked to loss of capacity, application of the recognition and enforcement provisions of Schedule 3 Part 4 still require that the circumstances of disapplication under paragraph 19 (3), (4) and (5) do not apply.

Senior Judge Hilder then turned to consideration of the individual cases before her. Perhaps the most important for wider purposes was that relating to TCM, seeking recognition of a Lasting Power of Attorney registered with the Office of the Public Guardian of Singapore. The purpose of the application appeared to be to enable TCM's wife and daughter to make decisions on behalf of TCM in respect of

his welfare (also his property and affairs but since he did not have any in England and Wales, this was less of a driving factor). Senior Judge Hilder noted the:

> *39.7* […] *possibility of a declaration pursuant to section 15 of the Act, that the attorneys will be acting lawfully when exercising authority under the power: there is a difficulty with meeting the requirements of Schedule 3. The evidence is that, at the time of granting the power, TCM was habitually resident in Singapore. The power is therefore not within the requirements of Schedule 3 paragraph 13(1). However, the evidence also indicates that England was not 'a connected country': at the time of granting the power TCM was not a UK national, he was not habitually resident in England and Wales, and he had no property in England and Wales. Moreover, TCM has given no written specification that the law of England and Wales should apply. So the power is not within the requirements of Schedule 3 paragraph 13(2) either. It falls into the lacuna identified at paragraph 22.5 above: Schedule 3 paragraph 13 makes no provision for the law applicable to the "existence, extent, modification or extinction" of this power.*
>
> *39.8. It has been suggested that "logic, and fidelity to the principles of the Convention […]" point to the applicable law in these circumstances (in respect of "existence, extent, modification or extinction" of the power) being the law of the state of habitual residence at the time of granting the power, ie Singapore. I agree. That approach also seems to me most closely consistent with the approach taken in Schedule 3 paragraph 13(2).* (emphasis added)

On the facts of the case before her, Senior Judge Hilder declared under s.15(1)(c) that the attorneys would be acting lawfully when exercising authority under the power in England and Wales, subject to modifications that the authority to make gifts is limited to the circumstances set out in s.12 MCA 2005 and that the authority to give or refuse consent to treatment did not extend to life-sustaining treatment to accord with s.11(8) MCA 2005, which sets out specific provisions in relation to such treatment which the Singaporean power did not mirror.

Commentary

That Senior Judge Hilder was required (for the second time, following *Re JMK*) to go through the exercise of considering how those acting under foreign powers can actually get institutions (in particular financial institutions) in England & Wales to accept their authority is rather depressing, given the clear wording of paragraph 13 of Schedule 3, which should mean that foreign powers valid on their own terms are automatically effective here.

It is particularly depressing given that, for these purposes, 'foreign' powers include those emanating from Scotland, although, in practice, banks and financial institutions do seem somewhat happier to accept those powers. In due course, were the UK to ratify the 2000 Convention in respect of England & Wales, the provisions of Article 38 of the Convention would be available, enabling the authorities in another Hague state to issue a certificate to the person acting under the power of representation which would serve as proof of the matters contained within it. The Government, though, has no plans at present to extend ratification to England & Wales (or Northern Ireland).

Lasting powers of attorney – abuse on the increase?

The number of legal actions taken by the Office of the Public Guardian against people with lasting power of attorney has more than doubled in the last two years, with more than 700 applications to court made in 2018/19 in relation to alleged misconduct by attorneys. Concerningly, this increase outstrips considerably the increase in attorneys on the register, indicating that financial misconduct is becoming more and more common. These trends are apparent from data collected by the law firm Nockolds and reported in the Law Gazette.

It should also be noted that the OPG began nearly 3,000 safeguarding investigations over 2018/19, which is 53% more than in the previous year.

PRACTICE AND PROCEDURE

Court of Protection User Group

The minutes of the most recent meeting, held on 15 October, have now been published and can be found here. One quite striking issue raised relates to community deprivation of liberty applications. The total number of such applications awaiting determination is presently 2,015 with the oldest being 8 months old. Additional judicial resources have been secured, and the minutes record Senior Judge Hilder's hope that the backlog will be cleared before the LPS scheme is implemented

Case management and expert evidence

London Borough of Southwark v NP & Ors [2019] EWCOP 48 (Hayden J)

Practice and procedure – case management

Summary[2]

This case, concerned with the welfare of a 17 year with cerebral palsy and atypical anorexia, is of interest on the facts for the way in which the court had to consider the complexity of a relationship between a mother and daughter and the influence of the latter upon the former. It is of broader significance for the observations made by the Vice-President, Hayden J, about case management.

Hayden J was concerned that the young woman's treating psychiatrist who was giving, in effect, expert evidence was doing so on the basis of incomplete information and incomplete information-sharing. At paragraph 30, Hayden J noted that he had:

> *enquired of the very experienced counsel in this case whether in Court of Protection proceedings, they have ever had experience of an Expert's Meeting being conducted. 1Only Ms Paterson had and then only on two occasions. For my part, I do not remember a document reflecting such a meeting being filed in any proceedings that I have heard. In a court arena where conflicts of expert evidence arise regularly and in which such evidence is commonplace this is, to my mind, very unusual. Additionally, I note that I am rarely called on to make Disclosure Orders and have frequently been concerned by blockages in channels of communication which ought otherwise to have been regarded as integral to informed decision taking. […] What requires to be considered, to my mind, is whether the Court and the lawyers can improve case management more generally. I am convinced that we can.*

Accordingly, Hayden J set down a set of "general principles" at paragraph 31 concerning both case management generally and expert evidence in particular:

> *i. Though the avoidance of delay is not prescribed by the Mental Capacity Act 2005, the precept should be read in to the proceedings as a facet of Article 6 ECHR (see: Imperial College Healthcare*

[2] Note, Katie having been involved in this case, she has not contributed to this report.

An NHS Trust v MB & Ors [2019] EWCOP 29). Any avoidable delay is likely to be inimical to P's best interests;

ii. Effective case management is intrinsic to the avoidance of delay. Though the Court of Protection, particularly at Tier 3, will frequently be addressing complex issues in circumstances of urgency, thought should always be given to whether, when and if so in what circumstances, the case should return to court. This will require evaluation of the evidence the Court is likely to need and when the case should be heard. This should be driven by an unswerving focus both on P's best interests and the ongoing obligation to promote a return to capacity where that is potentially achievable.

iii. Where, at any hearing and due to the circumstances of the case, it is not possible prospectively to anticipate what future evidence may be required, the parties and particularly the Applicant and the Official Solicitor (where instructed) should regard it as an ongoing obligation vigilantly to monitor the development of the case and to return to the Court for a Directions Hearing when it appears that further evidence is required which necessitates case management;

iv. Practice Direction 15A, Court of Protection Rules 2017 is intended to limit the use of expert evidence to that which is necessary to assist the court to resolve the issues in the proceedings;

v. The Practice Direction sets out the general duties of the expert, the key elements of which require to be emphasised:

> *1.It is the duty of an expert to help the court on matters within the expert's own expertise.*
>
> *2.Expert evidence should be the independent product of the expert uninfluenced by the pressures of the proceedings.*
>
> *3.An expert should assist the court by providing objective, unbiased opinion on matters within the expert's expertise, and should not assume the role of an advocate.*
>
> *4.An expert should consider all material facts, including those which might detract from the expert's opinion.*
>
> *5.An expert should make it clear—(a) when a question or issue falls outside the expert's expertise; and(b) when the expert is not able to reach a definite opinion, for example because the expert has insufficient information.*
>
> *6.If, after producing a report, an expert changes his or her view on any material matter, such change of view should be communicated to all the parties without delay, and when appropriate to the court.*

vi. In Court of Protection proceedings, the Court will frequently be asked to take evidence from treating clinicians. Invariably, (again especially at Tier 3) these will be individuals of experience and expertise who in other cases might easily find themselves instructed independently as experts. Treating clinicians have precisely the same obligations and duties upon them, when preparing reports and giving evidence as those independently instructed. Further, it is the obligation of the lawyers to ensure

that these witnesses are furnished with all relevant material which is likely to have an impact on their views, conclusions and recommendations. (see: Re C Interim Judgment: Expert Evidence) [2018] EWFC B9). This should not merely be regarded as good litigation practice but as indivisible from the effective protection of P's welfare and autonomy;

vii. Evidence of clinicians, experts, social workers, care specialists etc is always to be regarded as individual features of a broader forensic landscape in to which must be factored the lay evidence. One expert or clinician is unlikely ever to provide the entire answer to the case (see: Re T [2004] 2 FLR 838). It follows that Experts meetings or Professionals meetings should always be considered as a useful tool to share information and to identify areas of agreement and / or disagreement;

viii. When evaluating the significance of expert evidence and particularly when the issues being considered are, as has regularly been the case in the Court of Protection, at the parameters or frontier of medical or expert knowledge, this should be properly identified and acknowledged. In considering the evidence, it is always helpful to reflect that yesterday's orthodoxies may become today's heresies. (see: R v Harris and Others [2005] EWCA Crim 1980);

ix. Witnesses from whatever disciplines may be susceptible to 'confirmation bias'. This is to say they may reach for evidence that supports their proffered conclusion without properly engaging with the evidence that may weaken it. ((see: Cleveland Report (report of the enquiry in to Child Abuse in Cleveland 1987 Cm 412 London: HMSO 010/1041225));

x. Consideration must always be given to relevant, proportionate written questions to an independently instructed expert.

Comment

The Vice-President's observations about case management sit alongside and amplify the obligations already imposed upon the parties (and, it should be added, the court) by both Part 1 of the Court of Protection Rules 2017 and the Case Pathways Practice Direction (PD 3B), both of which can be most easily accessed via the Court of Protection Handbook website here.

Short note: urgent applications (and DNA testing)

In *Bagguley v E* [2019] EWCOP 49, Hayden J confirmed that the Court of Protection can authorise (by the making of a decision under s.16 MCA 2005) the taking of a DNA sample to establish paternity. In this, he departed from the previously understood position (from *LG v DK* [2011] EWHC 2453 (COP)) that such testing was governed by the terms of Family Law Act 1969. Hayden J also confirmed that such an order would constitute appropriate consent for purposes of s.3(6) Human Tissue Act 2004 in the event that the person has died prior to the point of the sample being taken, or after the sample has been taken but before testing has take place.

Hayden J also took the opportunity to make observations as to the obligations upon parties in the case of urgent applications, which merit reproduction in full. Although, in fact, the case did not require the urgent decision that it appeared it did at first sight:

> *43. […] Had the facts been as presented, it would have created a challenge in securing representation for E. This same dilemma can occur when an urgent application e.g. relating to urgent medical procedure, is made to the out of hours emergency judge. In those circumstances there may not be time to contact the Official Solicitor. Certainly, she will not have the opportunity to conduct independent investigations. Thus, she will not be able to contribute to the decision anything that is not already available to a judge. Nonetheless, the experience, the unique professional obligations to P and the accumulated welfare and legal knowledge of the Official Solicitor may provide an important contribution even where the OS has no greater, possibly even a lesser factual knowledge of the available evidence. The problem has not arisen here, nor do I think I should go further than to say that in situations which are a true emergency it will have to be a matter of judicial discretion as to whether it is necessary or whether time is available to contact the Official Solicitor. It is quite impossible to be prescriptive.*
>
> *44. What does, however, require to be signalled, in clear and entirely unambiguous terms, is that where an application is brought before the Court of Protection, on what is said to be 'an urgent basis', evidence of urgency must be presented which is both clear and cogent. This is to be regarded as a professional obligation on all the professionals involved but most particularly on the lawyers who bring the application. To this I would add the obvious and related point, an application which becomes urgent in consequence of professional delay in decision making is, equally, a professional failure which always militates against the interests of the protected person. An urgent hearing puts everybody concerned under very great pressure. Where such hearings are capable of being listed in circumstances which enable the parties to be appropriately represented and permit all involved the opportunity to consider and reflect upon the issues, they must be. This I emphasise is a facet of the Article 6 Rights of all involved but most particularly P's rights.*
>
> *45. There is no absolute requirement that P should be joined as a party in every case. Indeed, the imposition of such a requirement would be unworkable. It is a fact, for example, that P will not be made a party in the vast majority of Property and Affairs applications. Even where the Court is considering a deprivation of liberty it may not be possible to join P as a party where a crisis situation has developed. This is notwithstanding the obiter dicta comments in Re: X (Court of Protection Practice) [2015] EWCA Civ 599. In an emergency the judge will have to evaluate the proportionality of the arrangements in the context of the crisis and, if an order is made, it is likely to be tightly time limited with an expeditious return to Court.*
>
> *46. Court of Protection Rules 2017 rule 1.2 and Practice Direction 1A place a duty on the Court to consider the participation of P and as to whether or not to join P as a party to the proceedings. In doing so the Court is directed to have regard to a number of matters including the nature and extent of the information before the Court; the issues raised by the case; whether a matter is contentious; and whether P has been notified. Where P is joined as a party, the joinder will only have effect once a litigation friend has been appointed (r1.2(4)). Where the Official Solicitor is appointed to act as*

> *litigation friend for P it is her usual practice to ensure that her criteria for accepting appointment are met and that arrangements are in place to meet her costs before she will act.*
>
> *47. I am aware that the OS is investigating the possibility of providing an out of hours service in the kind of circumstances I have highlighted. This has not been available in the past or at least not for the last decade. If it does become possible it will require to be used sparingly and probably regarded as 'exceptional'. That, in any event, is for the future.*

Short note: ruling out options and the power of permission

In *A North East Local Authority v AC & Anor* [2018] EWCOP 34, Cobb J applied case-law from proceedings concerning children to hold that it was legitimate for the court to rule out a possible outcome or option before reaching a firm conclusion on best interests. In eliminating one significant option for the future care of the person before him, AC, he noted that he had:

> *followed the essential reasoning of Black J in North Yorkshire CC v B* [[2008] 1 FLR 1645] *and Sir James Munby P in Re R* [[2014] EWCA Civ 1625]. *I have followed the guidance of the Court of Appeal in Re B-S [*[2013] EWCA Civ 1146*] in focussing on the realistic options for AC: given that, on the evidence, placement with BC is not a realistic option, then I am entitled to that conclusion and rule her out. In short, I have been driven to the conclusion that rehabilitation would not be a realistic option for AC now or in the relevant future.*

It should be noted that this approach would apply in addition to the ruling out of options which are not, in fact, available, as per *N v ACCG* [2017] UKSC 22.

In a subsequent case relating to the same person, *A North East Local Authority v AC & Anor* [2019] EWCOP 44, Cobb J emphasised the importance of the permission requirement in s.50 MCA 2005 in the context of ongoing proceedings involving a litigant in person whom it was clear was coming close to being a vexatious litigant noting that this section "*provides, as we discussed at the hearing, that any new applications on a subject other than previous orders will require the court's permission to be issued. That is a provision which will now be strictly monitored and enforced going forward.*"

Contempt, committal and legal aid

North Yorkshire County Council v George Elliot [2019] EWFC 37 (HHJ Anderson)

CoP jurisdiction and powers – contempt of court

Summary

Mr Elliott was the subject of a sexual harm prevention order preventing him from having contact with children under 16. In circumstances that are not described in the judgment, he had come into contact with a young woman who had been declared to lack capacity to make decisions about contact with

others on the basis that she did not understand the risk posed by people with whom she might come into contact and lacked the ability to weigh up the pros and cons of having contact with them.

An injunction was made against him in Court of Protection proceedings preventing him from contacting or attempting to contact the young woman, whether directly, face-to-face or indirectly by any means whatsoever including telephone, texting or messaging, email, Skype, FaceTime or through any social media platform including, but not limited to, WhatsApp, Twitter, Instagram or Snapchat.

The injunction was subsequently amended to make it clear to Mr Elliot that the injunction included a prohibition on any communications with P, even if initiated by P. This was done by substituting the word "contacting" with the word "communicating".

Mr Elliot admitted three deliberate breaches of the injunction within hours of the injunction having being made to the court and having been explained to him by the judge.

In proceedings brought for contempt against Mr Elliott, the court took into account in mitigation the fact that Mr Elliot had blocked P from Facebook and all the other ways of communication available to them through social media.

The court sentenced Mr Elliot to imprisonment for twenty eight days in respect of the first breach suspended for one year, for a period of imprisonment of twenty-eight days in relation to breach number 2, again suspended for one year, and twenty-eight days' imprisonment in relation to breach number 3, again suspended for one year, with the sentences to be concurrent.

Comment

Whilst the precise nature of the relationship between Mr Elliott and the woman in this case is not clear from the judgment, this case is a reminder that, despite the treatment to which they are subject, it is often the case that a person in a relationship with a sex abuser is keen (at times) to continue the relationship. Thus where injunctions are made against the offender contacting P, the court also has to have in mind that it will often be P who initiates the contact. It is therefore interesting to see how this was dealt with in the Court of Protection proceedings by the use of the word ‘communicating’ rather than ‘contacting’.

The case also gives an opportunity to highlight that the Court of Appeal in *Re O (Committal: Legal Representation)* [2019] EWCA Civ 1721 has – again – had to make clear that a person who is the subject of a committal application, including an appeal against a committal order, is entitled to publicly-funded representation. Legal aid for committal proceedings is not means tested, and is available as of right, i.e. whether it is in the interests of justice for representation to be provided.

The inherent jurisdiction and vulnerable adults – confirmation as to governing procedural rules

Redcar & Cleveland Borough Council v PR (No 2) [2019] EWHC 2800 (Fam) (High Court (Cobb J))

CoP jurisdiction and powers – Interface with inherent jurisdiction

Summary

This is the costs judgment arising from the substantive judgment in *Redcar & Cleveland Borough Council v PR & Ors* [2019] EWHC 2305, concerned with a 32 year old woman (PR) who had been affected by mental health problems which had resulted in admission to hospital as a voluntary patient. During her admission she made allegations against one of her parents and was extremely anxious about returning to live with them (to the point of threatening to take her own life).

When she was ready to be discharged, the local authority considered that it was required to safeguard her by applying to the High Court for orders under the inherent jurisdiction preventing PR from returning to live with her parents.

Interim orders were granted, initially without notice, and were kept in place for around 4 weeks. Ultimately, PR decided she did not want to return to live with her parents, and they in turn agreed to have limited contact with her and not to try to persuade her to return home, and the inherent jurisdiction orders were discharged.

PRs parents sought their costs of the proceedings from the local authority. They argued that the proceedings were unnecessary and expensive and the local authority should have canvassed with them the possibility of either an undertaking or entering into a written agreement as a pre-action step before launching the application.

The first question was as to the rules governing costs. Cobb J held that:

1. As proceedings under the inherent jurisdiction concerning an adult are not family proceedings within the definition set out at s.32 Matrimonial and Family Proceedings Act 1984, the rules that are to be applied by the court are the Civil Procedure Rules (CPR).

2. Accordingly the rule to be applied by the court when determining the application is CPR 44.1 and 44.2 which gives the court a discretion as to whether costs are payable by one party to another, and if so, the amount of those costs. Cobb J also noted the general rule that the unsuccessful party will be ordered to pay the costs of the successful party, although the court may of course "make a different order" (rule 44.2).

3. CPR 44.2(4)/(5)) requires the court to have regard to all the circumstances, including (but not limited to) the conduct of all the parties and whether a party has succeeded on part of its case, even if that party has not been wholly successful.

Turning to the substance of the application, Cobb J reminded himself that at the time of the application in March 2019:

1. PR had recently disclosed aspects of her home life with her parents which gave the professional safeguarding and care agencies considerable concern about her future well-being should she return there;

2. There was a suggestion in the documents that parental influence over her was disabling her from making true choices. At that time, PR was threatening to end her life if she did not receive protection;

3. PR appeared to be a vulnerable person because of her range of mental health difficulties, and she was believed to be susceptible to coercive or controlling influence at home;

4. There was sufficient evidence that PR was confused in her thinking about her immediate future and/or was possibly being coerced and thus unable to make a decision of her own free-will; she was also suffering from a possible mental disorder;

5. After a period of time however the proceedings became "counter-productive" as PR has started to withdraw her co-operation from the programs and therapies designed to assist her, as she was worried that information she shared confidentially in the sessions and programs would ultimately be disclosed to the court;

6. It was PR's case that the Local Authority should have used *other* (statutory) remedies against her parents (instead of using the inherent jurisdiction); it was not her case that proceedings should not have been brought to regulate the behaviour of her parents.

Cobb J held that there had been no obviously 'successful' party. Thus, there was no easy application of the 'general rule' (i.e. "that the unsuccessful party will be ordered to pay the costs of the successful party"). He further held that on the information available to the local authority at the outset it was reasonable for them to conclude that if they notified PR's parents of the intention to apply for an order this could have exposed PR to undue or inappropriate pressure from them. He further noted that: (1) the situation developed quickly and was an emergency; (2) PR was so distressed she was at risk of suicide; (3) once the proceedings were underway the local authority reacted to the evolving evidence and modified their case. Accordingly, he concluded, it was not unreasonable for the Local Authority to approach the court for protective orders, rather than attempting to obtain voluntary agreements for the parents to the safeguarding regime which they wished to create for PR. Cobb J therefore made no order for costs.

Comment

Cobb J was undoubtedly right that the CPR applies in a case of this sort. This is to be compared with a case concerning a child where the court is being asked to exercise the inherent jurisdiction. Those

cases are family proceedings to which the Family Procedure Rules apply, and the starting position is that there will be no order for costs. The same rule also applies in relation to welfare proceedings before the Court of Protection. Cobb J was also right to highlight that the CPR is not a comfortable fit costs-wise for cases which, substantively, bear a strong resemblance to welfare proceedings before the Court of Protection. They are equally an uncomfortable fit in terms of the other aspects of these proceedings, the CPR being (at root) designed to address the resolution of adversarial civil proceedings, and the FPR/COPR being designed to enable the inquisitorial determination of the position of the subject matter child/adult. Even if it is not possible to introduce specific provisions within the CPR to address (e.g.) the evidential obligations upon parties in such inherent jurisdictional proceedings, it is to be hoped that if the recent explosion in the case-law in this area continues unabated that a Practice Direction can be issued to address such matters.

On the facts of the case, the judgment will no doubt be extremely welcome to public bodies considering approaching the court to invoke the inherent jurisdiction. Given that the large majority of the cases in which the court is being asked to exercise its powers pursuant to the inherent jurisdiction arise because someone is being unduly influenced or coerced, the scope for trying to come to agreements with the alleged perpetrator of the coercion/influence so as to avoid litigation without putting the subject matter of proceedings at risk, is likely to be limited.

Short note: covert recordings and medical practitioners

The case of *Mustard v Flower* [2019] EWHC 2623 (QB) addresses the question of the lawfulness (or otherwise) of covertly recording an assessment by a medical practitioner.

The Claimant in this case was a victim of a road traffic accident in which her stationary vehicle was rear-ended by the Defendant's Fiat Punto. Notwithstanding the nature of the crash, the Claimant claimed to have suffered a sub-arachnoid brain haemorrhage and a diffuse axonal brain injury, the combined effects of which were said to have left her with cognitive and other deficits. Significant differences between the Claimant and the Defendant (this being the Second Defendant as insurer to the First Defendant driver) as to the velocity and nature of the crash and resulting injuries led to expert evidence being permitted in eight different categories ranging from orthopaedics to engineering.

It was the Claimant's solicitor's usual practice to advise clients to record consultations with medical experts. In light of this, the Second Defendant invited the Claimant to record and share her examinations with her own medical experts: she did not. The Second Defendant also warned its experts that they were likely to be recorded.

While most of the recordings were done by consent, two were carried out covertly. Furthermore, one consultation with a defendant expert, specifically the one who considered the Claimant to be labouring under a 'factitious disorder', was recorded covertly by accident, the Claimant having agreed to record only half of the consultation but then having inadvertently failed to switch off her recording device.

Those experts who had been recorded covertly objected to the recordings being relied on as evidence on the basis that the practice of covert recording was "*wanting in honesty, transparency and common courtesy*." The Second Defendant attempted to have them excluded on the basis that they were unlawful under the Data Protection Act 2018 and the General Data Protection Regulations 2016.

Master Davison rejected this submission in fairly short order, holding that the recording of an examination by a doctor would fall into Article 2(c) GDPR, ie that the Regulation does not apply to "*the processing of personal data by a natural person in the course of a purely personal… activity*."

Despite considering the process of recording covertly to have been 'reprehensible', Master Davison noted that the Claimant had acted on the advice of her solicitor and that her motives had been understandable. He held: 'while her actions lacked courtesy and transparency, covert recording has become a fact of professional life' (para 23). He noted that, once the evidence from the covert recordings had been considered, it was difficult 'to put this particular genie back in the bottle'. Going forward he suggested it would be sensible for an "industry-wide" agreed model on how meetings with expert evidence could be recorded.

This case concerned a personal injury claim, governed by the CPR. It is, however, of assistance by analogy in relation to the question of the acceptability – in principle – of covert recording of consultations and/or examinations with medical practitioners. It should be noted, however, that the Vice-President has previously expressed unease with the use of video recording by family members of P for purposes of investigating or assessing capacity or best interests, observing in *Abertawe Bro Morgannwg University Local Health Board v RY & Anor* [2017] EWCOP 2 that:

> *It is axiomatic that they are highly invasive of* [P's] *privacy and that he has no capacity to consent to them. They have been viewed by a variety of professionals.* […]*, I do not consider that video recordings should ever be regarded as a routine investigative tool. Both the videoing and their distribution will require strong and well-reasoned justification.*

THE WIDER CONTEXT

National Mental Capacity Forum news

In order to widen its reach, and to ensure consistent access to its work, the National Mental Capacity Forum (NMCF), led by Baroness Finlay, has migrated its content from a members-only website to the main pages of the website of the Social Care Institute for Excellence. It has also launched a (free) survey to assess whether there have been improvements in empowering and supporting those with impaired mental capacity to live as fully and independently as possible. The survey can be found here, and we urge readers to take part – and, in particular, to highlight the fact, for all its sterling work, the NMCF is simply no substitute for the statutory champion of the MCA that the House of Lords recommended in 2014. Addressing poor implementation of the Act, which still remains the case some 5 years after its post-legislative scrutiny report, the House of Lords Select Committee recommended as follows:

> *11. Recommendation 3: We recommend that overall responsibility for implementation of the Mental Capacity Act be given to a single independent body. This does not remove ultimate accountability for its successful implementation from Ministers, but it would locate within a single independent body the responsibility for oversight, co-ordination and monitoring of implementation activity across sectors, which is currently lacking. This new responsibility could be located within a new or an existing body. The new independent body would make an annual report to Parliament on the progress of its activities.*
>
> *12. The proposed independent oversight body would not act as a regulator or inspectorate, but it would work closely with such bodies which have those responsibilities in relation to the Mental Capacity Act. The body should act as a support to professionals required to implement the Act.*
>
> *13. The composition of the new independent body should reflect the professional fields within which the Act applies, and it should contain professional expertise. It should also include representation from those directly affected by the Act as well as their families and carers. This is vital to ensure credibility. Other key features of the independent body will be continuity, expertise, accountability and accessibility.*
>
> *14. Recommendation 4: The Mental Capacity Act Steering Group is a welcome first step in this direction, and we recommend that it be tasked with considering in detail the composition and structure of the independent oversight body, and where this responsibility would best be located. The former Mental Health Act Commission strikes us as an effective, cost-efficient and credible model from which lessons may be learned.*

We suggest that these recommendations remain just as valid now as they did 5 years ago.

NICE Consultation: Decision-making and mental capacity

NICE is consulting on a quality standard will cover decision-making in people using health and social care services who are 16 years and over and may lack capacity to make their own decisions (now or in the future).As the NICE briefing paper, the quality standard aims to support implementation of the ethos and principles introduced by the MCA 2005 and relevant codes of practice but does not substitute these. The consultation closes on 4 December, and the relevant materials can be found here. Our thoughts on the underlying NICE guidance (NG 108) on decision-making and capacity can be found here.

Learning disability and autism – the Joint Committee on Human Rights reports

In a very hard-hitting report published just before the dissolution of Parliament, the Joint Committee on Human Rights both highlighted the entirely unacceptable position of young people with learning disability and autism detained in mental health hospitals, and set out detailed recommendations for urgent changes to practice and the law. The (now former) Government response was to announce that all 2,250 patients with learning disabilities and autism who are inpatients in a mental health hospital will have their care reviewed over the next 12 months. Further, for those in long-term segregation, an independent panel, chaired by Baroness Sheila Hollins, will be established to oversee their case reviews to further improve their care and support them to be discharged back to the community as quickly as possible. The Government also published on 5 November proposals for mandatory training for all health and social care staff in autism and learning disability. We will watch with interest whether and how the new Government acts further after the election, and as for its response to the recommendations of the Independent Review of the Mental Health Act 1983, which the JCHR said that the Government must act upon.

Separately, Community Care reports that a settlement has been reached in the case brought on behalf of Bethany, the young woman with autism detained at St Andrew's hospital in Northampton.

An agreed public statement said:

> *At mediation on 25 September 2019, agreement was reached which has resolved matters, including the claim for damages, without the need for further litigation.*
>
> *St Andrew's Healthcare and NHS England have accepted that the care provided to Bethany did not always comply with the Mental Health Act Code of Practice and the NICE Guidelines on managing violence and aggression. This affected her wellbeing and made it harder for her to return to live in the community.*

Walsall Council and NHS Walsall Clinical Commissioning Group have accepted that there were unfortunate delays in moving Bethany from what became an unsuitable placement for her.

Force-feeding, the MHA and the inherent jurisdiction

JK v A Local Health Board [2019] EWHC 67 (Fam) (High Court (Family Division) (Lieven J)

Medical treatment – advance decisions - Mental Health Act 1983 – interface with MCA

Summary

In this case, Lieven J had to grapple with the intersection between the MCA, the MHA and the inherent jurisdiction in addressing the question of whether it would be lawful to force feed a person detained under the Mental Health Act 1983 who was refusing to eat and had made an advance decision to refuse any medical intervention.

The case concerned JK, a 55-year-old man with a diagnosis of Autism Spectrum Disorder (ASD) made late in life. He was currently on remand for the alleged offence of having murdered a close relative, the index offence having taken place in September 2019. He was transferred from prison to hospital, a medium secure psychiatric hospital on 23 October 2019 under s.48 MHA 1983, two medical practitioners having assessed him as suffering from a mental disorder which made it appropriate for him to be detained under the MHA 1983.

Since shortly after arriving at the prison, JK had been saying consistently that he wanted to die, and that he intended to starve himself to death. He refused food for 23 days, then ate limited food for a few days because he was concerned that he might be found not to have capacity to make a decision (the context suggests about eating) if he was in a weakened state. He then returned to refusing food, but he did started eating again at the prison because he wished to be able to attend and give evidence before the court.

His clinical team, including those at the prison and at the hospital, were very concerned about the impact of his refusal to eat and drink, including the risk of re-feeding syndrome developing even if he did decide to eat at some later point. On 28 September 2019 JK made an Advance Decision stating that he did not wish for any medical intervention to occur even if his life is at risk. Subject to questions as to JK's capacity to make it, there was ultimately no issue that this was a valid and applicable Advance Decision (and, he made a further advance decision in effectively the same terms dated 31 October 2019).

The medical evidence before the court was that JK had capacity to make the decision to refuse food and medical treatment (including palliative care), and also that he had capacity to conduct the proceedings.

The Health Board responsible for JK applied to court in respect of possible future treatment of JK, seeking (at the outset of the hearing):

(1) a declaration that it would be lawful for treatment to be provided pursuant to s.63 of the Mental Health Act 1983 (MHA 1983) such that JK could be force fed;

(2) in the alternative, a declaration under the inherent jurisdiction that such treatment would be lawful; and a declaration under the MCA 2005 that the advance decision made by JK could be disregarded as a result of actions by him that were inconsistent with it.

The position of the Health Board evolved during the hearing, conceding that it could not seek a declaration under the inherent jurisdiction, and also that there was not, at that point, sufficient evidence for the court to be able to tell whether force-feeding would be in JK's best interests, appropriate and lawful.

As Lieven J noted, the primary issue in the case was whether the terms of s.63 MHA 1983 were met: i.e. whether force-feeding could be considered medical treatment for mental disorder in JK's case, because, if they were, JK's consent would not be required. This further raised the interaction between the Mental Capacity Act 2005; the Mental Health Act 1983 and the High Court's inherent jurisdiction, although some of the issues have narrowed during the hearings. Lieven J identified the following issues potentially arise, "*although some have become less important, and (e) does not yet arise;*

a) Does JK have capacity to make a decision to refuse food?
b) Where the court is invited to make a declaration that a proposed course by the Health Board is medical treatment under s.63 MHA, what legal test should the Court apply?
c) Is the proposed treatment, i.e. force feeding, treatment that falls within s.63?
d) If the proposed treatment does not fall within s.63 can the court authorise the force feeding pursuant to its inherent jurisdiction? this raises two sub-issues;
i. Is there a lacuna in the statutory scheme which the inherent jurisdiction can appropriately fill?
ii. Is JK a vulnerable person within the meaning of SA (Vulnerable Adult with Capacity: Marriage) [2006] 1 FLR 867?
e) Is it appropriate on the facts to order that JK can be force fed?

Against a starting point that every citizen of age and of sound mind has the right to make decisions about their treatment, even if those decisions bring about their death, Lieven J observed that there were three circumstances in which adults can have treatment imposed upon them without their consent: *"if they lack capacity under the Mental Capacity Act 2005; if they are detained under the Mental Health Act 1983 and the treatment falls within the terms of s.63 (or s.58); or if they can be categorised as "vulnerable" under the High Court's inherent jurisdiction."*

Lieven J conducted a brief, but comprehensive, survey of the relevant provisions of the MCA 2005 and the MHA 1983 and the relevant case-law. In relation to the inherent jurisdiction, Lieven J noted that:

The Health Board originally put its application to the Court on the alternative basis of either seeking a declaration under the section 63 of the MHA, or that if the Court found there was no power to force feed under s.63 then there was such power under the inherent jurisdiction. However, by the time of the hearing on 4 November 2019 the Health Board had accepted that there was no power under the inherent jurisdiction on the facts of this case to grant a declaration that JK could be force fed. The basis for this concession was that JK was not "vulnerable" within the meaning of SA (Vulnerable Adult

with Capacity: Marriage) [2006] 1 FLR 867 and as further considered by the Court of Appeal in A Local Authority v DL [2012] 3 All ER 1064.

Lieven J considered that this concession was correct:

> *56. In my view, relying on what McFarlane LJ said at [53] in DL some caution needs to be exercised over the extent of the category set out at [78iii] of SA* [i.e. "for some other reason deprived of the capacity to make the relevant decisions, or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent"] *given that some of those matters would go directly to mental capacity under the MCA and therefore are covered by that Act. In DL the gap in the statutory scheme was that the MCA covered those who lacked mental capacity to make the decision in issue, but not those whose will had been overborn in making that decision by reason of their vulnerability, for example by coercion.*
>
> *57. The inherent jurisdiction cannot be used to simply reverse the outcome under a statutory scheme, which deals with the very situation in issue, on the basis that the court disagrees with the statutory outcome. Here the vulnerability which the Health Board originally relied upon was JK's mental disorder, namely his ASD. Despite his ASD JK undoubtedly has capacity, so he cannot be compulsorily treated under the MCA. If I had found that his decision not to eat was not a manifestation of his mental disorder, then he could not have been compulsorily treated under the MHA. In my view that would have been the end of the matter, because the two statutory schemes deal precisely with someone in JK's situation, and there is no factor such as coercion which lies outside those considerations.*
>
> *58. Therefore, either it can be said that there is no lacuna in the statutory scheme which would leave space for the inherent jurisdiction; or alternatively, as the Health Board now accept, JK is not "vulnerable" within the meaning of SA. He is not "vulnerable" because this is not a case of JK's will being overborn by some factor outside the scheme of the statutes, but rather his decision having been made in circumstances entirely contemplated by the statutes. These two analyses reach the same end result, that JK's situation either allows treatment without consent under the MHA, or not at all.*

Lieven J therefore turned to consider, first, JK's capacity. She heard from JK, and having heard him, had no reason to doubt the assessment of the consultant psychiatrist who had reported.

The next issue was the test to apply under s.63 MHA 1983. As she noted:

> *66. The MHA gives the power to decide whether to compulsorily treat a patient to the responsible clinician and not to the Court. This is a fundamentally different scheme to that in the MCA where many decisions are given by statute to the court. The difference makes sense because the MHA is a statutory scheme for, inter alia, detention and compulsory treatment in the public interest, where the responsible clinician has a specific role in the statutory scheme. There is no statutory process in the MHA to question the decision of the clinician. However, if the clinician decides to impose treatment then the individual can judicially review that decision, as happened in R v Collins ex p ISB. However, in the present case what is in issue is a proposed future treatment where the clinicians have not yet*

> *drawn up a treatment plan, and not yet weighed up the factors for and against force feeding. In A NHS Trust v A Baker J at [80] said; that in cases of uncertainty under s.63 MHA "where there is doubt whether the treatment falls within section 145 or section 63, the appropriate course is for an application to be made to the court to approve the treatment". Baker J did not explain what jurisdiction the Court would be exercising in order to make any such declaration and judicial review would not be apposite at this stage as an actual decision to treat has not yet been made. However, the inherent jurisdiction can be used to make declaratory orders, and I can see no reason why a similar principle would not apply here. I therefore will consider the making of declaratory relief.*

Following the Court of Appeal decision in *R (JB) v Haddock* [2006] EWCA Civ 961 ,Lieven J noted that:

> *68. It therefore must follow that any decision under the inherent jurisdiction both as to whether proposed treatment falls within s.63, as being for a manifestation of the mental disorder; and as to whether it is "treatment" within s.145 under the MHA, must also involve a full merits review.*

The next question was whether the proposed force feeding did indeed fall within s.63. This was a decision for the court, although it was: "*necessarily a matter on which the Court will be heavily reliant upon medical, and in particular, psychiatric evidence. The interrelationship between the patient's mental disorder and the treatment which is proposed, is in my view one primarily of medical expertise rather than legal analysis*." Lieven J therefore set out the evidence before reaching her conclusion, thus:

> *70. It is Dr L's clear view that JK's refusal to eat is a manifestation of his autism. Dr L is not only a consultant psychiatrist but also one with a particular expertise in the assessment and treatment of patients with autism. Dr L appeared to me to be a measured, highly knowledgeable and careful witness, whose evidence I can give the maximum weight to. He had met JK twice, once for quite a prolonged interview, and had clearly listened carefully to what JK had said and the information he had gathered. It is true that Dr L and the court, have relatively little information about JK's mental health before the index offence and the fact that none of the clinicians have been able to speak to JK's family limits their understanding of his presentation outwith the highly traumatic recent circumstances. However, I do not accept Mr McKendrick's submission that without such "longitudinal evidence" it is not possible to conclude that the refusal to eat is not a manifestation of JK's autism.*
>
> *71. I take in particular from Dr L's evidence that JK's rigid and "shutting down" response of saying that he has nothing to live for and refusing to eat, is a not uncommon approach from a person with autism dealing with a crisis situation. JK has been through a quite exceptionally difficult and traumatic few weeks, and it should not be forgotten that the index offence only took place two months ago. It is hardly surprising given his mental disorder perhaps exacerbated by chronic depression, that his response is suicidal. Issues around food and eating appear to have been a feature of his autism, and possibly also OCD, and a refusal to eat therefore has an obvious relationship to his mental disorder.*
>
> *72. I do accept that with a condition such as autism which is a fundamental part of JK's personality, it is exceptionally difficult to see how any decision making is not a manifestation of that disorder. I also accept that it is possible that many people faced with JK's situation would feel despair and potentially be suicidal. However, I do not think the task for me is to try to compare JK's response to his situation with that of a hypothetical person without autism. It is rather, to try to analyse the degree*

to which JK's own response relates to his condition, and the way his mind works because of that condition.

73. In my view his refusal to contemplate any alternative paths, and his rigid belief that refusing to eat is his only way forward, is a consequence of his autism and as such falls within s.63. The proposed force feeding is therefore certainly capable of being treatment for the manifestation of his mental disorder.

However, importantly, that was not the end of the matter:

74. However, that does not mean that I by any means accept that force feeding JK would be in his best interests, or critically would be "treatment" that falls within the definition in s.145(4) of the MHA, as being "to alleviate or prevent a worsening of the disorder…". It is apparent that force feeding is a highly intrusive process, which involves sedating the patient whilst the naso-gastric tube is inserted and potentially having to restrain the patient for fairly prolonged periods. This process would be extremely upsetting for any patient, but for JK with his ASD and his aversion to eating in front of other people, the process would be even more traumatic. JK said in oral evidence that he viewed the possibility as abhorrent, and it was clear from that response how incredibly upsetting for all concerned having to go through that process would be. If it came to that stage close consideration would necessarily have to be given to the terms of article 3 ECHR and the caselaw such as Herczegfalvy v Austria [1993] 15 EHRR 437 and the test of medical necessity.

Lieven J recorded that:

75. The position at the moment is that the Health Board are drawing up a detailed treatment plan and are in discussions with appropriate clinical experts. If JK reverts to refusing to eat, and the Health Board decide pursuant to s.63 that he should be force fed, then the matter will need to be restored to court. This could be done by way of a judicial review of the Health Board's decision at that stage, that force feeding is treatment which falls within s.145(4), the decision having already been made by the court that it is capable of being treatment within s.63. However, given that this is a full merits review, and Baker J said that in cases of uncertainty it was appropriate to bring the matter before the court, it seems to me that the most straightforward route is to give JK liberty to apply to bring the matter back before me sitting in the Family Division, if needed. There is no benefit, and potentially additional cost and complication, by requiring a judicial review action to be commenced.

Helpfully for future cases, Lieven J's judgment then set out the order that was made.

Comment

This case represents the paradigm example of how the law in this area is able to answer the question as to whether something "can" take place, but is not obviously well-placed to answer the question as to whether it "should." Lieven J's careful analysis of the law sets the framework within which the clinicians would have to decide whether to force feed JK (if he continued to refuse to at) by determining that force-feeding could on the facts of his case fall within the scope of s.63 MHA 1983. But the question of whether they *should* then decide to use s.63 to force feed-is one that is as much ethical as

it is legal. It is of some interest that Lieven J appeared to assume that the clinicians in making that decision (and the court if it were to return to her) would be considering JK's best interests. Section 63 does not refer to best interests, and the test in s.58 (as amended in 2007) for a Second Opinion Appointed Doctor to consider is whether the treatment is "appropriate." Pre-2007 case-law (such as *Haddock*, referred to by Lieven J) had proceeded on the basis of "best interests," but – perhaps surprisingly – there has not been a case subsequent to the passage of the MHA 2007 in which the test has been considered by the courts. "Best interests" is undoubtedly a more calibrated test than "appropriate," and the Independent Review of the MHA 1983 recommended that the test be changed to "best interests." It did, so, however, in relation to those lacking capacity to make decisions about their medical treatment, and it is not perhaps immediately obvious how the test applies to someone, such as JK, who is considered to have such capacity.

In determining what course action to take, no doubt the clinicians will also have in mind – as will the court if it returns to it – the presence of JK's advance decision, Mostyn J having emphasised in *Nottinghamshire Healthcare NHS Trust v RC* [2014] EWCOP 137 the weight to be placed on advance decisions to refuse medical treatment for disorder even when they are not formally binding because the treatment is being delivered within the framework of the MHA 1983.

Lieven J's (obiter) observations about the inherent jurisdiction are also of interest as reinforcing the need to be clear as to whether or not there is, in fact, a gap in the statutory schemes in play. They sit at possible odds to the decision of Cobb J in *CD v London Borough of Croydon* [2019] EWHC 2943 (Fam), discussed elsewhere in this report, in which he contemplated the use of the inherent jurisdiction against a person in a situation of self-neglect, refusing access to carers and others.

Safeguarding, homelessness and self-neglect

The Policy Research Unit in Health and Social Care Workforce (part of the National Institute for Health Research) has recently published a fascinating paper which identifies, in the context of cases with a homelessness element, serious failings by local authorities in relation to self-neglect. The paper is entitled "Safeguarding, homelessness and rough sleeping: An analysis of Safeguarding Adults Reviews" and is freely available here.

The report analyses the findings from 14 Safeguarding Adults Reviews (the current mechanism for "learning lessons" where there is evidence that agencies have not worked well together in discharging their responsibilities towards those who have suffered abuse or neglect). One of the report's key conclusions is that agencies failed to understand self-neglect as a potential safeguarding issue, and that the difficulties were particularly acute when there was issues of alcohol and substance dependence and/or fluctuating mental capacity.

The report also found that local authorities were failing to comply with the low threshold for a needs assessment under s.9 Care Act 2014, apparently assuming that rough sleepers had housing problems rather than potential rights to care and support – including accommodation – under the Care Act.

Relying on your own incapacity

Fox v Wiggins & Anor [2019] EWHC 2713 (QB) High Court (QBD (Julian Knowles J))

Practice and procedure – other

Summary

In this case, Julian Knowles J had to consider what to do in civil proceedings when a party's capacity to conduct the proceedings is put in issue by the person themselves. The person in question was the Sixth Defendant in a libel action brought against her and a number of other former partners of a musician. She and her 'co-conspirators' were accused of making serious defamatory allegations about the Claimant and his violent conduct online. While all of the other Defendants filed defences to the Claimant's claim, the Sixth Defendant, despite engaging in the litigation to the extent of requesting extensions of time, failed to do so. As a result, judgment in default was entered against her.

The Sixth Defendant, in an application supported by her mother, sought a declaration that she lacked capacity within the meaning of CPR r 21.2(2)(c) as a result of Crohn's disease, depression, anxiety and post-traumatic stress disorder. She also sought an order setting aside the default judgment and granting relief from sanctions. Considering both the application of CPR Part 21 and s.3(1) MCA 2005 and the guidance set down by Baker J (as he then was) in *A Local Authority v P* [2018] EWCOP 10, and HHJ Hilder in *London Borough of Hackney v SJF and JJF* [2019] EWCOP 8, Julian Knowles J analysed whether the Sixth Defendant had adduced sufficient evidence to overcome the presumption of capacity as set out in s.1(2) MCA 2005.

Disregarding submissions that evidence from the Sixth Defendant's treating psychiatrist should be rejected on the grounds that it failed to meet the requirements of CPR Part 35, Julian Knowles J nonetheless did not consider the Sixth Defendant's psychiatric evidence sufficient to set aside the presumption of capacity. Nor was he convinced by evidence from the Sixth Defendant's mother as to her daughter's lack of capacity on which he held at paragraph 81:

> *Her evidence does not establish that her daughter is never able to give instructions. It merely suggests that there are times when her daughter becomes very emotional and finds it hard to communicate with her. Again, there is no discussion of what other steps have been, or could be, taken in order to assist her daughter.* ***To find that an adult lacks capacity is a significant step with far reaching consequences. For example, it deprives her of civil rights, in particular her right to sue or defend in her own name, and her right to compromise litigation without the approval of the court****. These are important rights, long cherished by English law and safeguarded by the European Convention on Human Rights: Masterman-Lister, supra, [17]; In re Cumming (1852) 1 De GM & G 537, 557. Such a decision should therefore only be taken on the basis of cogent evidence. I find that cogency is lacking here. The evidence is sparse.* (emphasis added)

Furthermore, Julian Knowles J considered evidence such as the Sixth Defendant's social media presence on the extent to which she was unable to engage with life as alleged. He held at paragraph 84 that:

> *Having regard to the evidence that is before me, I am not satisfied that the Sixth Defendant has discharged the burden on her to show on the balance of probabilities that she currently lacks capacity, or did so between 4 May 2018 and now. I accept that she has a number of physical and mental ailments. I accept that being confronted with this litigation is stressful for her. However, at a minimum, I would have expected that Dr Inspector would have had a full consultation with the Sixth Defendant and considered the litigation with her, and then reported properly, fully and completely on his findings as to her ability to conduct litigation with reference to the tests for capacity under the MCA 2005 and the principles to which I have referred. He did not do that, but merely provided a brief opinion based upon what appears to have been a short discussion with his patient. Given the time which has passed since May 2018 (at the latest) when this issue first emerged I would also have expected expert evidence about the Sixth Defendant's mental state. There is none. I agree with the Claimant's submission that I am prevented from carrying out any detailed analysis of the evidence with regard to the tests under the MCA 2005, because there is no evidence to analyse other than Dr Inspector's bare assertions and* [the Sixth Defendant's mother's] *generalised evidence.*

His finding of capacity and that she had no realistic prospect of successfully defending the claim notwithstanding, Julian Knowles J did grant the application to set aside judgment, noting that the Sixth Defendant did indeed suffer from serious medical issues and was without legal representation at the time at which judgment in default was entered.

Comment

It is very unusual for a person, themselves, to assert that they lack capacity to conduct proceedings, as this is more often put in issue either by another party or the court (sometimes at the instigation of their legal representative). Ms Dunhill did so, retrospectively, and the Supreme Court held that her (at the time unrecognised) lack of litigation capacity rendered subsequent steps in the proceedings void. It was to Ms Dunhill's benefit in that case for the settlement she had entered into to be set aside; similarly, it would have been to the Sixth Defendant's benefit, even if only temporarily, to have a finding made of incapacity so as to render steps taken against her – including the grant of default judgment – set aside.

It is quite understandable, therefore, that Julian Knowles J proceeded on the basis that the Sixth Defendant had, in essence, to prove her own incapacity, and that the Claimant's representatives sought to challenge that assertion on an adversarial basis. It is perhaps important to emphasise, however, that any court considering litigation capacity is, in fact, conducting an inquisitorial exercise, because it is for the court to be satisfied whether or not a party before it has capacity to conduct the proceedings. As Rimer J put it in *Carmarthenshire CC* v *Lewis* [2010] EWCA Civ 1567: "*once the court is possessed of information raising a question as to the capacity of a litigant to conduct the litigation, it should satisfy itself as to whether the litigant does in fact have sufficient capacity*." For further discussion of the issues, see

also *Z v Kent County Council (Revocation of placement order - Failure to assess Mother's capacity and Grandparents)* [2018] EWFC B65.

Comparative capacity

In other news, the Family Law in Europe Academic Network have chosen as its first working field the Empowerment and Protection of Vulnerable Adults. Written by leaders across the 28 European Nations, it provides really helpful summaries of the capacity and protective measures in place to enable a rich comparative analysis of the differing European approaches to CRPD compliance. Well worth a read for those wishing to broaden their European capacity law horizons.

SCOTLAND

The Mental Welfare Commission for Scotland publications

The Mental Welfare Commission for Scotland has recently published the following good practice guides and reports.

Capacity, consent and compulsion for young people with borderline personality disorder: Good Practice Guide

This very detailed guidance covers the complex issue of treating young persons (defined as someone under 18 years of age) with borderline personality disorder. It also provides guidance for children (defined as a person aged under 16) and their parents with borderline personality disorder. Specifically aimed at professionals it does state that it might additionally be useful for patients, and their relatives and carers.

'Personality disorder' falls within the statutory definition of 'mental disorder' in Scotland allowing non-consensual interventions under the Mental Health (Care and Treatment) (Scotland) Act 2003 and Adults with Incapacity (Scotland) Act 2000. The guidance notes that it is rarely recorded as the only reason for compulsion but that when it does occur then it tends to be in relation to short term detention as opposed to longer term Compulsory Treatment Orders or guardianship.

The guidance's focus is on decision-making capacity and consent, and how these can be assessed and supported. Although there is not much detailed discussion of the underpinning human rights requirements for the recommended approaches there is clear evidence that cognisance is taken of relevant ECHR and CRPD standards and applied within the existing legislative framework and principles. Some useful illustrative case studies are also provided.

Use of Seclusion: Good Practice

This is an updated version of the Commission's previous guidance on the use of seclusion for persons with 'mental disorder' (as defined by the Mental Health (Care and Treatment) (Scotland) Act 2003). Its purpose is to provide guidance for the use of seclusion in accordance with safeguarding individual rights, welfare and safety. It points out that seclusion can be physical or psychological and can occur in both hospital and community settings. The guide is not, however, intended to cover seclusion in prisons, young offenders' institutions, other custodial care settings or schools.

Importantly, the guidance makes it clear from the start that seclusion should not be used as a first line response to aggressive and/or violent behaviour or as a therapeutic intervention but only exceptionally circumstances to manage extremely difficult behaviour. In keeping with Scotland's mental health and incapacity legislative and human rights principles it points out the need to look for alternative ways of addressing such behaviour and that 'Failure to do this has the potential to lead to inhuman and degrading treatment of some of the most vulnerable people in our society.' and amount to human

rights violations.[3] Again, as with the *Capacity, consent and compulsion for young people with borderline personality disorder* guidance some illustrative case studies are provided.

Mental Health Act Monitoring Report 2018-19

On 23rd October 2019, the Commission published its annual monitoring statistics for the Mental Health (Care and Treatment) (Scotland) Act 2003 for 2018/2019. A broader range of figures, and comparisons over the last ten years is also included. Obviously, amongst other information and evidence, the Scott Review will be considering these findings.

The findings must be read in context so please do look to the report itself for more detail but essentially numbers of instances of all forms of civil compulsion (Emergency Detention Certificates (EDCs), Short Term Detention Certificates (STDCs) and Compulsory Treatment Orders, hospital or community based) are up, and are the highest they have been since the 2003 Act was implemented. Continuing episodes of detention over the past ten years have also increased (increasing by 25.6% from 2,840 in January 2010 to 3,567 in January 2019).

Rates of emergency detention (including those granted with Mental Health Officer (MHO) consent) vary across the health boards in Scotland and the numbers of young persons detained under EDCs and STDCs have increased. Significantly, and worryingly, the greatest increase in rate of EDCs per 100,000 population in the past year has been young men aged 16-17 and both young men and women aged 16-17 have shown the greatest increase in emergency detentions across the observed ten year period. In addition, STDCs have risen by 122% for women under the age of 25 since 2009/10.

The Commission highlights that there is a gap in the completeness of data relating to ethnic minorities subject to the 2003 Act in Scotland. Reflecting the decreasing numbers of MHOS in Scotland but their important role local authorities are also reminded of their statutory duties to designate MHOs for each patient's case[4] and to appoint sufficient MHOs to discharge statutory functions.[5]

In the criminal justice sphere, however, numbers of persons with a mental disorder who are accused or convicted of a criminal offence and who are placed on a Criminal Procedure (Scotland) Act 1995 order requiring them to be treated in hospital or in the community remain similar across the last ten years. Additionally, the work of Police Scotland with others has resulted in the use of police stations as a place of safety falling to one of its lowest levels (3% of use of place of safety rather than 18% in 2011/12).

Autism and complex care needs

This themed visit report looking at support for people with autism was published on 30th October 2019. Essentially, the message is that more appropriate and tailored support is required in terms of care and

[3] pp 6 and 20.
[4] s229 2003 Act.
[5] S32 2003 Act.

treatment. Clearly, the timing of this report is very pertinent given that the Independent Review on Learning Disability and Autism in the Mental Health Act is due to report later this year.

The Commission met 54 people with autism[6] living in hospital or in the community across Scotland as well as speaking with medical and care staff and with family members and carers. The visits resulted from a recognition of the particular complex needs of people with autism which are not always being met in settings designed for people with other conditions. In general terms, it was found that there is a wide variation in how services are currently able to meet the needs of persons with autism.

It was found that whilst appropriate environments tended to be provided for those living in the community and thought had been given in hospital as to how to make changes to accommodate particular needs of persons with autism this was not always possible. It also found that a wide variation in assessment and post-diagnostic support exists across Scotland and a dual diagnosis can be seen as a barrier to proper assessment of autism. Moreover, a large proportion (45) of the 54 persons with autism who were spoken with were prescribed psychotropic medication on a regular basis (40 of whom were being prescribed regular antipsychotic medication). Delays in hospital discharge owing to lack of availability of suitable accommodation was also noted and affected significant numbers (13) of the 28 persons with autism who were hospital. The impact of diagnosis and care, and lack of support, on families is also noted.

The report concludes that providing appropriate support through designing services to properly address the complex needs of persons with autism requires time, expertise and resourcing. However, failure to take this action could not only prove to be even more expensive but fails the individuals concerned.

Jill Stavert

[6] Aged between 18 and 65 years old, who were either (a) inpatients in NHS Adult Acute, PICU or Learning Disability inpatient wards and units; (b) subject to a formal civil order under the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA) or Adults with Incapacity (Scotland) Act 2000 (AWIA): or (c) in specialist autism services.

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Conferences

Conferences at which editors/contributors are speaking

Mental Capacity Law Update

Neil is speaking along with Adam Fullwood at a joint seminar with Weightmans in Manchester on 18 November covering topics such as the Liberty Protection Safeguards, the inherent jurisdiction, and sexual relations. For more 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 – our 100th – will be out in November. 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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