



Welcome to the September 2017 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: alcohol and best interests, the price for failing to support, patient choice from the other side of capacity, and Bournemouth brought to life;

(2) In the Property and Affairs Report: Denzil Lush and LPAs, the Law Commission consultation on wills, professional deputies run amok and OPG updates;

(2) In the Practice and Procedure Report: s.21A, medical treatment and the role of the courts, the extension of the pilots, and guidance on CoP visitors;

(3) In the Wider Context Report: mental capacity in (in)action in SARs, litigation friends in tribunals, legal services and vulnerability, and the Committee on the Rights of Persons scrutinises the UK;

(4) In the Scotland Report: a Scottish perspective on powers of attorney problems and attorney registration updates.

You can find all our past issues, our case summaries, and more on our dedicated sub-site [here](#), and our one-pagers of key cases on the SCIE [website](#).

We also take this opportunity to say goodbye to our fellow editor Anna Bicarregui and thank for all her dedication in producing contributions against the odds – we will miss you.

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

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HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

When is one drink too many?

DM v Y City Council [2017] EWCOP 13 (Bodey J)

Article 5 ECHR – deprivation of liberty

Summary

Mr DM was a 69 year old man who had a long history of alcoholism and a longstanding diagnosis of Korsakoff's syndrome. He neglected himself to a significant degree necessitating admission to hospital and was discharged to a 'dry' care home, apparently with his agreement. By the time of the proceedings he had been residing in a care home for 5 years without access to alcohol. For the previous 2 years he had been subject to 24 hour one-to-one supervision and was not allowed to access the community when he chose, after an incident when he purchased alcohol. DM had no relatives and was reported to have only one friend, another resident of the care home. DM wished to leave the care home and to consume alcohol and brought proceedings challenging his deprivation of liberty under s.21A MCA 2005.

Bodey J decided that it was not in DM's best interests to move to another care home where the consumption of alcohol was permitted, despite this being DM's expressed wish and his acceptance of the risk that it would shorten his life, noting that '*everybody has to die sometime*'. There was medical evidence that if DM resumed drinking he would become very unwell, as he had advanced liver disease, and had a life expectancy of about 7 years if not drinking and 3 years if drinking even a relatively modest amount. DM had no recollection of the events that had led to his admission to the care home.

The court's decision was described as 'finely balanced' and the judge admitted that on first reading the papers his view was that DM should be allowed to move to a care home where he could consume alcohol. In the end, the judge concluded that DM should remain in the care home for a number of reasons:

- a. It was not clear that DM would be happy in a new care home as his alcohol consumption would not be unlimited, and he would suffer a faster decline in his mental and physical health.
- b. Even though DM had a compulsive wish to drink, when he had been taken to visit the alternative care home, he said that he didn't know if he wanted to move there and would need to live there for a month or so before deciding. This suggested his wish for drink was not as strong as might have been thought.
- c. DM would lose his only friendship if he moved and it was far from certain that if DM changed his mind, he could return to the same placement.

The judge also concluded there was therefore no benefit in a trial period in an alternative home as this would just give DM a renewed taste for alcohol and it would be cruel to expect him to revert to a dry environment if the trial failed.

Bodey J concluded his judgment by noting that DM would not welcome the decision and saying that the transcript of his decision should be made available so that it could be considered in the event that DM brought a further s21A challenge because his continued residence at the care home was causing him real ongoing frustration and unhappiness.

Comment

This decision is an example of a relatively common scenario that arises in the Court of Protection in respect of people with long histories of alcohol misuse. It is perhaps unsurprising that the judge did not consider DM's wishes determinative given the evidence of serious harm to his mental health, as well as his physical health, if he resumed drinking, meaning that the assertion that acceding to DM's wishes would make him happy was too simplistic.

Whatever one's views of this decision, comparison of the reasoning in this case with that of the Court of Appeal in the *RB* case demonstrates just how far we have come since 2014 as regards engagement with the principle that constructing a best interests decision starts with the individual.

Paying the price for a failure to support

CH v A Metropolitan Council [2017] EWCOP 12 (Sir Mark Hedley)

Article 8 ECHR – contact – mental capacity – sexual relations – COP jurisdiction and powers – damages

Summary

CH was born with Downs Syndrome and an associated learning difficulty. In 2010, he married his wife, WH, and they lived together in his parents' home. They sought fertility treatment, during which a consultant psychologist concluded in late 2014 that CH lacked capacity to consent to sexual relations. On 27 March 2015, the couple were informed of the capacity assessment and WH was advised that she must abstain from sexual intercourse with her husband as that would, given his incapacity to consent, comprise a serious sexual offence under sections 30-31 of the Sexual Offences Act 2003. She was also given to understand by the local authority that should she fail to comply, safeguarding measures would be taken which would require the removal of CH (or herself) from their home. His wife moved into a separate bedroom and significantly reduced any expression of affection so as not "to lead him on". CH could not understand why she did that and, as Sir Mark Hedley noted, "[t]he impact of all this on CH is not difficult to imagine."

Importantly, the consultant psychologist had made clear that CH needed a course of sex education to assist him to achieve the necessary capacity. As Sir Mark noted “[t]hat advice was of course in line with the principle set out in Section 1(3) of the Mental Capacity Act 2005 (MCA 2005) which provides – “A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.” However, “[f]or reasons that have never been satisfactorily explained, the Local Authority failed to implement that advice despite requests and protracted correspondence.” In the end, it required proceedings initiated by CH’s sister in February 2016 to bring about both that education and, in due course, a determination that CH had the requisite capacity.

A court order implemented the original psychological advice and the education course finally began on 27 June 2016. The therapist reported that CH had made sufficient progress in all areas but did not understand the health risks from a sexually transmitted disease. However, given that CH and WH were in a committed monogamous and exclusive relationship, he questioned whether that was ‘relevant information’. The court-appointed expert psychiatrist advised that further sex education would be necessary and the same therapist delivered this in early 2017, as a result of which CH now had capacity to consent to sexual relations. The court made a declaration to that effect on 2 May 2017, after which the couple were entitled to and did resume a normal conjugal relationship.

A claim was then brought under the Human Rights Act 1998 on the basis that the local authority breached CH’s rights under Article 8 ECHR. And the court was invited to approve the claim on behalf of CH. As Sir Mark Hedley noted:

12. However, Article 8 is a qualified right and it is important to note where it is alleged the breaches occurred. There can be no criticism of the fact that there was an assessment in late 2014. Given the outcome, the letter of the 27th March 2015 was inevitable having regard to the provisions of the criminal law. The sex education was a response wholly consistent with Section 1(3) of the MCA 2005. Whilst there may have been legitimate debate about the necessity for the second course [of sex education, at the suggestion of the jointly instructed expert] in early 2017, it would not be actionable given the advice tendered to the court and the court’s acceptance of it. It follows that some incursions on the conjugal relations of CH and WH would have been justifiable by Article 8(2).

13. The gravamen of the claim is the delay in implementing the advised programme of education: that is to say the period between 27th March 2015, when conjugal relations were required to cease, (although the lack of capacity had been established in January 2015) and the start of the first sexual education programme on 27th June 2016. Given that the Local Authority would have needed some time to set up the programme, the actionable delay over all is one of not less than 12 months. The Local Authority has not sought to contest that conclusion nor that they are apparently in breach of Section 6(1) of the HRA 1998.”

Sir Mark Hedley made the important observation (rather lost in the press coverage) that:

15. Before turning to the proposed settlement itself one further observation may be ventured. This case is unusual; indeed thus far it may be unique in being applied to a settled, monogamous and exclusive married relationship. In those rare cases where the courts have made declarations of

incapacity to consent to sexual relations, they have generally been cases of restraining sexual disinhibition to protect from abuse or the serious likelihood of abuse. However, logically the question of capacity must apply also to married relations and the criminal law makes no distinction between settled relations and sexual disinhibition or indeed between sexual relations within or outside marriage. Society's entirely proper concern to protect those who are particularly vulnerable may lead to surprising, perhaps even unforeseen consequences. Such, however, may be the price of protection for all."

CH's wife had already brought her own claim for a violation of Article 8 ECHR which had been settled on confidential terms. But for CH, the local authority made the following offer to settle the claim:

1. to make a formal apology to CH for the delay from January 2015 to June 2016 in providing him with the sex education to which he was entitled;
2. to pay to CH damages in the sum of £10,000 as a result of that delay;
3. to pay CH's pre-action costs associated with this claim in the sum of £7,395 (inclusive of VAT);
4. to pay CH's costs of the Part 8 application and seeking the approval of the court for this settlement (in respect of which outline agreement has been reached).

The local authority had also agreed to pay CH's costs of the Court of Protection proceedings agreed at £21,600 (inclusive of VAT). This ensured that the damages would not need to be recouped by the Legal Aid Agency under s.25 of the Legal Aid, Sentencing and Punishment of Offenders Act 2012.

The court approved the terms of the settlement as being in CH's best interests and reflecting a fair outcome to the proceedings. Sir Mark Hedley emphasised, however, that "[m]any would think that no couple should have had to undergo this highly intrusive move upon their personal privacy yet such move was in its essentials entirely lawful and properly motivated. As I have said, perhaps it is part of the inevitable price that must be paid to have a regime of effective safeguarding" (para 25).

Comment

This important decision raises a substantive issue relating to the capacity to consent to sexual relations. In particular, whether the risk of sexually transmitted diseases is relevant information where the individuals are in a committed monogamous and exclusive relationship. Compared to those situations where sexual disinhibition puts P at serious risk of abuse, the sexual health risks must be negligible.

The case also provides a useful opportunity to reflect upon whether capacity to consent to sexual relations ought to be "on a general and non-specific basis" (*IM v LM and others* [2014] EWCA Civ 37, at [77]) or whether a more sensitive person-specific approach ought to be adopted. After all, sex is a form of contact and capacity to consent to contact is person-specific (see '[The opacity of sexual capacity](#)' (2012) 2 Elder Law Journal 352). In our view, it would be entirely logical, for example, for CH to have

capacity to consent to sexual relations with his wife whilst lacking capacity to consent to sexual relations to others as the nature and degree of risks are different.

It is interesting that English law seems comfortable making best interests decisions that P has contact with Y but prohibits in MCA s.27 a decision that it is in P's best interests to have sexual relations with Y. The logic appears to be that such a decision would be too personal to make on behalf of P. But why? Is it not just as personal *not* to make such a decision? To have to do what CH's wife did in this case so as not "to lead him on"? Could it be argued that the absolute prohibitive nature of MCA s.27 is in fact contrary to Article 8 (and potentially 12) ECHR? The warning letter from the local authority in this case also vividly illustrates the stark interface between sexual incapacity and the criminal law. Whether the blanket prohibition in the Sexual Offences Act 2003 is necessarily the appropriate response has also been called into question (for example, see Bartlett, 'Sex, Dementia, Capacity and Care Homes' (2010) 21(2) Liverpool Law Review 137).

We note, finally, that something may have gone awry procedurally (at least as it is reported). Sir Mark Hedley noted that, pursuant to the decision in *Luton v SW* [2017] EWHC 450 (Fam), the claim had to be brought under the Civil Procedure Rules as a Part 8 claim. To comply with *H v Northamptonshire CC* [2017] EWHC 282 (Fam) at [117], a letter before action was sent on CH's behalf. Sir Mark Hedley then noted that the court's approval to the proposed settlement was required under CPR rule 21.10.

The difficulty with the course of action set out above is that it seems to have conflated two things: (1) the fact that a separate claim for HRA damages should have been brought, something which now appears to be the right course of action in almost all cases (not least to avoid problems with the LAA statutory charge); and (2) the location for such a claim. A CoP judge, as CoP judge, has no ability to hear a Part 8 CPR claim. Either the CoP judge should be hearing and determining a claim brought within the CoP under the CoP Rules (and Practice Direction 11A), or they should be sitting as a judge endorsing a settlement within civil proceedings.

All life is an experiment – patient choice from the other side of capacity

B v D [2017] EWCOP 15 (Baker J)

Best interests – medical treatment

Summary

In this fascinating case, Baker J had to consider whether it was in the best interests of a soldier, D, to travel to Serbia to receive stem cell treatment for a traumatic brain injury he had suffered at the hands of a fellow soldier. This proposal was advanced by his mother – who brought the proceedings herself, and acted in person – and who Baker J noted was "*utterly devoted to ensuring that he receive[d] the best possible care and support.*" As D had resources to pay for the treatment from a compensation payment, the question for the court was whether it was in his best interests (i.e. this was not a case where the

options open to him were constrained by public funding, notwithstanding the fact that the Ministry of Defence remained responsible for his overall care and treatment).

It was clear that D did not have the capacity to make the decision. His mother served with her application evidence from D's treating neuropsychologist to the effect that, as a result of the impairment to his brain, D lacked the capacity to make decisions concerning his medical treatment:

[...] In particular, he lacked the capacity to understand, use and weigh the relevant information. The neuropsychologist expressed the opinion that, due to his cognitive difficulties, D was not able to understand more complex information. He was able to say that the stem cells will make him "normal" but was not able to follow the description or the rationale of how they work. Furthermore, as a result of his difficulties, he was unable to use or weigh up the options as part of the decision-making process. His rigid thinking patterns made it impossible for him to think flexibly about the pros and cons of the treatment. The neuropsychologist added that D was assessed as being vulnerable to being suggestible to others. He said that his mother thinks the treatment will make him "normal" and therefore he will do it."

D very much wanted the treatment. As Baker J relayed his conversation with him:

"D told me that he wished to have the stem cell treatment and that it would work for him. He said the reason why he wanted to have the treatment was that he wanted to be a normal person and thought the treatment would help. I asked whether he was ok about flying to another country for the treatment and he said yes. I asked whether he understood that there was no guarantee that the treatment would work and he replied that it would work for him. I asked whether he was happy to take the risk that it would not work and he replied "I am". When I asked D how he was getting on at Y Hospital and whether it was better than where he had been before, he replied "no". When I asked whether he was making progress there, he replied "not at all". When I asked what else he would like to say to me about the treatment, he repeated: "I just want to be normal". Mrs B then spoke, thanking him for coming to the phone and telling her his wishes. She said that she would call him later. D replied "I want stem cell mum, I want to leave here and don't want..." It was not possible to discern precisely what D said at that point, but Mrs B summarised what she understood D had said he wanted, namely that he said that he wanted the treatment because he thinks his speech will improve and the tightness on his left side will improve. At that point, we said goodbye to D."

The evidence before the court included, importantly, evidence from the chief doctor of the clinic in Belgrade, Dr Bulboh, and evidence from an Italian expert, Professor Martino, who was opposed to the treatment.

The proposal was opposed by both the Ministry of Defence and the Official Solicitor as his litigation friend, for slightly different reasons. A balance sheet for and against having the treatment was drawn up by Baker J combining the balance sheets produced by their respective Counsel. As he noted (at

paragraph 55) this set out "an aide memoire of the key factors and how they match up against each other and as a route to judgment rather than a substitution for the judgment itself," and is reproduced below.

Having the stem cell treatment

Advantages	Disadvantages
It accords with D's consistent and strongly-held wishes and feelings	The efficacy of this treatment has not been established through any clinical trials. According to Prof Martino, Swiss Medica does not adhere to the international regulations that should be followed in these matters
It accords with the views of his mother	D will be exposed to known risks (allergic reaction, developing a tumour, risks associated with the procedure e.g. lumbar puncture and use of a catheter) and also to unknown risks which cannot be excluded because of the absence of clinical trials or research.
Any adverse psychological reaction to being prevented from having the treatment is avoided. Regardless of treatment outcome there may be psychological benefit to D arising from (1) his having his wishes respected and (2) knowing that what he sees as a potential treatment avenue has at least been tried.	Travelling to Serbia to undergo the treatment risks disrupting his rehabilitation programme and the ongoing physical and psychological work.
There is a potential for improvement, although the evidence for this is only the anecdotal evidence of Dr. Bulboh unsupported by any research or by the opinion of Prof Martino.	He has made substantial progress through rehabilitation and is anticipated, at some point, to move on to a community step-down placement. If he develops a serious illness as a result of the treatment, his future prospects would be considerably worse.
	D may have an adverse psychological reaction when he does not see any benefit from the treatment
	The treatment is expensive. He will be spending the money he received from his compensation award on an ineffective treatment when he could otherwise spend the money on care/therapies /treatment or on other things he would like to do to enhance his life

Not having the treatment

Advantages	Disadvantages
He does not undergo a treatment which has no scientifically proven benefit	The decision does not accord with D's wishes
D is not exposed to known and unknown risks	There is a risk that D will have an adverse psychological reaction when told that he will not undergo the treatment
The progress he has made through rehabilitation is not put at risk	The decision does not accord with the wishes of his mother
He does not spend a substantial amount of his compensation monies on a treatment which may be ineffective.	He loses the opportunity of a possible improvement which the treatment might achieve.

Having directed himself earlier as to the approach to best interests by reference to the *Aintree* approach, Baker J then analysed precisely how this mapped onto the facts of the case directly before him. As he noted:

56. The key factor amongst the advantages of allowing D to undergo stem cell treatment, and the disadvantages of refusing, is that it accords with D's wishes. I accept that D has a significantly limited understanding of what the treatment entails and of the prospect of success and of the possible risks. But I am satisfied that he wants the treatment and that he wants it very much. I agree with the observation of Peter Jackson J in the Wye Valley case quoted above that

"once incapacity is established so that a best interests decision must be made, there is no theoretical limit to the weight or lack of weight that should be given to the person's wishes and feelings, beliefs and values. In some cases, the conclusion will be that little weight or no weight can be given in others, very significant weight will be due."

*Wishes and feelings of an incapacitated adult are an important factor in any best interests analysis. As Ms Dolan recognised, the fact that D, although lacking capacity, is in cognitive terms relatively high-functioning does not by itself mean that his wishes and feelings carry greater weight. But it may make it easier to discern and understand what those wishes and feelings are – easier, adopting the words used by Baroness Hale in the *Aintree* case, to "see things from the patient's point of view". In this case, I am very clear that D has a very strong wish to undergo stem cell treatment.*

57. I also find, as Ms Dolan, I think, accepts, that the views D is expressing are his own views. I do think that B has some influence over her son, but from his own statements, in particular his statements to me, I am very confident that the wishes he is expressing are genuinely his own. The Official Solicitor and the MOD have both relied on D's statement that he wants the treatment so that he can be "normal" as evidence of his lack of understanding of the treatment and its prospects of

success. But I see this statement more as an expression of the strength of his wish to have the treatment. He may be over-optimistic as to the extent to which the treatment may improve his condition, but I find he is aware that it may not work at all. As he said to his mother – “Mum, if I don't try, I'll never know”

However, as Baker J noted:

58. The key factors on the other side of the argument – the disadvantages of allowing treatment and the advantages of refusing it – are that it is unsupported by any or at least any significant body of research, that it has not been subjected to clinical trials, and that the evidence that it is, or might be, an effective treatment for traumatic brain injury is almost entirely anecdotal. [...]

Having outlined the key medical evidence, Baker J noted that Dr Bulboh accepted that his treatment was experimental – but that:

60. But all life is an experiment. In my thinking about this case, I have repeatedly come back to those words of Munby J in Re MM, and to the rest of the passage, in particular:

“Physical health and safety can sometimes be bought at too high a price in happiness and emotional welfare. The emphasis must be on sensible risk appraisal, not striving to avoid all risk, whatever the price, but instead seeking a proper balance and being willing to tolerate manageable or acceptable risks as the price appropriately to be paid in order to achieve some other good – in particular to achieve the vital good of the elderly or vulnerable person's happiness. What good is it making someone safer if it merely makes them miserable?”

In this case, I think it almost certain that D will be much more than miserable if he is denied the opportunity to have stem cell treatment. I do not accept that his reaction will be confined to mere “disappointment”. It is highly likely that he will demonstrate an adverse reaction in his behaviour which may significantly impede and delay his rehabilitation. In saying that, I do not deny the possibility that D may also be distressed, and suffer an adverse reaction, if the treatment does not go well, or if he suffers side-effects or contracts an illness as a result of the treatment. But, as Peter Jackson J observed in the Wye Valley case, as cited above, “for people with disabilities, the removal of such freedom of action as they have to control their own lives may be experienced as an even greater affront than it would be by others who are more fortunate.” Thus, as identified in the balance sheet above, regardless of treatment outcome there may be psychological benefit to D arising from his having his wishes respected and knowing that what he sees as a potential treatment avenue has at least been tried. As Baroness Hale emphasised in the Aintree case, decision-makers must look at the patient's welfare in the widest sense, not just medical but social and psychological. If D is denied the opportunity to have stem cell treatment on the grounds that this is the safer option, there is in my judgment a strong argument that his safety may be bought at too high a price in terms of his happiness and emotional welfare.

61. I have not found this an easy decision but, having appraised the risks and considered the advantages and disadvantages of the options in this case, I have ultimately reached the clear conclusion that this court should give its provisional consent to D travelling to Belgrade to receive

stem cell treatment [subject to a stringent series of conditions that would have to be met before he could give final approval.]

Comment

This case shows – again – the *Aintree* effect. D was, of course, ‘lucky’ that he had his own resources so that the decision that Baker J had to construct on his behalf was not one constrained by the willingness of statutory bodies (here the MOD) to fund particular options. But the willingness of Baker J to take a calculated risk on the part of D is striking.

For those who want to think more about this decision sits with the CRPD, see Alex’s post [here](#).

DOLS – where now?

Readers may have seen an article in [Community Care](#) in the summer suggesting that the Government is considering introducing interim measures pending a full-scale replacement of DOLS. These are said to include relaxing the statutory timescales for DoLS applications and the criteria for DoLS assessors, including BIAs and mental health assessors. We understand that Government officials have met with a number of DoLS leads and best interests assessors to discuss a limited number of potential measures. But no final decision has been taken. We also understand that – contrary to the suggestion in the story – there has been no decision to put implementation or consideration of the Law Commission’s proposals on hold until at least 2019 because of Brexit-induced lack of space in the Government’s legislative programme. We await the new Government’s formal response to the Law Commission’s proposals which should shed more light on the path ahead.

Clinical Trials Regulations

For aficionados of ss.30-34 MCA 2005 and the provisions there relating to mental capacity and research, you will wish to be aware that the European Medicines Agency recently [confirmed](#) that the EU Clinical Trials Regulations (which will affect the governing framework within which many of the research investigations covered by the sections) will not now be coming into force into May 2019 at the earliest. Quite how this will then play out domestically in light of Brexit is another matter...

The legacies of Bournemouth and Mr C

BBC Radio 4’s test case series have recently dramatised [HL](#)’s detention in Bournemouth hospital and re-broadcasted [Mr C](#)’s gangrenous leg case, each providing a drama of the events followed by commentary on the legacy of the rulings. Compulsory listening, they provide the missing human side to even the most humanised of legal judgments. We learn that HL now has the confidence that he is understood but, still 20 years after his experience, retains an inherent distrust of strangers that look official. Now in his 60s and found not to be deprived of his liberty at home, HL is a “*chilled out fellow*” and goes out with Mr and Mrs E when he wants to. For Mr C, after the court decided that he had

capacity to weigh up the risks of death from not having the amputation, he told his solicitor he wanted to leave all his money to himself when he died. Er...

With great sadness...

We report the untimely passing of Paul O'Donnell, Professional Advisor for mental health and capacity law across both health and social care in Cumbria. Over many years, Paul inspired countless trainee best interests assessors and AMHPs with his resolute commitment to a human rights based approach to practice. Born in London, where he worked for the BBC, Paul moved to Cumbria pursuing a career in the Probation Service before qualifying as an approved social worker. He was instrumental in the developing BIA and AMHP courses at the University of Cumbria, with his keen analytical mind dedicated to improving the standards of mental health social work. But he also had a significant interest in philosophy, gift for language and a sharp ear for pomposity. His greatest joy was the imparting of knowledge to others and his greatest forte was to translate the spirit of the legislation into professional practice.

Paul was open, honest, a man of great integrity and true gent. He was not afraid to tell you what you did not want to hear and would not tolerate continued ignorance once told. But that was the measure of the man: an incredible ability to see through the fog of a dispute and lead others in the direction that was right for the person at the heart of it. For example, in one of his reported cases, after receiving the judgment his first reaction was, *"This is the best outcome for George; see I knew we were right!"*. Indeed, his love of the law and all things human rights, and passion he instilled in others, will be deeply missed... Our Cumbrian sounding board has gone... He went far too soon.

For those able to come, Paul's funeral is taking place on 14 September 2017 at 1.40pm at the crematorium on Dalston Road, Carlisle, followed by the repass from 2.30pm at the Blue Bell Inn, 6 The Square, Dalston, Carlisle CA5 7PJ.

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PROPERTY AND AFFAIRS

Denzil Lush and LPAs

On 15 August, the BBC interviewed Denzil Lush (former long standing Senior Judge at the Court of Protection) on the Today programme. The subject of the interview was Denzil Lush's views concerning LPAs that he had expressed in the foreword to the new edition of Cretney and Lush on Lasting and Enduring Powers of Attorney. The BBC followed this up with an article on its website.

Denzil Lush pulled no punches, describing LPAs as risky and saying that he would not use one himself because of the lack of safeguards (as opposed to the close supervision provided to deputies).

The interview and article provoked much media and interested party comment. One such was that by Tor with contributions from Heledd Wyn and Barbara Rich published by the Transparency Project.

The OPG has not commented directly but in its blog on 23 August continued to press the virtues of LPAs

The main thrust of Denzil Lush's criticism was in respect of property and affairs LPAs and the ease with which they can be abused. Very different considerations arise in respect of welfare LPAs.

So far as the former are concerned, lay clients when they seek advice about what they fear may be financial abuse by an attorney are often surprised by the limited powers available to the OPG and the Court of Protection. In particular, they are often surprised to learn that the Court of Protection has no power to order a delinquent attorney to make good any losses to P's estate.

Some tightening up in this area might be in order without impinging on the principle of autonomy or creating unnecessary expense. Perhaps a power for the OPG (without a court order) to require accounts backed up by a civil penalty for non-compliance coupled with powers given to the Court of Protection to make summary orders for restitution (to save the expense of the appointment of a deputy with power to bring recovery proceedings in the County Court or Chancery Division.

Finally, we should note that the position in Scotland is different – for an update on the view from the across the border, see the article by Adrian Ward in the Scotland section of this Report.

Law Commission Consultation on Wills

The Law Commission published on 13 July a major consultation on the potential for reforms to the law of wills in England and Wales. The detailed and comprehensive report can be found here, along with a summary and some useful infographics, and the consultation period runs until **10 November**. The Law Commission particularly welcomes views from medical professionals on its plans on mental capacity and the general public on questions around their experiences of making a will.

The consultation document is lengthy, but we suggest that all those remotely concerned with wills look, at a minimum, at the admirably crisp [summary](#). For present purposes, we highlight a number of specific aspects of particular and immediate interest from both a mental capacity and CRPD aspects.

Mental Capacity

As the Law Commission notes, the legal test of testamentary capacity currently used is from the nineteenth century decision in the case of *Banks v Goodfellow*. The Commission provisionally proposes (in Chapter 2) that testamentary capacity should instead be governed by the capacity test in the MCA 2005, and be accompanied by a specific code of practice for testamentary capacity. For our part, it seems to us that this an obviously necessary step for a host of reasons (not least to stop the need to keep explaining to doctors and lawyers that they look to one test for purposes of statutory wills and an entirely different test for purposes of making a will outside the scope of the CoP).

Statutory wills

The Law Commission discusses the position of statutory wills in Chapter 3 – including by reference to the requirements of the CRPD. The Commission provisionally concludes that substantive reform is not required (although this is, in part, in the context of the earlier suggestion in the Mental Capacity and Deprivation of Liberty [report](#) that the s.4 test should be amended to require particular weight to be given to the individual's wishes and feelings). The Commission may well welcome some assistance in formulating its final proposals in light of the absolutist position set out in Concluding Observations of the Committee on the Rights of Persons with Disabilities discussed in the Wider Context section of this Report.

The Commission also solicits views as to whether any steps could be taken to reduce the cost and length of statutory will proceedings. In any consultation response, you may well wish to take account of what Charles J said (just too late, we suspect, for the Report) about the way in which parties and the Court need to approach the statutory will process in *ADS v DSM* [\[2017\] EWCOP 8](#).

Supported will-making

Chapter 4 contains a detailed discussion of the arguments for and against the introduction of a scheme of supported will-making, in particular through the prism of the CRPD. The Commission also outlines in detail what a supported will-making scheme could look like – in parallel with the supported decision-making scheme proposed in the earlier Mental Capacity and Deprivation of Liberty project (indeed, the Commission concludes that the draft enabling power in the Draft Bill appended to that project is wide enough to encompass a specific scheme for support with will-making). We would urge anyone interested in making concrete the Article 12 CRPD commitment to secure support for the exercise of legal capacity to respond specifically on this aspect.

Undue influence

The Law Commission sets out a provisional proposal in Chapter 7 for a statutory doctrine of testamentary undue influence. This is of particular interest and potentially no little use in fleshing out the meaning of “conflict of interest and undue influence” in the context of Article 12(3) CRPD (which requires the implementation of safeguards to ensure that measures relating to the exercise of legal capacity are “free of conflict of interest and undue influence.”

A sorry tale: professional deputyship run amok

Public Guardian v Matrix Deputies Limited and London Borough of Enfield [2017] EWCOP 14 (Senior Judge Hilder)

COP jurisdiction and powers – costs – deputies – financial and property and affairs

Summary

In this case the Public Guardian made applications in respect of the deputyships (some 44) of Matrix Deputies Limited (and 2 of its former employees). The Public Guardian sought revocation of the orders and refusal of appointments in pending cases.

The case concerned deputyships in the London Borough of Enfield that had arisen out of an outsourcing arrangement between the borough and Matrix. The allegations were serious. Broadly they were:

- a. Excessive fee charging: fees were charged to individuals in excess of what the deputyship appointment permitted and/or irrespective of work actually done by the deputy;
- b. Inappropriate/inadequate arrangements for holding/recording client funds and transactions: all clients' funds were held in a single account, with unexplained discrepancies between closing and opening balances, inconsistencies with reports submitted to the Public Guardian and no clear record of individual balances;
- c. Conflicts of interest arising from inappropriate relationships with other bodies: individuals held positions in both Matrix and another company, or were family members of key personnel in those other companies, whose services were engaged to provide services to individuals at considerable cost and without appropriate evidence of competitive tendering and best interests decision making;
- d. Failure to provide information requested/comply with orders for disclosure: the response to the February 2016 order for disclosure was insufficient for the completion of investigations such that a further application to court, and a second report, were required.

The 2 individuals agreed at relatively early stages to orders in respect of their deputyships but Matrix continued to contest the applications until, after 20 months litigation, it agreed that their deputyships should be revoked and no further ones made.

Given that Matrix admitted some allegations that were serious in themselves, namely taking commissions from estate agents on the sale of 3 properties and they only gave full disclosure after the court had made an order permitting entry on their premises to obtain documents, the concession was probably inevitable.

That left the issue of costs. The borough sought its costs from Matrix on the indemnity basis, Matrix argued for no order.

The Judge set out the relevant law from *R (Boxall) v Waltham Forest LBC* (2001) 4 CCL Rep 258 QBD (Admin), where Scott Baker J confirmed that the court has power to make a costs order when the substantive proceedings have been resolved without a trial, but when the parties have not agreed about costs; specifically in relation to compromised cases...he observed that:

at each end of the spectrum there will be cases where it is obvious which side would have won had the substantive issues been fought to a conclusion. In between, the position will, in differing degrees, be less clear. How far the court will be prepared to look into the previously unresolved substantive issues will depend on the circumstances of the particular case, not least the amount of costs at stake and the conduct of the parties.

This principle had previously been applied to COP proceedings by Cobb J in *JS v KB & MP* [2014] EWCOP 483 at paragraph 13.

Senior Judge Hilder held that the admitted conduct and the failure to disclose, together with the fact that the application was wholly successful justified a departure from Rule 159 of the COP Rules (see paragraph 39). She ordered Matrix to pay the borough's costs.

Senior Judge Hilder then considered whether those costs (which amounted to £250,000) should be paid on the indemnity basis. At paragraph 42, she held the Matrix's conduct had been wholly out of the norm justifying an award of costs on the indemnity basis.

Comment

Costs orders against parties are unusual in the COP. Where, as here, a paid deputy defaults and then obstructs the court's process, clearly an order for costs is justified. Defaulting deputies should not believe that they can have a free ride in this respect.

OPG Annual Report 2016-2017

On 19 July 2017, the OPG published its [annual report](#), which provoked some considerable media coverage in light of revelation that it had for some period of time prior to the reduction in costs in April

2017 mistakenly been charging fees well above the costs incurred in processing applications without the requisite statutory authority to do so. The amount owed in consequence to registrants – which will be refunded during the current financial year – is estimated at £89 million.

The report contains some further interesting statistics in light of Denzil Lush's comments reported in this issue.

There were 648,318 applications to register either LPAs or EPAs (the latter numbering 12,778) with 2,478,758 instruments on the register. By contrast, the OPG is currently supervising only 57,702 deputyship orders.

That represented an increase in the number of registrations of 102,311 LPAs over the previous year. The number of deputyships had increased by only 1.02%.

The OPG received 5,327 safeguarding referrals in the year, a decrease of 15% (in part due to a change in counting method).

In the circumstances, it must be at least doubtful that the OPG and the Court of Protection could cope with a wholesale change from the use of LPAs to deputyships of the nature envisaged by Denzil Lush.

OPG's new Safeguarding Policy

On 4 July, the OPG published an [updated version](#) of its Safeguarding Policy

Of particular interest in relation to property and affairs is the section on spotting abuse in this area. This is at section 11 and mentions:

- A change in living conditions.
- Selling possessions.
- Being unable to pay bills, or an unexplained lack of money.
- Money being taken out of an account without a reason.
- Financial documents being lost without a reason.
- Someone being cut off from family, friends or their social network.
- The carer having more money to spend on things like clothes, travel or accommodation.
- Sudden changes to a bank account or how someone uses it.
- New, recent authorised signers on a client or donor's account card.
- Money being taken without permission from the adult at risk's ATM card.

- Changes in how the ATM card is being used (such as more frequently or from different locations)
- Sudden or unexpected changes to someone's will or other financial documents.

There are very useful sections on reporting concerns and also what the OPG cannot investigate.

Short Note: show your workings

In the clinical negligence case of JR v Sheffield Teaching Hospitals NHS Foundation Trust [2017] EWHC 1245 (QB), William Davis J had to decide on rival contentions as to deputyship costs. Each side called an expert experienced in deputyships. C's produced detailed workings as to what hours needed to be spent by what level of fee earner. D's put forward global annual figures based on his experience.

One issue was what would be required in the first year. Unsurprisingly perhaps, the judge preferred C's expert and allowed the £30,000 odd claimed against the £12,000 D's expert had put forward. (see paragraphs 104-109).

There is a clear lesson to be learned here.

PRACTICE AND PROCEDURE

Congratulations

We congratulate Peter Jackson J on his appointment to the Court of Appeal – even as we will miss his presence in the Court of Protection (and his soundbites of such utility for training purposes). We also congratulate Gwynneth Knowles QC and Jonathan Cohen QC on their appointment to the High Court Bench (Family Division) and – we presume – also to take up roles as nominated judges of the Court of Protection.

Legal aid, medical treatment and the role of the courts

Director of Legal Aid Casework et al v Briggs [2017] EWCA Civ 1169 (Sir Brian Leveson, King and Burnett LJ)

Article 5 ECHR – deprivation of liberty – DOLS authorisations – best interests – medical treatment – treatment withdrawal

Summary

The Court of Appeal has overturned the decision of Charles J that he could, within the scope of MCA s.21A proceedings (and hence non-means-tested legal aid), consider whether life-sustaining treatment should be continued to be provided to a man in a minimally conscious state subject to a standard DoLS authorisation. The court was intensely alive to the consequences of their decision as regards legal aid (see paras 10 and 113-14) but reached their conclusion on the basis of a strict construction of the statute.

Giving the leading judgment, King LJ held that challenging detention under MCA s.21A “relates to decisions about the deprivation of liberty and not, as suggested by the judge, to the circumstances which lead up to the deprivation of liberty” (para 89). Best interests, like capacity, is decision-specific and the particular decision is whether it is necessary, proportionate and in the best interests of P to be a detained resident (paras 89-90). Moreover:

92. In my judgment, a question in relation to serious medical treatment is not fundamentally a question in relation to deprivation of liberty. The issue before the court, as was accepted by the judge, was whether P should or should not be given certain medical treatment. It may be that following the making of such a decision there will be implications in relation to P's liberty as was recognised by the judge. For example: there may have to be a deprivation of liberty to prevent a woman from leaving the labour ward in circumstances where she lacks capacity and refuses a caesarean section which is clinically indicated and in her best interests. In my view, in such circumstances, the deprivation of liberty is secondary. The real question is whether it is in her best interests to have the surgery, whether or not it is in her best interests to be deprived of her liberty is then determined against the backdrop of the decision in relation to the proposed serious medical treatment. In my judgment that makes the

appropriate application an application made under s.15 – s.17 MCA and not an application under s21A.

The Court of Appeal did not narrow the scope of MCA s.21A – and by extension, DoLS – as much as had been sought by the Legal Aid Agency, which argued that “*under Schedule A1, all that is required within the best interests assessment is for the assessors to satisfy themselves that there is in fact a care plan and a needs assessment in place. No further detailed examination or consideration of the contents is [...] either required or appropriate.*” However, King LJ recognised that:

93. Having said that, in my judgment, [the Legal Aid Agency] has sought to place too narrow a scope on Sch. A1. There are many issues which relate to a deprivation of liberty which need appropriately to be considered by the assessor and which may be reflected in recommendations for conditions in the assessor’s report and which may even be determinative of whether a standard authorisation is made.

94. Where a dispute is referred to the court under s.21A, the issue is often in relation to P and the family’s wish for P to go home, set against the assessor’s view that it is in P’s best interests to be placed in a care home and consequently deprived of his or her liberty. Miss Richards has helpfully provided the court with a table of cases where applications have appropriately been made under s.21A; on closer examination, each of them has involved a dispute as to whether P should reside in some form of care home or return to either his home or to live with a family member in the community. Such cases are focused specifically on the issue as to whether P should be detained and are properly brought under s21A. 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. The weighing up of such options are part of the best interests assessment process in relation to which the professionals who are eligible to be assessors are peculiarly qualified to conduct.”

Medical treatment issues, King LJ noted, were a separate matter, about which best interests assessors have neither the expertise nor the facilities to intensely scrutinise; nor is such a decision necessary for them to decide whether the deprivation of liberty of itself was required. If there was an outstanding treatment issue, she held, P can be protected by limiting the duration of the standard authorisation (para 97).

The Court of Appeal set out a number of observations in relation to medical treatment, both as to the application of the concept of deprivation of liberty and also as to the potential need for the involvement of the court. King LJ noted that:

105 ... For my part, I find it hard to see how an argument could now be framed to the effect that Mr Briggs was being deprived of his liberty during the months he was in hospital and being cared for in a minimally conscious state. That being so, no standard authorisation was necessary and, as a consequence, the only available application open to the respondent in relation to the withdrawal of CANH should have been through the conventional s.16 route.

106. In my view, Ferreira confirms what I myself would regard as an obvious point, namely that the question of deprivation of liberty does not arise where a person who lacks capacity is so unwell that they are at risk of dying if they were anywhere other than in hospital and therefore, by virtue of their physical condition, they are unable to leave the hospital. It may be the case however that as the treatment progresses and P's physical condition improves, his or her ongoing care becomes a deprivation of liberty and, at that stage, a standard authorisation or court order will be required if the continued retention of P on the ward is not to become unlawful.

107. All parties agree that circumstances will continue to arise where a person requiring treatment will meet Lady Hale's 'acid test'. For that reason the court decided to hear the case, notwithstanding that this case itself is now academic, not only because Mr Briggs has now died, but also because in this court's view no standard authorisation was necessary, and his case was therefore outside the scope of s.21A in any event.

108. The proper approach to a case where the central issue is medical treatment (serious or otherwise) following Ferreira is therefore as follows:

- i) If the medical treatment proposed is not in dispute, then, regardless of whether it involves the withdrawal of treatment from a person who is minimally conscious or in a persistent vegetative state, it is a decision as to what treatment is in P's best interests and can be taken by the treating doctors who then have immunity pursuant to section 5 MCA.*
- ii) If there is a dispute in relation to medical treatment of an incapacitated person, and, specifically, where there is a doubt as to whether CANH should be withdrawn, then the matter should be referred to the court for a personal welfare determination under sections 15-17 MCA.*
- iii) Where, as a consequence of receiving life saving treatment, P is unable to leave hospital, that is not a deprivation of liberty which falls foul of Article 5(1). A standard authorisation is not therefore required and any application in relation to treatment will properly be made under s.16 MCA.*
- iv) If, as a consequence of ensuring that P receives the treatment that is in his or her best interests, P will become subjected to a deprivation of liberty of a type that falls within Article 5(1), then there must be authorisation for that deprivation of liberty:*
 - a) If already in hospital or in care under Schedule A1 (or S4A(5)): or*

- b) Pursuant to a court order under section 4A(3) MCA.
- v) The Sch. A1 decision will be made pursuant to para. 16 on the basis that the proposed deprivation of liberty is in P's best interests, necessary and proportionate; conditions of the type envisaged by the DOLS Code of Practice can be recommended if necessary.
- vi) If there is a disagreement as to whether there should be a standard authorisation, or in relation to the conditions attached to such an authorisation, then the matter can be brought to by way of an application under s.21A to determine any question relating to the authorisation and to make any appropriate order varying or terminating the authorisation. Clinical issues in relation to treatment will remain in the hands of the treating physicians. (emphasis added)

Comment

This is a significant decision in a number of respects. Reinforcing *Ferreira*, it narrows the scope of Article 5 ECHR where P is "so unwell that they are at risk of dying if they were anywhere other than in hospital and therefore, by virtue of their physical condition, they are unable to leave the hospital." Indeed, the court considered that Mr Briggs was not deprived of his liberty. It also strives to draw a distinction between "the deprivation of liberty" and "the circumstances which lead up to the deprivation of liberty". Following *Cheshire West*, it has become increasingly difficult to distinguish between these two. Indeed, the Law Commission's [proposal for reform](#) is very much founded upon an approach that is contrary to that expected in the present case:

1.29. A DoLS authorisation simply authorises "deprivation of liberty". By contrast, an authorisation under the Liberty Protection Safeguards would authorise particular arrangements for a person's care or treatment insofar as the arrangements give rise to a deprivation of liberty. This is an important difference. It focuses attention at the authorisation stage not simply on the binary question of whether a person should be deprived of their liberty or not, but on the question of the ways in which a person may justifiably be deprived of liberty... (emphasis added)

The Court of Appeal also noted at para 56 that "The statutory DOLS code therefore says in terms that the assessor is to make conditions in relation only to the deprivation of liberty itself." But, again, given how low the threshold is for deprivation of liberty, it is difficult to distinguish the deprivation from the care. Note also how issues of contact clearly fall within the best interests assessor's remit.

Separately, the observations at para 108(i), whilst strictly obiter, are of considerable importance in light of the current debates as to whether, and how, Practice Direction 9E to the Court of Protection Rules should be amended – and whether, and, if so, on what basis, medical treatment decisions need to come to court. This – strong – Court of Appeal (including both the President of the Queen's Bench Division and the new Lord Chief Justice) has clearly taken the view that it is only in the case of dispute that a medical treatment decision ever needs to come to court, (see further in this regard, inter alia, Alex's [article](#) on s.5 and the articles in the [July 2017](#) issue of the Journal of Medical Ethics).

Extension of pilots

The Court of Protection pilot schemes on Transparency, Case Management, and Section 49 Reports have all been extended until 30 November 2017. The intention is that a full revised and consolidated package of the Court of Protection Rules and their supporting Practice Directions, providing for the piloted procedures to become part of normal court procedure, will be laid before the end of the year and therefore the pilots have been extended until the date when the consolidated Rules will come into force to avoid a gap.

The Court of Protection gets electronic seals

In a step which will gladden the heart of all those who have had to include “This order takes effect notwithstanding the fact that it is not yet sealed” in their orders from the Court of Protection, the Court of Protection from 21 July, has been endorsing all non-financial orders with an electronic seal. For more details, see the letter from HMCTS [here](#).

Court of Protection visitors and the release of their reports

Summary

The OPG has published [guidance](#) on when Court of Protection visitors’ reports can be released and who they can be released to. There are four main circumstances:

- *Regulations allow the Public Guardian to release a copy of a visitor’s report to people the visitor has interviewed while preparing the report;*
- *A visit report may be released to people or organisations included in a Public Guardian application to the Court of Protection or supplied to the police or a local authority in an investigation;*
- *Personal information in a visit report may be released following a Data Protection Act subject access request; and*
- *The Court of Protection can order reports by a visitor to help with its decision-making. Reports produced for the court can only be released with the court’s permission.*

Anonymisation of judgments

The Transparency Project has published a [guidance note](#) for families and professionals in relation to the publication of family court judgments. The unofficial but detailed guide is designed to assist those involved in family court cases to think through issues around publication of judgments in those cases. The same approach is likely to be helpful by analogy to the publication of Court of Protection judgments. The guidance is divided into two parts: (1) should the judgment be published? and (2) if so, the anonymisation checklist. There is useful consideration of the pros and cons of publishing a court judgment and a detailed checklist which provides a helpful practical tool for anonymisation.

THE WIDER CONTEXT

CURRENT PRACTICE

Mental capacity in (in)action: Thematic Review of SARs in London Region

[Editorial note: we are very grateful to Professors Suzy Braye and Michael Preston-Shoot for providing us with this article summarising the review that they have just published]

Mental capacity features prominently in a thematic review of Safeguarding Adult Reviews (SARs) commissioned and completed by Safeguarding Adults Boards in London since implementation of the Care Act 2014. The review was commissioned by the London Safeguarding Adult Board and undertaken by Professors Suzy Braye and Michael Preston-Shoot, and their report has just been published by London ADASS.

The sample comprises twenty seven published and unpublished SARs. Analysis focuses firstly on the nature of the reviews – case characteristics (such as gender, ethnicity and trigger for review), SAR characteristics (such as methodology, type of abuse or neglect) and number and type of recommendations. Key themes from the content of the reviews are then presented, focusing on four domains that enable cross-case systemic analysis:

- Direct practice with the individual adult;
- Organisational factors that influenced how the practitioners worked;
- Interprofessional and interagency practice;
- The SAB's interagency governance role.

Finally, themes emerging from SAR recommendations are analysed.

Organisational abuse and neglect, and self-neglect dominate the cases reviewed, where men slightly outnumber women, and ethnicity is usually unrecorded. Shortcomings in mental capacity practice are regularly highlighted, the focus falling on failures to assess and/or to review assessments, or poorly performed and/or recorded assessments. Sometimes reviews are critical of insufficient testing of the presumption of capacity and of missed opportunities to balance a person's autonomy and self-determination with a duty of care. Unsurprisingly, therefore, SARs also contain recommendations to promote understanding of, and to develop practitioner skills in mental capacity assessments.

Closely connected to mental capacity, particularly in cases of self-neglect, reviews are critical of how practitioners have responded to the challenges of engagement, often taking at face value and leaving unexplored a person's reluctance to engage. Reliance on the notion of lifestyle choices comes in for particular criticism.

A cornerstone of good practice is, of course, assessment, not just of mental capacity but also of risk and needs. SARs are particularly critical of the absence or inadequacy of risk assessments, with some containing recommendations designed to improve performance. With a particular focus on the commissioning of, and then care within, care homes, SARs also comment on the lack of personalised assessments and care or, conversely, the prioritisation given to a person's wishes to the exclusion of considerations of risk. Good assessment practice should also contain an understanding about a person's history and relationships. Some SARs offer recommendations in this area of direct practice too.

Direct practice, of course, takes place within an organisational and inter-agency context. Here SARs are equally critical. Within organisations, particular emphasis is given to the absence of supervision and managerial oversight, poor recording that means that crucial information is missing or underused, and inadequate resources, reflected in workloads, staffing levels and the availability of specialist placements. Several SARs are critical of the absence of legal literacy, resulting in a failure to scrutinise different options for lawful intervention and to pay attention to requirements on mental capacity, or safeguarding literacy, sometimes resulting in a failure to appreciate patterns of risk. Particular faith in terms of recommendations is placed by SARs in developing or reviewing guidance and in measures to improve assessments.

When focusing on the inter-agency context SARs are especially concerned about silo working and the failure to share information. The absence of legal literacy and safeguarding literacy emerges here too. SARs offer recommendations in particular on coordination of complex cases and communication and information-sharing.

Despite increasing interest in a systemic approach to case analysis, the focus of SAR inquiry and recommendations is inward-looking, into the immediate contexts surrounding the individual. Much less focus is given to exploring national contexts – the adequacy or otherwise of the legal rules in support of work with adults with or without capacity, the impact of financial austerity on health and social care services in particular, and the reliance on the market to develop provision for people with complex and challenging needs. Changes recommended by individual SARs, to be implemented by SABs and their partner agencies, may sometimes ultimately be frustrated by the legal, financial, policy and service architecture determined in Westminster.

More positively, throughout the SAR sample there are recorded examples of good practice. Although there are incidences where SABs have experienced difficulties in securing the co-operation of partner agencies in reviews, generally the review process appears to have been managed well, although not always completed within the recommended six month time frame. Here parallel processes, such as Coroner inquests, criminal proceedings and/or investigations by regulatory and inspectorate bodies, complicate the review schedule and process.

Thematic reviews offer a particular insight into the strengths and vulnerabilities within adult safeguarding. Their findings should, of course, be placed in a context where many individuals at risk of

abuse and neglect are being safeguarded effectively. Nevertheless, these same findings do pinpoint issues where further scrutiny is merited by central government and by SABs with their partner agencies locally, regionally and nationally.

Suzy Braye and Michael Preston-Shoot

Litigation friends in tribunals

Two recent cases have made clear that the Employment Tribunal has the power to appoint a litigation friend (*Jhuti v Royal Mail Group* [2017] UKEAT 0062/17), as does the Asylum and Immigration Tribunal *AM (Afghanistan) v Secretary of State for the Home Department* [2017] EWCA Civ 1123.

In *Jhuti*, the Employment Appeal Tribunal found the power to order the appointment of a litigation friend for a party who lacked capacity to pursue litigation in the court's general case management powers which had to be interpreted in accordance with the overriding objective to deal with cases fairly and justly, ensuring that the parties were on an equal footing. A person who lacked capacity to litigate and was without a litigation friend could not participate in the proceedings in any real sense. There was no justification for construing the rules in a way which impeded the right of access for justice for those who lacked capacity.

In *AM*, the Court of Appeal found that although the Rules did not provide for the use of a litigation friend, they were sufficiently flexible to permit one to be appointed in the rare event that a child or incapacitated adult could not obtain effective access to justice without one.

It seems to us that these decisions must plainly be right, although their practical implications are significant. Where will these litigation friends be found? And/or will we see an extension of the approach in the Mental Health Tribunal and CoP (the ALR scheme) to enable solicitors to be appointed to act without litigation friends? Who will pay for these provisions? And what, if any, thought will be given to the recommendations regarding access to justice for persons with intellectual and/or psychosocial disabilities made by the CRPD Committee in their Concluding Observations on the UK?

Legal services and vulnerability

Summary

The Legal Services Board (LSB) has published some interesting and valuable research into the experiences of consumers in vulnerable circumstances (focusing on people with dementia/mental health problems and their carers) when they use legal services. This research provides valuable reading for those in the legal services industry to identify what can be done to improve accessibility, service experience and outcomes for consumers. The key finding is that for mental health problems and dementia, a safe space in which people feel comfortable to volunteer information or be sensitively asked about their needs is important. Other key findings/recommendations include:

For people with mental health problems

- Free initial services from third sector and regulated providers are valued.
- Customer support needs depend on the severity of the problem but include extra time for individuals to express themselves, extra communication and increased reassurance.
- It is important to feel listened to and understood, have services adapted to support them, have continuity of personnel and costs transparency.

For people with dementia

- There is a clear cluster of legal needs: wills, power of attorney and property issues.
- Those with early stage symptoms may not flag their needs in advance. Carers for those with later stage symptoms are more likely to.
- This group welcomes initial phone contact to discuss service adaptations, clear information before meeting on the legal issue, options and costs, home visits, 'dementia friendly' services, and a clear meeting record.

CQC report on specialist mental health services

The CQC has published its most recent [report](#) into specialist mental health services. The report covers the 3 years from 2014 to 2017 following inspection of specialist mental health services throughout England.

While the majority of services are found to be caring and compassionate towards patients, with 88% of NHS and 93% of independent services being rated good in this regard, only 68% more generally in the NHS and 72% of independent mental health locations are rated as good; and only 6% of NHS and 3% of independent core services were rated as outstanding. More worryingly, 36% of NHS core services and 34% of independent mental health core services were rated as requiring improvement for safety, with a further 4% of NHS and 5% of independent core services being rated as inadequate for safety.

The report notes that a lot of care remains overly restrictive and institutional in nature with significant examples of outdated care. It draws particular attention to the high number of people in "locked rehabilitation wards", far from home, leading to social isolation and institutionalisation rather than rehabilitation and a return to independence.

It is pointed out that long-term out of area care in hospitals whether through individuals with learning disabilities spending lengthy periods in hospital or in locked rehabilitation wards risks isolation and institutionalisation, but is also very expensive: better alternatives need to be found.

Finally, the report highlights concerns regarding the great variation in the use of physically restraint for challenging behaviour across the country. It notes the need to send a clear message to providers that services which resort frequently to the use of restraint and other restrictive interventions will find themselves under rigorous scrutiny.

Reviewing care plans

In a [report](#) published in August 2017, the service user watchdog, Healthwatch England proposed that care plans should be reviewed more than once a year to ensure that they are properly responding to service users' changing needs.

The report recommends that automatic notification systems could be introduced to update staff about important changes to care plans, or prompts could be left around people's homes as a reminder of their preferences.

The report also suggests local authorities needed to be more realistic in care plans about how much is achievable in the limited time available in most home care visits. It found that only just over half of people responding in one area felt there was sufficient time for care staff to complete all tasks set out in the care plan. Some service users also reported that care staff frequently lacked basic cooking and cleaning skills.

LOOKING TO THE FUTURE

Capacity, consent and mental health

Showing once again that distance can sometimes lend perspective, we draw readers' attention to a fascinating [speech](#) by Mark Hinchliffe, Deputy Chamber President FTT (HESC) – or, in English, the senior judge in day-to-day charge of the mental health tribunal jurisdiction in England, given in Hong Kong. In particular, he took the opportunity to ask himself whether the current mental health legislation “*embody the sort of respect and regard for modern principles of non-discrimination, autonomy, personal choice and self-determination that, in this day and age, should underpin the way we look at someone with a mental health problem?*” In answering the question, he sought to look, in particular, at whether capacity-based legislation would be the right way forward, giving a cautious ‘yes,’ so long as the relevance of dangerousness to others is considered – concluding that “*if we had a blank piece of paper, and could begin again, I fear that getting the balance right would be as ethically difficult and legally challenging now, as it was when we started down this road, nearly sixty years ago.*”

Paradigm shifts or mirages?

We have deliberately left to last in this Report discussion of the [concluding observations](#) of the Committee on the Rights of Persons with Disabilities on the compliance of United Kingdom with the

CRPD. We have done so because it seems to us to be useful to see those observations against a not untypical snapshot of issues in the mental capacity/mental health zone.

The report makes a very substantial number of hard-hitting, difficult to read (or refute) observations and recommendations about the ways in which the United Kingdom is letting down the rights of the disabled. The report can also, usefully, be read with the newly-adopted General Comment on Article 19: the right to independent living, with its host of detailed observations as to how states can and should take steps to ensure that individuals with disabilities are given a genuine choice as to how and where they wish to live their lives (at time of writing the General Comment has yet to appear in its final form on the Committee's website, but will do [here](#)).

For present purposes, we focus on the areas where the Committee – unsurprisingly – took on our mental health and mental capacity regimes where, respectfully, the recommendations are much more problematic. In material part, the Committee observed:

Equal recognition before the law (art. 12)

30. The Committee is concerned about:

- (a) The legislation restricting legal capacity of persons with disabilities on the basis of actual or perceived impairment;*
- (b) The prevalence of substituted decision-making in legislation and practice, and the lack of full recognition of the right to individualized supported decision-making that fully respects the autonomy, will and preferences of persons with disabilities;*
- (c) The insufficient support to all asylum seekers and refugees with psychosocial and/or intellectual disabilities, in exercising their legal capacity; and*
- (d) The high number of black people with disabilities compulsorily detained and treated against their will.*

31. The Committee recommends that the State party, in close consultation with organisations of persons with disabilities, including those representing persons from black and minority ethnic groups and in line with the Committee's general comment no. 1 (2014), abolish all forms of substituted decision-making concerning all spheres and areas of life by reviewing and adopting new legislation in line with the Convention to initiate new policies in both mental capacity and mental health laws. It further urges the State party to step up efforts to foster research, data and good practices of, and speed up the development of supported decision-making regimes. It further recommends that the State party ensure that asylum seekers and refugees with disabilities can exercise all rights enshrined in the Convention.

[...]

Liberty and security of the person (art. 14)

34. *The Committee is concerned that the State party legislation provides for involuntary, compulsory treatment and detention both inside and outside hospitals on the basis of actual or perceived impairment.*

35. *The Committee recommends that the State party:*

(a) *Repeal legislation and practices that authorise non-consensual involuntary, compulsory treatment and detention of persons with disabilities on the basis of actual or perceived impairment; and*

(b) *Take appropriate measures to investigate and eliminate all forms of abuse of persons with disabilities in institutional facilities.*

[...]

Protecting the integrity of the person (art. 17)

40. *The Committee is concerned that persons with disabilities, including women, intersex people, girls and boys with disabilities, are reported to continue to be subjected to involuntary medical treatment, including occurrences of forced sterilization, and conversion surgeries.*

41. *The Committee recommends that the State party repeal all types of legislation, regulations and practices allowing any form of forced intervention and surgeries, and ensure that the right to free, prior and informed consent to treatment is upheld and that supported decision-making mechanisms, and strengthened safeguards are provided, paying particular attention to women, intersex people, girls and boys. (emphasis in original)*

None of what the Committee says here comes as a surprise to those who have been following developments in this area.

Nor will it come a surprise to know that that there is – as far as we can tell – no realistic prospect that either the MCA or the MHA will be ripped up, even if both may well be amended (and possibly substantially) in the years to come. So to some extent all of what follows is academic. However, it means we will be in the position where one of the original driving forces at the UN remains resolutely out of kilter with what is said to be a core set of obligations. That does matter - at least to lawyers like us for whom (international) human rights matter.

Let us start with a number of essentially procedural regrets, namely that the Committee declined to engage with a number of core issues in this field that arise in the specific context of the United Kingdom, including:

1. The different legislative regimes in the various parts of the United Kingdom (for instance, the very different regime shortly to come into force in Northern Ireland – presumably failing to meet the tests set by the Committee);
2. The proposals advanced by the Law Commission to strengthen s.4 MCA 2005 and also to introduce regulation-making powers to enable supported decision-making schemes to be brought in;
3. The very expansive interpretation given to deprivation of liberty for our domestic purposes *Cheshire West*. Put another way: does the Committee consider that MIG is deprived of her liberty with her ‘mummy’ in her adult foster placement? If so, on what basis could this be justified on its interpretation of Article 14? If not, then how does the Committee’s interpretation of Article 14 CRPD differ from that given to Article 5 ECHR by the Supreme Court?
4. Evidence from those with (in Convention terminology) psychosocial disabilities that does not reject compulsory treatment in hospital out of hand. We note, here, in particular, the recent [report](#) of the Mental Health Alliance: *A Mental Health Act fit for tomorrow*, and would not presume to put any form of editorial spin upon the voices and views outlined therein.

That the Committee did not, in essence, do more than recite what is now a conventional ‘mantra’ in relation to Articles 12, 14 and 17 might – uncharitably – be said to show a concerning lack of interest in considering evidence before it as to the present, and potential future, regimes in place in the United Kingdom.

The explanation for this may well be that, politically, there is no desire to engage with the current legislative frameworks because that would be to give them credibility at a point when we should not be seeking to shore them up, but rather to rip them up and start again.¹

In the circumstances, however, it seems to us to be a distinct misstep (at a minimum) to fail to descend to the detail of (1) precisely what is wrong with the law and practice in the UK; (2) precisely how to achieve the goals set by the Committee; and (3) how and why these goals are, in fact, derived from the obligations imposed by the Convention.

Put another way, it is clear that the truths the Committee suggests are to be found in Articles 12, 14 and 17 are ones that do not appear to be self-evident, not only to Governments with arguably vested interests, but to courts concerned with fundamental rights (see, most recently, the decision in [AM-V v Finland](#)).

The failure to descend to the details, further, makes it all too easy to reject the Committee’s assertions as internally inconsistent. Some of these internal inconsistencies have already identified in other reports (see, for instance, the Essex Autonomy Project’s [work](#)). One particular issue here is that the

¹ See in this vein also the recent [statement](#) by the Human Rights Commissioner of the Council of Europe on the failure of member states of the Council to ‘internalise’ the new paradigm.

Committee's interpretation of the obligations imposed by Article 12(4) is focused solely upon respecting the will and preferences of the individual concerned, whereas the actual obligations imposed by Article 12(4) are to ensure that measures relating to legal capacity respect the rights, will and preferences of the individual. Those rights can include – for instance – the right to be protected (under Article 16 CRPD) against exploitation, violence and abuse. Steps taken to secure the right under Article 16 may, on their face, infringe the individual's will and preferences. In reality, therefore (and hardly surprisingly), the obligations imposed by the CRPD on the State in respect of individuals with disabilities in this area do not all point in one direction. From a whole range of different sources, we hear an increasing groundswell of real concern at the attempt by the Committee to impose a unity of obligation here which simply does not match the experiences of those seeking conscientiously to bring the Convention to life in practice.

We note here another internal inconsistency arising from the concluding observations. In a point that was not presaged in the list of issues, the Committee had this to say in relation to the right to life guaranteed by Article 10 of the CRPD

26. The Committee observes with concern the substituted decision-making in matters of termination or withdrawal of life-sustaining treatment and care that is inconsistent with the right to life of persons with disabilities as equal and contributing members of society.

27. The Committee recalls that the right to life is absolute from which no derogations are permitted and recommends that the State party adopt a plan of action aimed at eliminating perceptions towards persons with disabilities as not having "a good and decent life", but rather recognising persons with disabilities as equal persons and part of the diversity of humankind, and ensure access to life-sustaining treatment and/or care. (emphasis in original)

It is not obvious precisely what the Committee were referring to by "substituted decision-making" here. If they were referring to situations in which (for instance) DNACPR notices have been placed in the records of individuals with disabilities (egregious examples including those with Down's Syndrome) without consultation and on the basis of pre-conceptions by medical and other professionals, we could not agree more that such is wrong. But the courts have already made clear that such is wrong – see, for instance, the decision in Winspear, and on a proper analysis these do not represent substituted decisions but impositions.

On its face, though, the Committee's observations would seem to go further to encompass, for example, the case of Mr Briggs, and then into in a very difficult place indeed.

Mr Briggs self-evidently could not give "free, prior and informed consent" to the invasive treatment (CANH) that he was receiving. On the basis of the Committee's interpretation of Article 17, he should not have been provided with this treatment. But on the basis of the Committee's interpretation of Article 10 he had to be given this treatment – and should have been indefinitely ("the right to life is

absolute from which no derogations are permitted”) – notwithstanding the fact that those who loved him most were clear that this was the last thing that he would have wanted.

Assuming that the Committee is not advocating for this frankly terrifying situation, it is arguable that the only coherent way through is to recognise the reality of the situation. Mr Briggs was not functionally capable of making the decision whether to continue to receive CANH. His legal capacity – his agency – had to be exercised by another. It was, in this instance, exercised by the Court of Protection on his behalf, through a decision-making process that sought to construct a decision on his behalf which took as its starting point his identified wishes and feelings (his ‘will and preferences’). The MCA 2005 and the mechanisms it contains therefore did not deny him legal capacity but responded to his lack of mental capacity to support his legal capacity.

The blanket statements by the Committee, however, seem to rule this approach out. This leaves those who are sympathetic to the goals of the CRPD without any very sensible way forward to draft laws which are not intellectually dishonest (‘100% supported decision-making’) or take health and social care professionals and lawyers into zones which appear to them not just problematic but actively unethical, without any countervailing and convincing ethical justification. The seemingly incredible (in the true sense of the word) claims made by the Committee in this regard, further, undermine the position of those who are seeking to uphold the real goals of the CRPD and gains that it promises.

In the circumstances, however, we are hopeful that with work that continues to be done to operationalise in a grainy and grounded fashion² the real task of securing full recognition for those with cognitive impairments (from whatever source) as subjects, not objects, we can move forwards on solid ground, not pursuing potentially illusory – if not actively dangerous – mirages.

² See, for instance, the [Mental Health and Justice project](#).

SCOTLAND

A commotion next door

On BBC Radio Four Today programme on 15th August 2017, Denzil Lush – retired senior judge in the Court of Protection (England & Wales) - expressed concern about the lack of safeguards in the power of attorney system in England & Wales. His comments were widely reported. Denzil Lush is well respected here in Scotland, and internationally. He has participated in training and other events in Scotland. In this interview he was speaking solely about the mental capacity regime in England & Wales, contrasting potential dangers under lasting powers of attorney with the greater safeguards in the deputyship system. Unfortunately, the London-based media were as usual mostly blind to the fact that within the universe, and even within their range of coverage, there are regimes other than that of England & Wales. Interestingly, so far as can be ascertained, the concerns generated in Scotland extended mainly to solicitors, urgently asking for guidance as to how they should respond, rather than to the public.

One is tempted to say that it does no harm for the general public to be aware that financial abuse can happen, and is substantially more likely with an unwise choice of attorney, just as other problems can arise, most often with a poorly thought-out and drafted power of attorney document. The process of granting a power of attorney should not be undertaken lightly. The “begin the conversation” advertising campaign in the West of Scotland got it right: talk to family and others, discuss your situation and wishes with a solicitor with relevant expertise, and have the document individually drafted. As with most things, risks cannot be entirely eliminated, but they can be minimised. Sometimes, in Scotland, a guardianship will be the better option, accepting that the price of the higher protections is a more cumbersome, complex and expensive regime, and that – sometimes crucially – there is likely to be a gap between impairment of relevant capacity and guardianship powers becoming available for exercise. Even under guardianship, risks can be minimised but not eliminated.

Denzil Lush is reported as preferring deputyship (an approximate equivalent to guardianship) over an English lasting power of attorney. That would be his choice in his circumstances. Proportionality applies both at the individual level, and more generally. Judges see the protections of guardianship (or in this case deputyship) on a daily basis, and they will generally only encounter the power of attorney regime in the small proportion of cases where something has gone significantly wrong. They do not, in the course of their duties, generally see the vast number of attorneyships working satisfactorily.

There are differences between regimes in England & Wales and Scotland. For example, at time of granting Scotland requires certification by a lawyer or doctor. England & Wales accepts certification by any certificate provider. Scotland, without any fixed prescribed forms, offers greater scope for tailor-made solutions, though in practice one does not always see that happening. Going forward, the Scottish requirements are more likely to be adaptable to modern developments such as incorporation

of supported decision-making and co-decision-making arrangements in power of attorney documents, and other features already seen in some other regimes such as the supervising attorney.

Denzil Lush's comments were made in advance of publication, due later this month, of the 8th edition of "Cretney and Lush on Lasting and Enduring Powers of Attorney". We must await publication to see whether the authors go so far as to propose that England & Wales be set aside from the otherwise unanimous European consensus that: "States should promote self-determination for capable adults in the event of their future incapacity, by means of continuing powers of attorney and advance directives"; and that: "In accordance with the principles of self-determination and subsidiarity, states should consider giving those methods priority over other measures of protection" (Council of Europe Ministerial Recommendation (2009)11). That definition of "continuing" includes health, welfare and other personal matters, as well as economic and financial matters. Development of the use of such powers of attorney across Europe is still proceeding, rapidly. For example, Sweden's regime came into force on 1st July 2017, and Denmark's on 1st September 2017. Use of advance directives is even more under-developed. In some states they can be used as a "hybrid" arrangement under which the choice of guardian, and sometimes other aspects of the terms of any guardianship order, can be specified by the granter in advance.

In response to the concerns raised in Scotland by the interview with Denzil Lush, comments were posted both by the Public Guardian and by the Law Society of Scotland. We hope to be able to include further comments by the Public Guardian in next month's issue.

Adrian D Ward

Powers of attorney – registration update

[Editorial Note: We are grateful to Sandra McDonald, Public Guardian, for providing the comments and information below, and allowing us to reproduce here in the Report. The difference between powers of attorney received for registration, and actually registered, is significant. The remarkable rising trend in numbers received, which can reasonably be interpreted as reflecting numbers granted, has continued year-on-year without any dip. The gap between receipts and registrations completed, with registrations flattening off in the most recent three years, is simply explained by the fact that the rising flow of receipts hit the absolute maximum of resources available to deal with them. It is accordingly very much to be welcomed that Sandra has been able to obtain additional resources. The "mypowerofattorney" campaign, and accompanying rigorous analysis of outcomes, including savings to NHS in reduced levels of delayed discharge where powers of attorney are in force, demonstrate an overall benefit to public funds in having ever more people grant powers of attorney. It would be a false economy for OPG not to be provided with adequate resources to keep up with the inflow, on a permanent basis. One trusts that this will be done.]

There have a number of developments and initiatives with PoAs and this article offers a round-up of the current position.

Most significant is the continuing upward trend over the past 5 years the number of PoAs received. We record both number registered and number received categories, the number received figure is a more accurate reflection of PoA usage, given the difficulties we have currently with processing PoA demand.

The number received figures show that there has been a 21% increase in demand in recent years, and a 53% increase over the five years included in the table below. OPG is now processing more than 300 new PoAs each working day.

Increased volumes bring a rise in associated work such as requests for amendment, change of details or revocation. There are currently 80 such requests per day.

PoA Numbers

Year	No. Registered	No. Received
2012 / 2013	42528	47774
2013 / 2014	45576	52226
2014 / 2015	55527	60093
2015 / 2016	55007	67043
2016 / 2017	54919	72950

Processing developments

The OPG is presently recruiting an additional, sizeable, cohort of staff, on a fixed term basis, to address the issue of delays in processing PoAs which have been caused by this large increase in volumes. You will notice turnaround times progressively improving over the course of the latter half of this year – this will increase the volume of your return mail.

Rejection rates

One of the main causes of the processing delays is the substantially high level of rejected PoAs we have to deal with. Rejection rates are currently 22% for manual and 14% for electronically submitted deeds. This amounts to more than 12,000 deeds that require re-working – which in statistical terms is 75% of the backlog.

Please ensure you submit 'clean' deeds at first submission as this will help reduce the processing time enormously.

Public register

We receive a significant number of calls each day for public register information and these also impact on time we can give to processing new business. We are developing an online version of the public register, which we hope to have available later in the year.

Digital signatures

The (EPOAR) electronic PoA certificate is presently being revised to allow for a SMART card authenticated digital signature to be inserted. This will be available very shortly.

EPOAR

This digital option is only available for the electronic PoA function (EPOAR). If you do not use EPOAR and would like information or assistance with getting started, please contact us via the OPG email inbox OPG@scotcourts.gov.uk.

Sandra McDonald, Public Guardian

When a surviving spouse is not capable of acting as executrix-dative

A Note by Sheriff John Neil McCormick at Glasgow on 8th August 2017, [\[2017\] SC GLA 45](#), has clarified the position when a surviving spouse is entitled to the entirety of an intestate estate, but is not capable of acting as executor or executrix.

Common practice where a sole executor-nominate, or the only person entitled to be appointed executor-dative, is not capable of acting, is for a guardian to seek appropriate powers, or if there be no guardian, for a guardianship order to be applied for with appropriate powers. Typically the powers will include general power to act in the commissary matter of petitioning the court for appointment of the guardian as executor in the guardian's capacity as guardian; to apply for and obtain a bond of caution; to lodge an application for Confirmation; to obtain Confirmation; and to ingather and distribute the deceased's estate in accordance with the laws of intestacy. Where the adult is entitled to legal and/or prior rights, power is customarily sought to allow the adult to claim those rights. As a matter of prudence, the possibility of a Will being found is also covered, with power to distribute in accordance with the terms of such Will.

In the application before Sheriff McCormick, that route was not followed. Mr McNair died intestate. The prior rights of his widow would exhaust the estate. The couple's daughters, Alison Mary Russell and Beverly Jane McNair, sought in those circumstances to be decerned executrices-dative to the deceased. Sheriff McCormick held that the daughters had no title to be decerned executrices-dative. He therefore refused to warrant their application.

Sheriff McCormick helpfully reviewed the relevant authorities. He considered in particular the terms of section 9(4) of the Succession (Scotland) Act 1964: "Where by virtue of subsection (2) of this section

a surviving spouse or civil partner has right to the whole of the intestate estate, he or she shall have the right to be appointed executor". He was referred to *Murray, Petitioner*, 2012 S.L.T. (Sh Ct) 57, where, in similar circumstances, a petition by the deceased's son for appointment as executor-dative *qua* son (not as guardian) of the deceased was granted. Sheriff McCormick noted that in *Murray* the sheriff had not expanded on his reasoning, it was unclear whether earlier decisions (reviewed by Sheriff McCormick) had been brought to the attention of the court, and the value of the estate was not disclosed. Sheriff McCormick concluded (at [17]) that: "the purpose of section 9(4) is to make clear that the surviving spouse or civil partner is the only person to be appointed executor-dative where his or her rights exhaust the estate".

He pointed out that where an intestate estate exceeds the prior rights of a surviving spouse or civil partner, other relatives may apply. There was an inconsistency in statute in that such petitions are based on relationship to the deceased, not on beneficial interest in the estate, but that nevertheless is the position. Sheriff McCormick decided the case before him on the basis that there would be no surplus estate in which others would have an interest.

Sheriff McCormick made the following comment which will be of particular interest to adult incapacity practitioners:

[24] Secondly, the right to appointment rests solely with the surviving spouse or civil partner where his or her claim exhausts the estate. In my opinion, that right may be expressly declined allowing a surviving spouse or civil partner (who may be reluctant, elderly or ill, but not infirm) to be relieved of the administrative burden of winding up the estate. Until then, the right vests solely in the surviving spouse or civil partner. The right to appointment would have to be expressly declined in favour of a named petitioner. It would not be sufficient in my opinion for a petitioner merely to intimate the writ upon the surviving spouse or civil partner. This clarification should resolve many of the practical issues which have crept into commissary practice, while giving effect to the meaning of section 9(4) and protecting the interests of the surviving spouse or civil partner.

[25] In particular it avoids the implication that the right to appointment vests in the surviving spouse or civil partner exclusively, in the sense that it could not be declined, which is not within the 1964 Act but is a throwback to earlier legislation.

This would appear to open up the following possibility. If for some reason Mr McNair's daughters were determined to seek appointment as executrices in their own right, rather than as guardians to his widow, it would appear to be possible for an intervention order to be sought to authorise execution on behalf of the surviving spouse of a declination in favour of (in that case) the daughters. Whether in fact that would confer any advantages beyond the usual procedure may be open to question. However, that option would appear to be open.

(I am grateful to Alison Hempsey, partner, TC Young LLP, for confirming current practice where guardianship powers are sought to seek appointment as executor-dative as guardian to the person entitled to such appointment.)

Adrian D Ward

International Society of Family Law speech

Adrian recently delivered a keynote speech "*Do family laws reflect the realities of families with elderly and/or disabled family members*" at the 16th World Conference of the International Society of Family Law in Amsterdam. The speech is available [here](#).

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



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



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



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Annabel appears frequently in the Court of Protection. Recently, she appeared in a High Court medical treatment case representing the family of a young man in a coma with a rare brain condition. She has also been instructed by local authorities, care homes and individuals in COP proceedings concerning a range of personal welfare and financial matters. Annabel also practices in the related field of human rights. To view full CV click [here](#).



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

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



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Adrian is a practising Scottish solicitor, a consultant at T C Young LLP, who has specialised in and developed adult incapacity law in Scotland over more than three decades. Described in a court judgment as: "*the acknowledged master of this subject, and the person who has done more than any other practitioner in Scotland to advance this area of law,*" he is author of *Adult Incapacity, Adults with Incapacity Legislation* and several other books on the subject. To view full CV [click here](#).



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Jill Stavert is Professor of Law, Director of the Centre for Mental Health and Capacity Law and Director of Research, The Business School, Edinburgh Napier University. Jill is also a member of the Law Society for Scotland's Mental Health and Disability Sub-Committee, Alzheimer Scotland's Human Rights and Public Policy Committee, the South East Scotland Research Ethics Committee 1, and the Scottish Human Rights Commission Research Advisory Group. She has undertaken work for the Mental Welfare Commission for Scotland (including its 2015 updated guidance on Deprivation of Liberty). To view full CV [click here](#).

Conferences

Conferences at which editors/contributors are speaking

The Legal Profession: Back to Basics

Adrian is speaking at the [Annual Conference](#) of the Law Society of Scotland in Edinburgh on 19 September 2017.

JUSTICE Human Rights Law Conference

Tor is speaking at JUSTICE's [Annual Human Rights Law Conference](#) in London on 13 October.

Mediation Awareness Week

Tor is taking part in a [panel](#) on 16 October on "Mediating Medical cases after Charlie Gard" as part of Mediation Awareness week.

Adults with Incapacity: the Future is Now

Adrian is speaking at this half-day LSA conference on 18 October in Glasgow. For more details, and to book, see [here](#).

National Advocacy Conference

Alex is speaking at the [National Advocacy Conference](#) in Birmingham on 19 October. For more details, and to book tickets see [here](#).

National IMCA Conferences

Alex is speaking at the two Irwin Mitchell/Empowerment Matters National IMCA Conferences in [Sheffield](#) on 20 October and [London](#) on 10 November.

Deprivation of Liberty Safeguards: The Implications of the 2017 Law Commission Report

Alex is chairing this [conference](#) in London on 8 December.

Taking Stock

Neil is speaking at the annual AMHPA [conference](#) in Manchester on 19 October.

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

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