Welcome to the September 2022 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: Person-specific contact and sexual relations capacity; treatment plans for disordered eating; and updated DoLS statistics.

(2) In the Property and Affairs Report: Electronic billing pilot rolls out.

(3) In the Practice and Procedure Report: Transparency orders; and the BMA opines on s.49 MCA reports.

(4) In the Wider Context Report: Brain stem death testing; deprivations of liberty of young people in Scotland; the CRPD's application in the *Battersbee* case; foreign convictions; coercive control; litigation capacity; the Care Act considered in the Court of Appeal.

(5) In the Scotland Report: Further updates on Guardians' remuneration and the PKM litigation; nearest relatives; and the MHTS project concludes.

You can find our past issues, our case summaries, and more on our dedicated sub-site here, where you can also find updated versions of both our capacity and best interests guides.

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The picture at the top, "*Colourful*," is by Geoffrey Files, a young autistic man. 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

Contact and sexual relations with an abusive partner

Hull City Council v KF [2022] EWCOP 33 (28 July 2022)(Poole J)

Best interests – contact
Mental capacity – sexual relations
Mental capacity – contact

Summary

KF wanted to spend one last night with her long-term partner, days before he was due to be imprisoned for causing her grievous bodily harm. Given the absence of bail conditions, whether this could happen depended upon her capacity to make the relevant decisions and, if not, whether unsupervised overnight contact was in her best interests.

KF was 34 with a condition of agenesis of the corpus callosum, which caused her to have moderate learning disability, with an IQ of 49. Her life expectancy was limited to 3-18 months as metastatic breast cancer had spread to her liver, lungs and spine and, despite chemotherapy, the prognosis was poor. KF had previously given birth to two children, who were no longer in her care.

Her partner previously encouraged her to have sex with other men. Angered that one of those men had anal sex with her, he 'fisted' her which

caused tears to her vagina requiring hospitalisation, two units of blood and suturing without which she could have died. They separated but she returned to live with him and further violence was perpetrated. Social services were also seriously concerned about him exercising coercion and control, including taking her money, and overbearing her decision-making. KF moved to a care home placement. KW pleaded guilty to committing GBH and was soon to be sentenced but was on unconditional bail at the time of the application.

KF met remotely with the Judge, expressing her hope that her "wishes come true" to have some alone time with her partner ('KW') in private in a hotel room. She also stated to the expert:

> *16…"I have had two children. I can have sex with KW. If that's what I want, that's what I will do. No-one can stop me. I'm sick of this. You can tell the judge that too. It's my decision. I'm being treated like a child… I can make my own decisions. I want my freedom. I can make a decision about sex."*

Capacity

The first issue for Poole J was to carefully identify the matter(s) requiring a decision. It was possible to frame the decision to spend unsupervised overnight time with KW as a contact decision or a sexual relations decision and both needed to be considered. At para 24 his Lordship observed that, "*It is difficult to see how a person who lacks capacity to decide to have contact with a specific person could have capacity to decide to engage in sexual relations with that person. Sexual intimacy is a form of contact with another or others.*" And it was clear that KF lacked capacity to decide on contact with her partner.

In any event, the application for unsupervised overnight contact was person-specific and it was quite logical for her to have capacity to engage in sexual relations on a general basis, whilst lacking such capacity specifically in relation to her partner:

> *"24 … KF does not want to make decisions about having sexual relations in general, she wants to have (the opportunity for) sexual relations with KW and for that to occur within the next few days, prior to his likely incarceration. Information relevant to that specific decision includes information about the history and nature of the relationship between KF and KW. KW has been violent to KF in that relationship and has perpetrated sexual violence against her. KF is at specific risk of harm or assault by KW including in a sexual context. That risk is a foreseeable consequence of KF's decision-making about having sexual relations with KW. Dr Mynors-Wallis had already advised that KF cannot retain information about KW's past assaults on her or the risk that KW will assault her again. That is information relevant to the matter for decision, particularly given the nature and circumstances of the most serious assault by KW on KF, which was a sexual assault. Dr Mynors-Wallis also advises, that KF cannot weigh or use the foreseeable consequences of deciding to have sexual relations with KW, which include the risk of assault from him as has happened in the past. Dr Mynors-Wallis' previous report approached the matter for decision as general – the capacity to engage in sexual relations. He has now considered capacity to decide to engage in sexual relations in a person-specific context and, unsurprisingly given his previously expressed opinions, concludes that KF lacks capacity to decide to engage in sexual relations with KW.*

It was important for the Court not to approach questions of capacity in silos: "*I would regard it as incoherent to find that KF did not have capacity to decide to meet KW alone for a meal in a restaurant but did have capacity to decide to have sexual relations with him. Decisions about capacity must be coherent and allow those responsible for caring for and safeguarding KF to make practical arrangements"*. [24] Poole J went on to emphasise:

> *24…In cases in which it has been determined that P lacks capacity to make decisions about contact with a past or potential partner because of the risk of harm to P or by P, and it has been determined that P has capacity to decide to engage in sexual relations, consideration should be given to P's capacity to decide to engage in sexual relations with that partner. Failure to do so could result in incoherent capacity decisions. It was right to consider capacity to engage in sexual relations as a person-specific issue in this case."*

Given her inability to retain, weigh and use the additional relevant information specific to engaging in sexual relations with KW in particular – namely, that he sexually assaulted previously which was very harmful, the risk of a further assault and/or harm to her, the degree of that risk, the consequence if it should materialise, and the means by which the risk could be mitigated – it was declared that she lacked capacity to make the decision (para 26).

<u>Best interests</u>

If unsupervised overnight contact did take place in a hotel room, any sexual intercourse would be rape given her inability to consent. On the eve of his possible incarceration for assaulting her, her partner's mood might well be unpredictable, he might again become angry and take that out on her. There was no adequate means of ensuring that she could be kept safe and she could not be relied upon to seek support to prevent sexual relations taking place. Moreover, it would be unreasonable to expect support works to enter the hotel room to intervene. In the circumstances, any such contact was not in her best interests. Instead, it was in her best interests to continue to have supervised contact during the day and in a public place, such as a park, café, or restaurant, where they could kiss and cuddle, with support works supervising nearby.

Comment

The facts and judgment in this case illustrate the more nuanced approach to sexual relations that can be taken following the Supreme Court's decision in *JB*. Whilst KF was *able* to engage in sexual relations on a general basis, she was *unable* to do so in relation to KW. That is because there was much more at stake for her to comprehend, given the reasonably foreseeable risks and consequences that he presented.

The approach taken – to focus on contact first and then a person-specific take on sexual relations – is sensible and focused on 'the matter' about which a decision was needed. It provides a much more individualised perspective, sensitive to the particular risks. To do otherwise risks a greater, unnecessary intrusion upon a person's autonomy. For example, to silo capacity to have contact 'with others' and to engage in sexual relations in general runs the risk of greater interference as compared with the more targeted approach taken here. In a case of this nature, where the reasonably foreseeable consequences did appear to focus on KF and KW's relationship and the risked he posed to her, to focus on capacity to decide on contact with person X, and if sexual relations is a reasonably foreseeable consequence of such contact, to then take a

person-specific approach in that latter regard. Whilst proxy consent to sexual relations cannot of course be given on a best interests basis, support scaffolding can be put in place on a best interests basis so as to create where possible a safe environment for contact.

Injunctive Relief

Re TT (Injunctive Relief) [2022] EWHC 2185 (Fam) (04 August 2022) (HHJ Scully sitting as a DHCJ)

COP jurisdiction and powers - Injunctions

The court considered the best interests of TT, a 46-year-old man of Asian heritage with a diagnosis of a mild learning disability. TT lived with his parents until 2019, when he moved into a supported living accommodation. The case considered applications for injunctions to prevent P's mother from interfering in the exercise of his personal autonomy, heard simultaneously in High Court under the Inherent Jurisdiction and in the Court of Protection.

The background to the case concerns the relationship between TT and his mother ST. Within earlier proceedings in 2019, HHJ Moir (sitting in the High Court) found that ST had done her best to care for TT but found: *'she has controlled TT, or sought to coerce TT, throughout his life, as she sees it, for his benefit and she has not made the transition from caring for a child, to supporting an adult to make the best of his life.'* In 2021, TT's social worker began raising concerns about ST exerting pressure and influence on TT to return to the family home.

This judgment concerned the power of the COP '*to grant injunctions to support and ensure compliance with its best interests' decisions and its orders*.' HHJ Scully considered the judgment of Keehan J in SF [2020] EWCOP 19 at para 33

> *I so find for the following reasons:*
>
> *i) s.47(1) of the 2005 [Mental Capacity] Act is drafted in wide and unambiguous terms;*
>
> *ii) it must follow that the Court of Protection has the power which may be exercised by the High Court pursuant to s.37(1) of the 1981 Act to grant injunctive relief;*
>
> *iii) this conclusion is fortified by the terms of s.17(1)(c) of the 2005 Act which permits the court to prohibit contact between a named person and P;*
>
> *iv) it is further fortified by the terms of ss. 16(2) & (5) of the 2005 Act. The provisions of s.16(5) are drafted in wide terms and enable the court to "make such further orders or give such directions….as it thinks necessary or expedient for giving effect to, or otherwise in connection with, an order….made by it under subsection (2)";*
>
> *v) finally, the 2017 Rules, r.21 & PD21A , make provision for the enforcement of orders made by the Court of Protection including committal to prison for proven breaches of court orders.*

HHJ Scully also considered the case of *Re SA* [2005] EWHC 2492 (Fam) in relation to the court's powers under the inherent jurisdiction; and that, following Munby J's judgement at paragraph 79 it *'can be invoked wherever a vulnerable adult is, or is reasonably believed to be, for some reason deprived of the capacity to make the relevant decision, or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent. The cause may be, but is not for this purpose limited to, mental disorder or mental illness.'*

ST's evidence was that '*does not and has not sought to control or exert pressure on her son'* and that '*TT "plays games" with the staff and everyone*

else about where he wants to stay.' [23] The judge had a '*clear impression of ST is of a mother who loves her son dearly and who believes that her actions are well founded,*' however '*ST is unable to see that TT has any real autonomy in respect of many decisions around his life or that he deserves the opportunities, as the social worker put it, to be supported and assisted where possible, to exercise that autonomy.'* [paras 31-32]

After reminding herself of the words of Munby J in SA in relation to the influence of a parent or other close and dominating relative that '*is in TT's best interests and as a vulnerable adult, that the court should properly exercise its jurisdiction, both within the Court of Protection so far as it is able and under the inherent jurisdiction, to grant the relief sought*.' [36] The order therefore included injunctions on ST, specifically that:

> *37…ST shall not: (whether by herself or instructing, encouraging or permitting any other person):*
> *i. Prevent TT from living at 'the placement', save that and solely subject to his wishes, he is at liberty to spend a maximum of two nights per week at his family's home*
> *ii. Allow TT to live at the family home*
> *iii. Seek to persuade or coerce TT into not returning to 'the placement'*
> *iv. Take any action to prevent TT returning to 'the placement'*
> *v. Seek to persuade or coerce TT once he has returned to 'the placement' into moving back to the family home and/or to reside with ST anywhere, or to move to or reside at any property, premises or otherwise other than 'the placement'*

Within the inherent jurisdiction of the High Court, it was ordered that:

> *38…'ST' shall not (whether by herself or instructing, encouraging or permitting any other person):*
> *i. Prevent, restrict, or seek to persuade or coerce TT not to have, or to have less, contact with 'Miss Y'.*
> *ii. Contact by any means Miss Y or Miss Y's mother.*
> *iii. Request, demand or take from TT any sum of money by way of 'rent' or contribution to expenses save in circumstances when TT remains overnight at ST's home when his contribution must be limited to a maximum of £5 per night.*

Eating disorders and disordered eating: treating in the face of serious risk, and withdrawing treatment

Pennine Care NHS Foundation Trust v Mrs T & Ors (Rev1) [2022] EWHC 515 (Fam) (11 February 2022) (Morgan J)

A Mental Health Trust v BG [2022] EWCOP 26 (24 June 2022)(Sir Jonathan Cohen)

Best interests – medical treatment
COP jurisdiction and powers – Experts
Media – Court reporting

In two recently-reported cases, one in the Court of Protection and one in the Family Division, courts considered applications by trusts to approve treatment plans for two young women who had either entirely or all but entirely ceased eating. One plan was a risky intervention to keep the patient alive so that treatment to continue; the other was a plan to withdraw all but palliative care.

In *Pennine Care NHS Foundation Trust v Mrs T and Others*, Morgan J considered a proposal to sedate and feed 'Amy', a 17-year-old detained under the Mental Health Act 1983 who was in a perilous physical state after refusing to eat for over two years. The proposed intervention was:

- Amy would be transferred to an Intensive Care Unit for a period of sedation under General Anaesthetic

- She would be sedated for 3-7 days to allow physical investigation and treatment, and a period of refeeding
- Amy would then be returned to the psychiatric setting *'to continue intensive mental health treatment and treatment to support her physically in that.'* [12]

The application was brought by Pennine Care NHS Foundation Trust, a mental health trust with responsibility for Amy; Northern Care Alliance NHS Foundation Trust was the acute trust which was to carry out the proposed medical interventions, which did not oppose the application but considered that the court should take the final decision on it.

The judgment records that in September 2019:

> *4…Amy started to show signs of what was later diagnosed as 'Obsessive Compulsive Disorder' [OCD]. There was, at first success with intervention and treatment but there came a time when her family noticed that she had started to show marked weight loss. She was restricting her calorific intake and increasing her use of those calories she did take in by exercising in an excessive way. She was referred to Community Eating Disorder services by which time her weight and her 'Body Mass Index' [BMI] were at less than 75% of that which would be desired. An intensive community re-feeding regime produced at first some improvement but matters deteriorated such that by April 2021 she was admitted (informally) to Royal Manchester Children's Hospital (RMCH). She refused all oral nutrition and 5 days after her admission tried to abscond. Following detention under s3 of the Mental Health Act 1983, the operation of s 63 of the Act meant she could be, and / or was, fed by means of restraint. Two months later she was moved to a small unit specialising in the care of young people with significant and or enduring mental health difficulties. Over time her refusal of nutrition and of treatment was accompanied by self-harm. Self-harm at a serious level. The refusal of treatment is characterised by those treating her as an 'inability' to accept it and is described as being pitched at 'an extremely high level'. That inability to accept interventions and assistance for herself is one of the manifestations of her mental illness…*
>
> *6. Those who are looking after her mental health are firmly of the view that she wants to live but that her will to accept the interventions she needs to be able to do so is overborne by the mental disorder from which she suffers. That firm view is shared by her parents…*

At the time of the application in 2022, Amy was refusing *'all medication, examinations, treatment, intervention or assessment save and except that there has been one recent instance in which she was compliant with a particular imaging assessment. She is fed involving restraint but has developed a mechanism whereby she is able to expel a significant proportion of the nutrient even when restrained. The result of this is that she is taking in so little of her required nutrition - an estimate of about half her minimum nutritional needs is what I have been given – that she is now on a downward trajectory which is overwhelmingly likely to end in her death. The extent and degree of supervision and restraint required to try to reduce her opportunity to harm herself is such as to markedly diminish her dignity.'* [7]

However, her treating mental health professionals (who had consulted broadly with other specialists nationally) felt that her overall prognosis for recovery was good, and that her OCD was treatable if her health could be stabilised sufficiently to allow for more time for treatment.

The court found that Amy lacked capacity to make decisions as to her treatment; while her parents consented to the treatment, the case had come to court due to the *'unusual…nature of the treatment proposed.'* The court noted precedent which stressed the importance of the views of a child's parents, it note that *'parental right is, however, subordinate to welfare.'* [10]

Amy was appointed a Guardian, though had been selectively mute and refused to speak with the Guardian. In written communications, Amy discussed wanting to recover and come home, and wrote about career ambitions she had. The court considered that these statements were not consistent with a wish to die.

The treatment was considered to be quite risky, and might lead to Amy dying or suffering from organ failure. It also put her at risk *'of delirium once re-awakened from sedation, which risk would be exacerbated by her already troubling mental health history.'* [12] Due to the risks of the procedure and risks to Amy's health due to her continued refusal of food, the procedure had to be carefully timed to commence not sooner than was absolutely required, but also before Amy had become so unwell that the probability of a positive outcome was very poor.

The acute trust did not feel able to predict the likelihood of success of the intervention, and emphasised that it could result in Amy dying or surviving with even worse health than she already had. The doctors also were clear that they had no previous experience with an intervention of this nature. While they were willing to perform the intervention, they did not feel able to affirmatively recommend it.

The court approved the proposed treatment plan in principle, summarising the extremely difficult situation in which Amy found herself:

> *26. Dr Ferris at the end of his evidence in chief said this: I think we all feel uncomfortable but here is a very unfortunate young woman who desperately needs help and I think the right thing to do is to offer that help at the right time. I agree. Cross examined by Mr Sachdeva about whether he could see any other option to the proposed plan if Amy continues to deteriorate against a background where the timescales for the psychiatric treatment are measured in terms of months, Dr Ferris's response was No I don't think there is any other choice. I agree with that also…*

The court gave discretion to the clinicians on the ground as to when it should be implemented.

In *A Mental Health Trust v BG*, the court considered an application for declarations that BG lacked capacity to make decisions about her care and treatment, including nutrition and hydration, and that it was in BG's best interests that no further treatment be provided against her wishes (including any artificial nutrition and hydration, and any life-saving treatment). The application was supported by the independent expert in the case and all parties to the application, including the Official Solicitor and BG's parents. A postscript states that BG died approximately two months after judgment was given and shortly before it was reported.

At the time the application was heard, BG was 19 years old. BG was described as both highly intelligent and much-loved by her family, and she participated actively in the proceedings. The judgment set out the background of the case:

> *6. From a very early age BG has been exceptionally sensitive and has struggled with regulating her emotions and dealing with the ordinary events of everyday life that others take in their stride. She took the weight of the world on her shoulders, and she was exceptionally anguished and distressed by, for example:*
>
> > *i)The recounting of historical events in which people had suffered;*
> > *ii) Accounts of suffering of animals or seeing roadkill;*
> > *iii) World events, whether they show the plight of humans or animals.*
>
> *All these events would lead her to become overwhelmed and inconsolable with distress.*

> *7. BG's emotional awareness of the suffering of others completely overwhelmed her. She felt the pain of everyone and everything and was unable to regulate her own emotions.*
> *8. BG first came into contact with mental health services aged 8. Her increased anxiety had led her to have not only the frequent overwhelming experiences to which I have already referred, but she became unable to sleep in her own bed and developed fears of terrorism, burglars and family death, for example, without any personal experience of the same. She had two courses of cognitive behavioural therapy, one when aged 10 and one when aged 13.*
> *9. BG's depression is estimated to have started when she was 14 years old and her suicidal and self-harm behaviours started soon afterwards. At that time she was completely dependent on her mother. In December 2017 self-harm by cutting commenced.*
> *10. In February 2018 BG was formally diagnosed with anorexia nervosa.*
> *11. Since early 2018 BG has been under the continuous care of psychiatric services.*

From 2018 until 2022, treatment for BG's anorexia and self-harming behaviours had continued. Though during some initial periods eating was established, BG remained suicidal and highly distressed. She had only been able to be at home for a few months in late 2020 and early 2021; by the time of her re-admission to hospital *'BG was very agitated, self-harming including banging her head, punching herself and cutting, culminating in her ingesting bleach.'* [13] BG had had a variety of treatments, none of which had resulted in any significant improvements in her condition.

> *14…BG's medication and treatment regime was summarised as follows:*
>
> > *i) Her nutrition was delivered twice per day via nasogastric (NG) tube and under restraint on all occasions. The nutrition maintained her weight at approximately Body Mass Index (BMI) 15 but her agitation and resistance to feeds worsened progressively during the second half of 2021.*
> > *ii) BG drank sugar free squash or water but declined any oral intake which might contain calories.*
> > *iii) She was prescribed 12 different medications.*
> > *iv) She received weekly psychological support, with little or any effect.*
>
> *15. BG had by then received over 1,000 NG feeds under restraint during her various hospital admissions. This has caused her immense distress. She has to be restrained by no fewer than 4 staff members as she struggled against it so much. I have no doubt that it was also highly distressing for those having to administer the feeds.*

By the time of the application, BG was described as having *'a deep desire to die and to be allowed to die by the withdrawal of her nutrition so that she can slowly die in her mother's arms in her bed.'* [24] Her treating psychiatrist, Dr Z, considered that all treatment options had been exhausted, and did not have any proposal that might alleviate BG's suffering.

BG's wishes and feelings were extremely clear:

> *38. BG has made it completely clear over a prolonged period of time that she would wish to take her own decision and exercise her own autonomy over her body. Her very clear decision is that she wishes to be discharged from hospital, to go home and determine for herself, what if any nutrition or hydration she takes.*

> *39.This is not a sudden decision. It has been a long and deeply held wish of hers. I have had the obligation and privilege of reading her diary over many weeks. It is a harrowing read, setting out her suffering and how it should be resolved.*

BG's parents supported her wish for treatment to be withdrawn, writing, *'[s]he is exhausted from being in so much intolerable pain for so long, and she would like to be sure that any palliative care plan guarantees pain relief such that she is not obliged to suffer further than absolutely unavoidable'*. [42]

BG's treating psychiatrist considered that BG lacked capacity to make decisions as to her treatment as *'BG's beliefs and her using and weighing in the balance the relevant information about care and treatment were dominated by her desire not to experience pain and she saw her death as the only escape. All of BG's views and beliefs had an underlying theme of not deserving anything except punishment and that she is bad.'* [28]

The court also summarised a best interests meeting which had been convened to consider BG's situation, which *'concluded that it was in BG's best interests for active treatment to be discontinued. The level of suffering that BG had experienced, her desire to be allowed to die, her family's agreement with her wishes and feelings, and the poor prognosis following the exhaustion of all treatment options led to that conclusion. The negative aspects of treatment appear to outweigh any potential benefits which would ostensibly be only to preserve her life which is not something that she wishes for.'* [46]

The court concluded with a plainly heavy heart that it was it was in BG's best interests for compulsory treatment to end.

<u>Expert evidence</u>
The court considered that independent expert evidence was needed for a number of reasons, and postponed a final decision in the matter for five weeks to accommodate this evidence. While the court offered no criticism (and indeed, high praise) for the evidence of BG's treating psychiatrist, 'Dr Z', it set out the reasons why it considered independent evidence was required in this case:

> *20…i) The court was being asked to make a decision which would lead inevitably to BG's death on the advice of just one doctor, albeit that she was reflecting a team view;*
> *ii) That doctor was in a therapeutic relationship with her patient which inevitably impacts on her independence;*
> *iii) Only a short time before Dr Z had been seeking the advice of a second opinion doctor but had been unable to obtain that opinion in time for the hearing. It seemed to me that if that second opinion was desirable then, it remained desirable.*
> *iv) Although the matter was plainly urgent, the necessity of making the right decision on the best evidence was paramount and the relatively short period of time, then thought to be about 5 weeks, seemed to me to be justified.*

An expert report was obtained from Dr Tyrone Glover, who had very limited substantive disagreements with Dr Z in relation to either BG's capacity or her best interests. He considered that *'BG is suffering from very severe, unremitting forms of mixed anxiety and depression and anorexia nervosa'* [32] and concurred with BG's views in relation to further treatment.

<u>Transparency</u>
The court also considered the position on reporting restrictions after BG had seen a reference to her case in a published tweet; the judgment described her as being 'deeply distressed', though she was not identifiable from the tweet. Blanket reporting restrictions were in place during preliminary hearing, and all parties to the proceedings sought to convince the court to continue the RRO as any report BG found about herself would likely only cause her further anxiety and distress in what were likely to be the

final days and weeks of her life. Brian Farmer on behalf of the Press Association argued against the order, asking how *'could it be justified for the court to take a decision that will almost inevitably lead to someone's death without the public being allowed to know that such a decision had been taken'*? [55]

The court wrote that it had:

> *57…considered the matter anxiously. I was persuaded by Mr Farmer that it would not be proper for a decision of this gravity to be made in secrecy, particularly in circumstances when the duration of BG's life was uncertain. Accordingly, on 23 May when announcing my decision I authorised publication in these terms:*
> *"The court today has been dealing with an application by a Mental Health Trust seeking orders permitting the ceasing of artificial nutrition and hydration to a young person suffering from a very complex condition including a severe eating disorder. The inevitable result will be that the young person will die unless he/she chooses otherwise. The application is supported by the young person and the immediate family and the independent expert instructed by the Official Solicitor. I have allowed the application and will, in a reserved judgment, give my reasons in this very difficult case. I will reconsider the issue of further publication after I have handed down my reserved judgment. In the meantime, there is to be no additional reporting or identification of the Mental Health Trust, the Acute Trust, the young person, their family or the treating doctors or the geographical location in which any of the above are situated."*

Updating DOLS statistics published

The DOLS statistics for England during the period of 1 April 2021 to 31 March 2022 have been published and are available here.

The main headlines are:

- DOLS applications rose slightly: There were 270,650 DoLS applications, up from 256,610 applications for DoLS received during 2020-21. This is a 5.5% increase, following an approximately 3% drop in the previous year. This is in contrast to growth averaging 14% each year between 2014-15 and 2019-20.'

- More than half of DoLS applications are not granted, usually due to changed circumstances: *'The proportion of completed applications in 2021-22 that were not granted was 56%. The main reason was given as change in circumstances, at 65% of all not granted cases.'*

- Applications are taking longer to process: *'The proportion of standard applications completed within the statutory timeframe of 21 days was 20% in 2021-22; this has fallen from 24% in the previous year. The average length of time for all completed applications was 153 days, compared to 148 days in the previous year.'* In in 2015-2016, the average duration was 83 days.

- Regional variation continues: as in previous years, the North East has continued to have the highest number of applications per capita, with 212 per 100,000 individuals (the next highest being the North West with 150 per 100,000 and the lowest being the East of England, with 105 per 100,000).

- Despite this, the East of England had the longest mean time for completing applications with 214 days; the North East had the second shortest average duration of completing applications, at

113 days, and London the lowest at 85 days.

- For some further statistics:

    - 150,740 authorisations granted were urgent authorisations, and 116,340 were standard authorisations

- 88,960 were in nursing homes, 80,225 were in care homes, 74,385 were in acute hospitals, and 5,330 were in mental health hospitals; others were blank, invalid or in other settings. The vast majority of the rise in applications were attributable to people in residential care homes or nursing homes.

- There were 28,015 people who had two standard authorisations, 6,585 who had three standard authorisations, and 2,290 who had four or more standard authorisations.

- Older people were far more likely to find themselves the subject of standard or urgent authorisations than younger ones, with 7,829 applications made per every 100,000 people over the age of 85, and only 127 per 100,000 people aged 18-64.

PROPERTY AND AFFAIRS

Electronic Billing in the Court of Protection

In a pilot scheme, running from 1 November 2022 until 28 April 2023, professional deputies appointed by the Court of Protection, their legal representatives and other legal professionals involved in Court of Protection cases, may file their bills in respect of general management and other applications where the relevant authority has been obtained from the Court of Protection in electronic spreadsheet form. This is not compulsory but costs practitioners will by now be well used to electronic bills and, assuming that the pilot is a success, it is very likely that the use of electronic bills will become mandatory.

This link goes to the the Courts and Tribunals Judiciary news item about the pilot; and this link goes to a helpful article on the Professional Deputies Forum.

PRACTICE AND PROCEDURE

Transparency Orders

Re EM [2022] EWCOP 31 (29 July 2022) (Mostyn J)

Practice and Procedure – Transparency

In *Re EM* [2022] EWCOP 31, Mostyn J expressed a number of concerns about the transparency order made in the case before him by Keehan J, in 'broadly standard' terms.[1] In particular, he expressed the concern (at paragraph 41):

> *that it may be technically unsound for two separate reasons namely (i) the order was made in the absence of a Re S-type balancing exercise, weighing the Article 8 ECHR rights of EM with the Article 10 ECHR rights of the public at large, exercised via the press; and (ii) notice of the intention to seek the order had not been given to the press pursuant to s12(2) HRA 1998.*

Mostyn J developed his concern[2] and continued:

[1] He also expressed strong views about the continued use of initials to anonymise orders and individuals within proceedings.

[2] Mostyn J then amplified his concerns as follows:

> *i) Rule 4.1(1) of the COPR provides that the "general rule is that a hearing is to be held in private". The rest of Rule 4.1 says nothing about what can be reported about such a hearing. It prevents a journalist attending the hearing, but its terms do not prevent any party talking to a journalist or that journalist subsequently writing a report.*
>
> *ii) Section 12 of the Administration of Justice Act 1960 imposes a blanket ban on reporting proceedings brought under the Mental Capacity Act 2005, but r.4.2 COPR and Practice Direction 4A allow, for the purpose of the law of contempt, certain disclosures to be made.*
>
> *iii) Rule 4.3(1) and (2) COPR supplies the court's power to order that a hearing be held in public and, consequentially to that order, to impose reporting restrictions.*
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> *iv) Rule 4.3(3) provides that:*
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> *"A practice direction may provide for circumstances in which the court will ordinarily make an order under paragraph (1), and for the terms of the order under paragraph (2) which the court will ordinarily make in such circumstances." (emphasis added)*
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> *v) Practice Direction 4C has been made under r4.3(3), and provides that:*
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> *"2.1 The court will ordinarily (and so without any application being made) –*
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> *(a) make an order under rule 4.3(1)(a) that any attended hearing shall be in public; and*
>
> *(b) in the same order, impose restrictions under rule 4.3(2) in relation to the publication of information about the proceedings.*
>
> *2.3 An order pursuant to paragraph 2.1 will ordinarily be in the terms of the standard order approved by the President of the Court of Protection and published on the judicial website at www.judiciary.gov.uk/publication-court/court-of-protection/. (emphasis added)*
>
> *vi) The emphasised passages in r. 4.3(3) and PD4C, paras 2.1 and 2.3, provide for a standard order to be made almost automatically: i.e. without any enquiry whether such an order is appropriate on the facts of a given case. That such an enquiry is necessary flows from the fact that the transparency order is undoubtedly a form of reporting restrictions order.*
>
> *vii) Reporting restriction orders can only be made following a court conducting the 'ultimate balancing exercise' between Article 8 and Article 10 ECHR rights as described by Lord Steyn in Re S (a child) [2004] UKHL 47; [2005] 1 AC 593 as follows:*

43. Plainly, on 1 July 2022 the media were not notified that a reporting restriction order was being considered. It is equally clear that a Re S balancing exercise undertaken was not undertaken. Had these steps been taken the order would have said so on its face. It is, however, a standard practice, condoned by r.4 COPR and PD4C, not to take these steps. That being so, I respectfully suggest that the correctness (I hesitate to use the word lawfulness) of this standard practice is reviewed by the Rule Committee with input from all relevant stakeholders.

Mostyn J identified a possible solution as being to leave the proceedings to be heard "in private" but to make a standard order at the beginning of the case which relaxes the strictures of section 12 of the Administration of Justice 1960 Act by permitting the press and legal bloggers to attend the hearings and allowing them (and the parties) to report the proceedings provided that they do not identify P directly or indirectly. He pointed to *Norfolk County Council v Webster & Ors* [2006] EWHC 2733 (Fam) where an equivalent order was made, although noted that Munby J considered in that case that such a permissive order should be characterised as a reporting restrictions order giving rise to both the need for a full balancing act and press notification.

"The interplay between articles 8 and 10 has been illuminated by the opinions in the House of Lords in Campbell v MGN Ltd [2004] 2 WLR 1232. For present purposes the decision of the House on the facts of Campbell and the differences between the majority and the minority are not material. What does, however, emerge clearly from the opinions are four propositions. First, neither article has as such precedence over the other. Secondly, where the values under the two articles are in conflict, an intense focus on the comparative importance of the specific rights being claimed in the individual case is necessary. Thirdly, the justifications for interfering with or restricting each right must be taken into account. Finally, the proportionality test must be applied to each. For convenience I will call this the ultimate balancing test." (emphasis added)

viii) There is no sidenote in the standard order template saying that a Re S balancing exercise must be undertaken, such as to prompt the judge to turn his or her mind to that exercise. Nor was there any statement in the specific order of Keehan J dated 1 July 2022 that this exercise had been actually undertaken.

ix) Save where there are compelling reasons why the press should not be notified, a reporting restriction order can only be made after all practical steps have been taken to give the press notice of the intention to seek such an order. But there is no provision to this end in r.4 COPR or PD4C. Such notification is required pursuant to s12 HRA 1998, which provides that:

(1) This section applies if a court is considering whether to grant any relief which, if granted, might affect the exercise of the Convention right to freedom of expression.

(2) If the person against whom the application for relief is made ("the respondent") is neither present nor represented, no such relief is to be granted unless the court is satisfied:

(a) that the applicant has taken all practicable steps to notify the respondent; or

(b) that there are compelling reasons why the respondent should not be notified."

x) There is no rubric or sidenote in the standard order template saying that the press must be notified prior to the order being made, nor is there any statement that this occurred in the order of Keehan J dated 1 July 2022.

Revisiting the standard transparency order, which dates from 2017, is undoubtedly something which could sensibly be done, not least to see whether it can be made simpler in light of experience. It also requires updating to take account of the fact that there is now a universal set of provisions relating to remote public access to proceedings. It is also to be hoped that the Law Commission's project on reforming the law of contempt can include consideration of the primary legislation under which the Court of Protection operates. That primary legislation dates from a time when almost all hearings were conducted in private. The position now, however, is that almost hearings take place in public, subject to limitations upon what can be reported (whether by member of the press or otherwise), designed, in particular, to secure the protection of the identity of P. However, because of the way in which the primary legislation operates, it is only possible to achieve that position by way of an individual order being made in each case.

Mostyn J's point (which appears to be one which he has taken of his own motion, as it does not appear to have been raised by the sole represented party before him) is a very important one – is the current practice of making such orders correct (or perhaps even lawful)?

In response, it might be said that Lady Hale appears to have considered that the court's approach is lawful, in observations made in relation to the pilot which preceded the changes introduced in the 2017 Rules. In *R (C) v Secretary of State for Justice* [2016] UKSC 2, concerning the approach to anonymity in civil cases concerning those subject to the Mental Health Act 1983, she outlined the specific considerations applying to proceedings before the Court of Protection before noting the pilot in apparently approving terms:

> *25. The other specialist jurisdiction dealing with people with mental disorders or disabilities is the Court of Protection. This decides whether or not, because of mental disorder, a person lacks the capacity to make certain kinds of decision for himself and if so, how such decisions are to be taken on his behalf. These include decisions about his care and treatment. Rule 90(1) of the Court of Protection Rules 2007 (SI 2007/1744)* [now Rule 4.1] *lays down the general rule that hearings are to be held in private. If the hearing is in private, the court may authorise the publication of information about the proceedings (rule 91(1))* [Rule 4.2]. *The court may also direct that the whole or part of any hearing be in public (rule 92(1))* [Rule 4.3(1)]. *But in either case the court may impose restrictions on publishing the identity of the person concerned or anyone else or any information which might lead to their identification (rules 91(3) and 92(2))* [Rules 4.2(4) and 4.3(2)]. *The starting point in the Rules, therefore, is both privacy and anonymity. However, from January 2016, there will be a six month "transparency pilot", in which the court will generally make an order that any attended hearing will be in public; but at the same time it will impose restrictions on reporting to ensure the anonymity of the person concerned and, where appropriate, other persons.*

In *V v Associated Newspapers Ltd & Ors* [2016] EWCOP 21, Charles J (the then-Vice President of the Court of Protection), who introduced the transparency pilot and the new provisions, identified that made clear that he considered that it would be wrong to take an approach to issues relating to reporting (and hence to the weight to be given to competing ECHR rights) which proceeded on the basis that the starting point would be that there would be a public hearing, and that any reporting restrictions would be sought or granted from that position. Rather, he made clear at paragraph 87, the starting point was the default rule which:

i) reflects a well-established exception to the general approach that courts sit in public, and
ii) founds a distinction, equivalent to that recognised in Re C at paragraph 21, between reporting restrictions orders and anonymity orders made by the COP and many such injunctions made in other circumstances.

Whilst Charles J considered that a *Re* S balancing exercise needed to be carried out, he also made clear (in his summary, paragraph 9) that there was a distinction between:

(a) cases where pursuant to the default or general position under the relevant Rules or Practice Directions the court is allowing access (or unrestricted access) to the media and the public, and (b) cases in which it is imposing restrictions and so where the court is turning the tap on rather than off.

As Mostyn J noted, Practice Direction 4C embeds the practice of the court 'generally making' an order that attended hearings are in public, but at the same time imposing reporting restrictions. Mostyn J did not address specifically in his observations the fact that Practice Direction 4C, read together with model transparency order, anticipates such an order would be made by the court at the point of listing the first attended hearing. In other words, and in the ordinary course of events, this would be an order made on the papers at the very earliest case management stage of the proceedings. Pragmatically, requiring (1) a full-scale *Re S* analysis and (2) notification of the press before any such order was made would build in a level of delay and complexity that would be unlikely to be attractive – let alone acceptable. Whilst I entirely agree that it would be appropriate for the ad hoc Rules Committee to take a further look at the practice and procedure, my starting proposition is that the pragmatic approach embodied in the transparency Practice Direction is defensible for the following reasons.

It is a perhaps unsurprising feature of the case-law such as *Re S* that it relates to situations where the competing rights are being asserted by specific individuals or organisations: most obviously, the press asserting a right under Article 10 ECHR, and a person or people asserting a right under Article 8. In other words, there are specific arguments being advanced in relation to a specific case. At that point, and as Lord Steyn made clear in *Re S*, the court's task to evaluate the competing rights with an intense focus as to their comparative importance.

The situation here, though, is rather different. It relates to the application of a general provision guiding judges as to the application of the *Re S* balancing exercise in circumstances where Parliament has decreed that the starting point is that the tap of publicity is off and the court is deciding whether to turn it on.

The making of a transparency order is a judicial decision. I would therefore suggest that the making of the order represents the implicit (summary) judicial determination that the appropriate *Re S* balance is as set down in the Practice Direction. In the absence of arguments having been advanced as to the comparative importance of the rights in play, I would suggest that such a summary determination is appropriate. It is clear from the work of the Open Justice Court of Protection Project that judges of the Court of Protection are acutely alive to the issues to which listing a hearing in public gives rise. The transparency order could undoubtedly include a recital expressly referring to *Re S*, but I would suggest that this would be likely to be more for form's sake than anything else.

As regards the application of s.12 HRA 1998, requiring prior notification [3] before relief is granted which might affect the exercise of the ECHR right to freedom of expression, it is important to note the observations of Charles J made in 2017. To put these observations in their context, at that point there was separate category of serious medical treatment cases governed by their own practice direction. In a note he published explaining why the then-Transparency pilot approach of no prior notification would be the same for all categories of case, Charles J identified that:

> *A change for serious medical cases is that prior notice of the making of a Pilot Order will not be given to the media. On that topic in the Schedule to my judgment in V v ANL I said:*
> *"To my mind proper notification to the media of the existence of the proceedings and of the date of the public hearing of a case relating to serious medical treatment and the terms of any reporting restrictions order made when a public hearing is directed is what really matters. And when that order follows a standard process referred to in a practice direction or rules it seems to me that:*
> 1. *there are compelling reasons why the parties bound by the reporting restrictions order need not be notified of the application (see s. 12(2) of the HRA 1998), particularly if they are defined by reference to those who attend the public hearing (or get information from those that do), and*
> 2. *this view is supported by the approach of the Court of Appeal in X v Dartford and Gravesend NHS Trust (Personal Injury Bar Association and another intervening) [2015] 1WLR 3647 in particular at paragraphs 25 to 35.*
>
> *If those bound by the order (and so the media) have such notification they can then attend the hearing knowing, in general terms, what the case is about and the terms of the reporting restrictions order and they can challenge that order then or at another time.*

There is now formally no category of serious medical treatment cases, even if they are, in practice, treated differently. That makes it all the clearer that the logic applied by Charles J to dispensing with prior notice of the making of a transparency order either applies to **all** cases or no cases.

As can be seen, Charles J's approach was predicated upon proper notification of the existence and nature of the hearing on the relevant listing pages. This is provided for at paragraph 3 of the model order. The Open Justice Court of Protection Project has been – rightly – vocal in its identification of the ways in which this has not always happened, for reasons (by way of explanation, not excuse) which are often outside the direct control of the Court of Protection. However, it is not clear – at least to me – that the problem is systematically so great that it means that the logic of Charles J does not still apply.

In conclusion, therefore, I would respectfully agree that Mostyn J was right to raise the questions that he did (albeit that it is perhaps unfortunate that he did so in a case where he does not appear to have had any submissions made to him or, for instance, to have the observations of Charles J drawn to his attention). If – or, as I hope, when – the MCA 2005 is amended, it seems to me that it would be possible to make clear in primary legislation (1) that the statutory default position is for hearings to be held in public subject to reporting

[3] Mostyn J appears to have thought in terms of notification of the press. However, the transparency approach in the CoP is to open the doors to all comers, rather than just the press. Members of the public at large could also in principle assert a right to freedom of expression, so logically, in fact, such notification would have to be to everyone.

restrictions; and (2) the penalties for non-compliance with any such reporting restrictions. That would make life both easier and clearer for all concerned.

In the interim, the reality is that there is a choice between the court defaulting back to purely private hearings or to maintaining the current pragmatic balancing act that it does. Mostyn J's proposed potential alternative of maintaining the proceedings in private but relaxing the effect of s.12 Administration of Justice Act 1960 undoubtedly merits consideration by the ad hoc Rules Committee. However, as he identified, Munby J considered that even the making of such required a full *Re S* balancing exercise and press notification. Such would therefore not solve problem that such is simply not viable on a wide scale.

However, for the reasons set out above, it seems to me that the current approach of the Court of Protection, whilst a clunky workaround, is a defensibly clunky workaround.

Alex Ruck Keene KC (Hon)

British Medical Association publishes note on s.49 MCA reports

The British Medical Association (BMA) has published a brief note for doctors who are called on to complete s.49 MCA reports; this appears to have been informed by the recent article on the impact on learning disability psychiatrists who are called upon to complete s.49 reports, discussed in our April 2022 report. The note is written for doctors who are called upon to complete the reports, and offers certain guidance to medical practitioners who may feel pressured to complete these reports on their own time without compensation. The note also considers the status of s.49 orders made in respect of GP practices. It states in relevant part:

> ***Can a Trust/Consultant charge a fee for the work undertaken?***
>
> *NHS Health bodies are not allocated funds by the CoP to produce these reports. There is huge variation between courts as to the number of reports requested. At the same time, trusts vary in their approach to getting the work done and compensating those who do it.*
>
> ***Engagement with stakeholders***
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> *…The BMA Medico Legal Committee will work in partnership with the Royal College of Psychiatrists and other key stakeholders to find long term solutions to explore the possibility of other professions doing this work, professionals outside of the secondary care mental health services, which are hugely overstretched. If it continues to be done by doctors, it is the BMA's view that they must be properly remunerated.*
>
> ***Obligations on Trusts***
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> *The BMA firmly believes that all Trusts must have a Section 49 policy agreed between the trust senior management and the local negotiating committee. There should be a named lead who receives all court orders. They can then monitor the number and types of requests and make provision for the work to be done. The named lead would also be able to clarify timescales for providing the report. Additionally, the named lead should report to the trust board at least annually on the number of reports requested from the trust, the time taken, and the discipline of staff who have completed them. Policies should stipulate clearly that this work is not restricted to doctors and describe the staff who can be approached to provide reports (***see above***). There should be consideration in the first instance of contracting an external expert to complete these reports for the court on behalf of the trust, particularly if the individual is not under the care of the organisation.*

It is the BMA's view, that individuals completing this work must be compensated for the time taken to complete the report, regardless of whether the patient is currently under the care of the trust or not.

Compensation could take the form of one of the following (or if appropriate a combination, e.g., of TOIL and pay):

– Cancelling Direct Clinical Care (the "DCC") sessions to compete the work
– A locum being employed to complete the DCC work on behalf of the person completing the report while they do it
– As this is non contractual work, being compensated at an hourly rate commensurate with their skills and experience and agreed with the trust Local Negotiating Committee (LNC).
– Administrative staff would also require appropriate compensation
– Time Off In Lieu ("TOIL")

Non contractual work

All non-contractual work needs to be agreed between the consultant and the employer and is subject to negotiation over terms, including pay. Consultants are within their rights to negotiate their own rates of pay and are not obliged to undertake this work if they deem the rates of pay to be inadequate. LNCs are able to negotiate standardised rates with employers locally. However, even where such agreements are in place this does not override your right to refuse non-contractual work.

BMA minimum rate card

The decision to engage in other activity worked beyond the standard contract (such as waiting list initiatives) rests entirely with the consultant. There is wide variation around the country in the amount paid for this work. In order to achieve uniformity, fairness and consistency, we have developed a BMA minimum rate card. The BMA is now advising all NHS consultants to ensure that such extracontractual work is paid at the BMA minimum recommended rate and to decline the offer of extracontractual work that doesn't value them appropriately.

General Practice

An NHS body takes its definition from section 49(10) of MCA 2005 and section 148 of the Health and Social Care (Community Health and Standards) Act 2003. The definition of NHS body in section 148 does not include GP practices. Therefore, GP practices cannot be directly ordered by the Court of Protection to produce a report under section 49.

The vast majority of GP practices in contract with the NHS are not NHS bodies even if their contractor CCGs/PCOs are. The court sending a Section 49 request to a GP practice is not able to compel the practice to undertake the work because the practice is not a public body. Orders under section 49 would normally be sent to an NHS body to complete itself, i.e., a NHS Trust delegates the most suitable clinician within the Trust to complete the report. However, it would be possible for an NHS body (e.g., an NHS Trust) that had been ordered to 'arrange for a report to be made' to request that a GP produce the report because it is entitled under section 49(3) to instruct 'such other person' that it 'considers appropriate' do it. However, in doing so, the trust cannot compel a GP as an independent practitioner to do the work and if the GP agrees to do the work, he/she is entitled to be paid a rate agreeable to the GP.

THE WIDER CONTEXT

Brain stem death

A (a child) (Withdrawal of treatment: Legal representation) [2022] EWCA Civ 1221 (Baker, Singh, Phillips LLJ) (7 September 2022)

Summary

The hospital trust applied for a declaration of brain stem death in respect of a 3-month-old baby. Brain stem death tests on two occasions in mid-June 2022 had resulted in no response, and brain stem death was confirmed by the hospital. A few weeks later, a PICU nurse noticed that the baby was breathing. The diagnosis of brain stem death was obviously wrong, and the court proceeded to deal with the application on the basis of best interests. At the first hearing, Hayden J refused to make a declaration that CPR should not be attempted, saying that since the evidence before him did not establish that "it will never be possible for A to go home, even if that should only mean, to die at home with his parents" and so his continued treatment in PICU was not futile. At the substantive hearing, Hayden J granted a declaration that continued invasive treatment was not in the baby's best interests, and refused the parents' application for an adjournment. By that stage the parents were in agreement that CPR should not be attempted.

The parents successfully appealed to the Court of Appeal. Their legal representatives had withdrawn three days before the substantive hearing as legal aid was not granted, and the parents were therefore unrepresented at the substantive hearing. The Court of Appeal held it had been procedurally unfair to refuse the parents' application for an adjournment, noting that:

a) the issue before the court was *'the gravest and most important any parent could ever face'* [34]
b) it was no fault of the parents that their legal representation had fallen through
c) it would have been extremely challenging for any parent to conduct proceedings themselves, and particularly for these parents who were not native English speakers. Their case had not been *'as central to the hearing as it would have been had they been represented'*. [42]
d) the hearing could have been relisted, with medical witnesses appearing remotely if necessary
e) even though all the medical evidence was 'one way', that did not mean the parents should not have had a proper opportunity to challenge it.

Comment

The AMRC Code of Practice on brain stem death applies to children aged 2 months and older, but states that testing should be 'approached in an unhurried manner'. The Code is reportedly now under review, with an updated version to be published in 2023. There are likely to be more cases where test results are disputed, particularly in children, in light of the extraordinary events in this case.

The Court of Appeal's judgment reinforces the importance of parents being able to participate effectively in substantive hearings of this nature, even though the prospects of successfully challenging unanimous medical evidence may be slim. Trusts bringing these applications should note that the Court of Appeal suggested that a contingency plan (probably pro bono representation) should be in place where legal aid has not been confirmed.

'Gurus' and coercive control: when does a cause of action arise?

Samrai & Ors v Kalia [2022] EWHC 1424 (QB) (16 June 2022) (Deputy Master Grimshaw)

Deputy Master Grimshaw considered an application by the Defendant to a strike out claim against him. The Defendant was various described as a head priest or guru of a religious organization, founded in the principles of the Hindu religion. The claimants had been

members of his congregation from 1987 onwards.

The Claimants, all of whom ceased their involvement with the congregation in late 2016 / early 2017, claimed that they were subjected to psychological domination by the Defendant, and that as a consequence of this state of belief or obedience they parted with substantial sums of money. Further claims were made by a subset of the first four Claimants in relation to sustained physical and sexual abuse and harassment. They sought *'equitable relief in the form of declarations, accounts and inquiries, restitution and/or equitable compensation for the monies paid and the value of the work done.'* [5]

The claims were brought outside of the primary limitation period, and the Claimants invited the Court to exercise its discretion pursuant to s.33 of the Limitation Act 1980 to allow the claim to proceed. The court agreed to do so, considering that it was *'at least arguable that some or all of the Claimants were heavily influenced and/or their will overborne by the Defendant, such that I can see that it is arguable that a Court could exercise its discretion pursuant to s. 33 Limitation Act 1980.'* [83]

The Defendant raised a number of criticisms of the claim including that:

1) The Schedules appended to the Particulars of Claim were unclear as to what monies were paid, what the monies were paid for and indeed whether they amounted to transactions;
2) Many of the donations made to the Defendant appear to have been voluntary;
3) Some of the financial claims seem to be extraordinary;
4) The claimants claimed for work which appeared to have taken more than than 24 hours per day.

When determining whether to strike out the claim, Deputy Master Grimshaw considered the two grounds of CPR 3.4(2):

- In relation to Ground (a) – no reasonable grounds for bringing or defending the claim. Despite insufficient detail in respect of alleged time periods and locations of alleged sexual assaults [para 104], the Court was satisfied that the "*Particulars of Claim do set out reasonable grounds for bringing the claims for these alleged torts. The facts and matters relied upon are set out, albeit would benefit from further particularisation in some respects"* [para 107]. It was also found that the Harassment claims [paras 111 – 114], the Work and Financial Claims [para 115] and Misrepresentation Claims [para 116 - 117] were not "*bound to fail"* nor is there "*no real prospect of them succeeding"*. Consequently, Deputy Master Grimshaw and refused to strike them out. It was noted that the Defendant did not made requests for further information pursuant to CPR Part 18

- In relation to Ground (b) – Abuse of Process. Although the Court expressed sympathy with the conduct of the case [para 118] the claims were "*intelligible legally recognisable claims"* and no Part 18 requests for further information had been made by the Defendant. The claim itself and the way it has been run "*has not reached the threshold of being abusive, in that it has not impeded the just disposal of proceedings to a high degree*" [para 123].

Deputy Master Grimshaw also considered Summary Judgement in brief [paras 126-127] and whether the Claimants had a real prospect of succeeding with their respective claims. He stated that although there may be some difficulty in proving some of the matters claimed, that they are the *"epitome of triable issues"*.

The Defendant's applications for summary judgement and to strike out of the Claimants' claims were refused.

Short note: aspects of litigation capacity

Tonstate Group Ltd & Ors v Wojakovski [2022] EWHC 1771 (Ch) (15 July 2022)(Falk J)

Two recent cases have shone a spotlight on different aspects of litigation capacity. In *Tonstate Group Ltd & Ors v Wojakovski* [2022] EWHC 1771 (Ch), Falk J had to consider whether a defendant to contempt proceedings arising out of a bankruptcy case had the capacity to conduct them. The concerns were raised by his solicitor, Karen Todner, an extremely experienced mental health solicitor. Falk J identified that Ms Todner was right to do so in circumstances, and that this was not a case of the defendant "*simply feigning or relying opportunistically on mental health difficulties*" (paragraph 71).

Falk J had two medical reports before her. In preferring the evidence of the expert instructed on behalf of the claimants, she did so, in part, because his report "clearly separated, and followed, the two-stage approach contemplated by the MCA and reflected in the statutory Code of Practice, first determining whether there is an impairment of the mind or brain, or disturbance affecting the way it works, and secondly considering whether that impairment or disturbance means that the person is unable to make the relevant decision" (paragraph 57). It is unfortunate in this regard that she did not have drawn to the attention the decision of the Supreme Court in *A Local Authority v JB* [2021] UKSC 35, in which the Supreme Court made clear that the Code currently has the two stages the wrong way around.

An oddity of the case is that it is not entirely clear from the judgment whether the defendant himself asserted his incapacity (it appears that he may, at least initially, have resisted the suggestion by his solicitor that he lacked it (see paragraph 71)). The case also throws into relief the somewhat curious position of legal representatives in civil proceedings who consider that their own client lack capacity to instruct them: on what basis are they entitled (for instance) to commission expert evidence? They could, in theory, rely upon the fact that the court has not – yet – determined the question of litigation capacity, but if they genuinely believe that their client lacks such capacity, it might be said that they are in difficult territory by reference (for instance) to the SRA's June 2022 guidance on accepting instructions from vulnerable clients.

A number of observations made by Falk J in the course of her detailed analysis leading to the conclusion that the defendant did have capacity to conduct the proceedings are of wider relevance. In particular, and in emphasising the importance of the 'support principle' in s.1(3) MCA 2005, she observed that the evidence from Ms Todner

> *demonstrates difficulty in obtaining instructions, and not that it is impossible to do so. The fact that emails are confused or thoughts disjointed, or that Mr Wojakovski might need more assistance than some clients, are certainly hindrances, but they are insufficient to establish a lack of capacity. Rather, the test requires an assumption that all practicable steps are taken to help the relevant individual to make a decision for himself.* (paragraph 66, emphasis in original)

In the same vein, Falk J also noted that she made no assumptions that the defendant would be assisted by a Mr Marx, a friend of his who had provided him with support in the underlying bankruptcy proceedings. As she noted at paragraph 69.

> *There is obviously no obligation on Mr Marx to provide assistance. Instead, Mr Wojakovski has the benefit of a legal team who should perform that function.*

In proceeding in this way – i.e. that she should consider the defendant's litigation capacity on the basis that she was considering "defendant + legal team" – Falk J[4] was wading into contested territory. Her approach meshes with that of MacDonald J, but not, it should be noted, with that of Mostyn J. In *Re P (Litigation Capacity)* [2021] EWCOP 27 Mostyn J noted (at paragraph 31) his disagreement with the conclusions of MacDonald J in *TB and KB v LH (Capacity to Conduct Proceedings)* [2019] EWCOP 14:

> *that if a person lacks capacity to conduct proceedings as a litigant in person she might, nevertheless, have capacity to instruct lawyers to represent her and that the latter capacity might constitute capacity to conduct the litigation in question. I differ because, as MacDonald J himself eloquently explained, conducting proceedings is a dynamic transactional exercise requiring continuous, shifting, reactive value judgments and strategic forensic decisions. This is the case even if the litigant has instructed the best solicitors and counsel in the business. In a proceeding such as this, a litigant has to be mentally equipped not only to be able to follow what is going on, but also to be able figuratively to tug counsel's gown and to pass her a stream of yellow post-it notes. In my opinion, a litigant needs the same capacity to conduct litigation whether she is represented or not.*

This difference of opinion between High Court judges (or, strictly, in the context of Court of Protection, Tier 3 judges) is unfortunate. The approach of Falk J and MacDonald J sits more comfortably with the approach set down in s.1(3) MCA 2005; it also maximises the chance that individuals (whether before the Court of Protection or other courts) will be seen to have capacity to conduct that litigation. It does, however, mean that the court determining litigation capacity is – colloquially – taking a punt on the support they have identified continuing to be available throughout the proceedings.

The case of *Shirazi v Susa Holdings* [2022] EWHC 2055 (Ch) raises a different issue: namely how the court is to proceed where it appears that the litigation friend may not be acting entirely of their own free will. At first instance, an application to remove the claimant's litigation friend – his wife – had been refused. That challenge had been brought, amongst other grounds, on the basis that the litigation friend, herself, lacked capacity to conduct the litigation. The Master had rejected that ground, and had further considered that the claimant's wife was able fairly and competently to conduct the litigation (the test set down in CPR r.21.4(3) (identical, in this regard, to the approach under the COPR and the FPR). The Master accepted that the claimant's son exercised "undoubted influence" over the lives of his parents – which gave her "pause for thought" – but, as Bacon J identified on appeal:

> *56. […] The difficulty with the following paragraphs of her judgment, however, is that the Chief Master seems to have accepted at face value, or at least given decisive weight to, the statements made by Mrs Shirazi that she makes her decisions independently after taking advice, and*

[4] Perhaps unknowingly, as she does not appear to have been addressed on this point.

> *the statements from her lawyers that they take their instructions from Mrs Shirazi and not from her son Borzou*

Bacon J continued:

> *It seems to me that this misses the point. The question is not whether Mrs Shirazi believes that she is acting independently or whether she, as opposed to Borzou, gives instructions to her solicitors. Rather, the question is whether, on all the evidence before the court, it appears that Mrs Shirazi is in fact able to act independently, objectively, impartially and in an even-handed manner in the present litigation, and in particular independently from Borzou and any interest that he may have.*

On the evidence before the court, Bacon J was clear that this was not the case at all. Bacon J also considered that the statement from the wife's solicitors that they were well aware of their responsibilities missed the point:

> *63.* […] *Mrs Shirazi's solicitors may be litigating on behalf of Mrs Shirazi and therefore on behalf of Mr Shirazi, but they cannot know what goes on behind closed doors when Mrs Shirazi takes decisions about the conduct of the proceedings and weighs up the advice that she has been given.*
>
> *64 In my judgment, in the circumstances that I have described, Mrs Shirazi cannot help but be influenced by Borzou. That is why Master Shuman correctly referred to the undoubted influence exercised by him over his parents. More than that, however, I also consider that that influence, in the circumstances described, inevitably affects and indeed compromises Mrs Shirazi's independence and objectivity in the conduct of these proceedings, whatever she might believe as to that.*

Bacon J also rejected the contention that, even if a new litigation friend were to be appointed, the proceedings would have no different outcome. She therefore allowed the appeal and directed that Mrs Shirazi be removed as her husband's litigation friend.

The case therefore serves as an important reminder that mere abstract competence to conduct proceedings is insufficient – a litigation friend must actually be able to do so "independently, objectively, impartially and in an even-handed manner."

Alex Ruck Keene KC (Hon)

Does the Care Act 2014 require a local authority to fund a family holiday to Florida?

R(BG and KG) v Suffolk County Council [2022] EWCA Civ 1047 (26 July 2022) (Baker LJ, Nicola Davies LJ, Phillips LJ)

For those who prefer to listen to a discussion of the case, Arianna and Sian Davies have recorded a podcast discussing the implications of the case which is available here.

The Court of Appeal considered the appeal of Suffolk County Council to the judgment of Lang J in *R(BG & KG) v Suffolk County Council* [2021] EWHC 3368 (Admin). The case related to a decision by the local authority to cease providing direct funding for activities and holidays (rather than carers to facilitate participation in those activities or holidays) for two brothers with autism and learning disabilities who were supported almost entirely by their mother.

BG and KG were brothers in their late thirties. Both have diagnoses of autism, learning

disabilities and epilepsy, and both experienced significant anxieties. Both had issues of night incontinence; KG had poor mobility and used a wheelchair due to his fibromyalgia. Both men required 24-hour support, and both were considered to have capacity to take decisions as to their care.

SQ was their mother, who cared for them during the day; she was also up every night attending to them. SQ had some support from BG and KG's stepfather, sister and brother-in-law, but all of these individuals had other responsibilities, but the judgment is clear that SQ provided the vast majority of the care. The brothers had previously been abused at a day centre and did not wish to return, and would not tolerate external carers in their home.

From 2011, KG and BG had both received direct payments, which could be used for access to the community by way of outings and activities (including to pay for food during trips out to cafes, and entrance fees at activities). From 2013, they also received a respite budget specifically for holidays. In 2014, following SQ's request for a respite budget so that she could take KG on a supported holiday and planned trips away, it was agreed that a one-off yearly payment of £3,000 would be requested for each brother. Direct payments of £150-£300 per week for each brother continued with rises through 2018.

The direct payments were given for the purposes of meeting the brothers' needs by supporting them to access the community, with a goal to developing their confidence; they also allowed SQ to have respite time away with family. BG's support plan emphasised the importance of access to the community and to nature in particular, for the purpose of building his confidence and trust, and gaining greater independence.

From approximately 2019, the local authority stated that it would pay for care to support the men to engage in activities and holidays, but would not provide funding to allow the men to purchase food in cafes (which they were regularly attending to increase their social networks and reduce anxiety in public settings), or to pay for membership to the National Trust, RSPB, local zoo and aquarium and transportation to and from these locations. It was accepted that a holiday could meet SQ's needs for support, but the local authority did not consider that paying for the holiday itself was a permissible way of meeting the brothers' needs.

The family challenged these decisions and were supported by mental health professionals, who felt that the trips out were very important to them and gave the family a break from the stress of being at home and allowed the brothers to pursue their interests in wildlife. A CPN working with the family emphasised the importance of the holidays as respite for SQ's welfare where no regular respite care was available. It also appears that the brothers' mental health suffered on the removal of support for trips out, with a subsequent assessment recording that, *'[d]ue to [BG's] mental health (anxiety) this is challenging. [BG] states that he has lost his socialisation as he can no longer access the cafes in which he made these relationships.'* [15]

Before Lang J, it was agreed by the parties that SQ's needs as a carer could, as a matter of law, be met with payments to allow the family (including BG and KG) to have a holiday. It was also agreed that a person could have a need to have a carer to support access recreational facilities. The dispute was as to whether KG and BG's needs could be met through provision of a holiday and financial support to attend activities and for making purchases for things other than care to meet their needs. The local authority argued that as a matter of law, it had no power to pay 'universal costs', including holidays, transportation food at cafes and entrance fees for activities.

At first instance, the court found in favour of BG and KG and found the local authority did have

such a power. The court accepted that brothers had needs around making use of necessary facilities and services in the local area; making use of recreational facilities and making use of recreational services. Both the first instance court and the Court of Appeal also accepted that '*Recreational facilities and services are not confined to the local area.*' [59]

The Court of Appeal considered three grounds:

> *41…(i) In holding that the appellant's assessment of the respondents' care needs, conducted in October 2019, were defective, such that they could not be relied upon to defend the 3 March 2020 decision, in circumstances where the respondents had advanced no challenge to the assessment;*
> *(ii) In declaring that the appellant has a power, as a matter of law, to provide financial support for recreation activities and holidays, under section 18 of the CA 2014; and*
> *(iii) In holding that section 19 of the CA 2014 confers the power to provide financial support for recreation activities and holidays.*

The local authority accepted that BG and KG's needs had not decreased over time, but argued that it had been in error in ever finding that they had had had an eligible need to attend recreational activities and holidays under the Care Act 2014. The Court of Appeal disagreed, and made some notable comments on the scope of what 'care and support' is under the Care Act:

> 69. *Section 1 of the CA 2014 is clear as to the purpose of the statute namely the promotion of an individual's well-being, within that is recognition of the autonomy of that individual. This is also reflected in the Statutory Guidance which identifies the broad nature of the concept of well-being, the need by a local authority to consider the particular circumstances of each individual and to recognise that each person's needs are different and personal to them. The core purpose of this provision of adult social care and support as set out in the CA 2014 is to help individuals to achieve outcomes which matter to them in the life which they lead.*
> 70. *Of note is the language used: the adult's needs for "care and support" are the basis of the s.9 assessment and the s.18 duty. In my view, "support" begins with the identification of the needs and wishes of the particular individual and, is or should be tailored, to address the same…*

The Court of Appeal contrasted the term 'care and support' with the former term of 'care and attention', which

> *70…does not reflect the development in the approach which local authorities are now to adopt as set out in sections 1, 9 and 18 CA 2014 which recognise the autonomy of the individual and the need for care and support. In my judgement, the needs under the CA 2014 can no longer be described as "looked-after" needs as such a description does not properly reflect the individual nature of the assessment, its recognition of the autonomy of the individual and the tailored and broad nature of the support which can be provided.*

The Court of Appeal found that the Care Act intended to '*broaden the discretion and flexibility of local authorities in their provision of care and support to adults.*' [71] It accepted that provision of recreational needs and holiday '*would meet two of the eligibility criteria set out in regulation 2 of the 2015 Regulations namely: (g) developing and maintaining family or other personal relationships; and (i) making use of necessary facilities or services in the local community including public transport and recreational facilities or services. I do not accept that it is possible to use recreational facilities merely by the provision of support to access the facility if the*

adult in question cannot afford to pay for the entry requirements.' [74]

The Court of Appeal also considered that BG and KG's well-being was assisted '*by the taking of holidays, visiting nature reserves and similar activities, which is no doubt the reason why the appellant previously provided financial support for the same*'. [75] It found:

> *75…The financial support, previously provided by the appellant, is not simply a means of paying for the respondents to take part in such activities and to go on holiday, it is a means of meeting their needs which arise from and are related to the physical and mental disability from which each suffers. It is a need which cannot be met without financial support from the appellant.*

In BG and KG's case, accessing holidays and recreational activities were not just a 'universal need'; and in any event, there was no prohibition under the Care Act from meeting a 'universal need.' The Court of Appeal concluded that it was:

> *76…satisfied that the needs of each respondent are specific to each rather than a universal need. I do not interpret the relevant provision of the CA 2014 as prohibiting the provision of what is termed a "universal need"; rather, it guides the need to be assessed by reference to the eligibility criteria of the adult. It follows, and I so find, that the need for holidays and recreational activities, arising as they do from the respondents' physical or mental impairment, are eligible needs and can be met by the provision of goods or facilities in this case financial support in the form of a direct payment (section 8(1)(d), section 8(2)(c) CA 2014)…*
>
> *78. SQ cannot meet all her sons' needs for recreation as she is unable to afford entrance fees, transport and other costs. To find, as the appellant did, that SQ as their carer can meet all the eligible needs of the respondents is to ignore a key element of those needs namely the ability to fund the means to access and take part in recreational activities including holidays.*

Comment

The judgment is of interest for its consideration of the flexibility of the Care Act for what actions can be taken to 'meet needs.' It is perhaps an unsurprising judgment insofar as the Care Act framework was designed to move away from meeting needs through a pre-defined list of services and interventions in the community and in residential settings, and the Care and Support Statutory Guidance specifically suggests interventions of attendance at a gym as a way of meeting needs.

The judgment does not militate that a local authority must fund a holiday, and any body considering how to meet needs must have consideration both for the individual and the larger body of people it is supporting.

What is the evidentiary value of foreign convictions?

W-A (Children : Foreign Conviction) [2022] EWCA Civ 1118 (05 August 2022) (Bean LJ, Peter Jackson LJ, Dingemans LJ)

Summary

This case concerned the question of whether a conviction for a criminal offence in a foreign country is admissible in care proceedings, as evidence with presumptive weight.

The care proceedings were in respect of two girls aged 11 and 16. Their mother's husband (MH) had been convicted of sexual offences against a child in a Spanish Court. Mrs Justice Lieven at first instance had held that the conviction was admissible evidence, and the fact of the

conviction was proof of the facts underlying it unless MH could rebut that presumption on the balance of probability. The effect of the ruling was that the foreign conviction was treated in the same way as if it was a conviction of a court in the United Kingdom.

MH appealed to the Court of Appeal.

Lord Justice Peter Jackson giving the leading judgement, with which the other judges agreed, held that the fact finding role of the Court could not be 'isolated' from the welfare decision to be made. '*The characteristics of family proceedings therefore speak strongly against the existence of artificial evidential constraints that may defeat the purpose of the jurisdiction.*'

He had no trouble in rejecting the appeal, concluding that:

- In family proceedings all relevant evidence is admissible. Where previous judicial findings or convictions, whether domestic or foreign, are relevant to a person's suitability to care for children or some other issue in the case, the court may admit them in evidence.
- The effect of the admission of a previous finding or conviction is that it will stand as presumptive proof of the underlying facts, but it will not be conclusive and it will be open to a party to establish on a balance of probability that it should not be relied upon. The court will have regard to all the evidence when reaching its conclusion on the issues before it.

Comment

Of particular interest, is what the Court has to say about the inquisitorial form of family proceedings and their welfare-based nature which led the Court to conclude that exclusionary rules such as estoppel, the doctrine *res inter alios acta* (*the* principle that a contract made by other people cannot affect the rights of a non-party) and the ratio of the Court of Appeal decision of *Hollington v Hewthorn* [1943] 2 All ER 35 (which would ordinarily be binding on the Court of Appeal), do not apply in such proceedings because '*they would not serve the interests of children and their families or the interests of justice*.'

While this issue arose in the context of public law proceedings, the Court made it clear that the same issue might arise in private law proceedings, pursuant to proceedings under the inherent jurisdiction in relation to children or in relation to welfare proceedings in the Court of Protection.

It remains to be seen what if any use, Court of Protection practitioners may make of this judgment in disapplying other exclusionary rules.

Guest Article by the Child Law Network: Scottish Regulations and Advice/Ideas on how to navigate them

[This month, the Mental Capacity Report features a Guest Article from Shauneen Lambe of the Child Law Network in Scotland, which discusses children who are accommodated in Scotland under conditions which deprive them of their liberty (under child protection/care legislation, rather than mental health or AWI).

If you are looking for legal advice in connection with a child on DoLs in Scotland, you can use the Law Society of Scotland's find-a-solicitor tool to search all Scottish solicitors by the relevant area of law. Alternatively, you might consider consulting a solicitor with an Accredited Specialism in Child Law, details of whom you can also find on the Law Society website.

The Child Law Network Guest Article appears below.]

In June 2022 the President of the Family Division Sir Andrew McFarlane announced the launch of a National Deprivation of Liberty (DoLs) Court. The court will deal with applications seeking authorisation to deprive children of their liberty, based at the Royal Courts of Justice.

The creation of this Court follows the Supreme Court decision of 2021 T(A child) [2021] UKSC 35 which addressed the shortage of approved secure children's homes placements in England and Wales, giving local authorities the ability to apply to the High Court's 'inherent jurisdiction' to authorise DoLs. The Supreme Court found DoLs permissible but expressed grave concern about using them to fill a gap in the child care system caused by inadequate resources.

Significant numbers of children on DoLs orders are placed across the border into Scotland. Until recently each cross-border placement had to be heard by the Court of Session in Edinburgh. However the Scottish Parliament has now passed The Children's Hearings (Scotland) Act 2011 (Effect of Deprivation of Liberty Orders) Regulations 2022 which came into force on 24 June 2022. These regulations automatically give DoLs the same effect as a Scottish compulsory supervision order ("CSO") although the DoLs is not *converted* into a CSO. The Regulations therefore remove the need for an English, Welsh or Northern Irish Local Authority, seeking to place a child in Scotland, to petition the Court of Session. DoLs can be implemented for renewable periods of up to 3 months (Regulation 5). The regulations only apply to children on DoLs orders – they do not apply to children on secure accommodation orders.

The office of the Children and Young People's Commissioner Scotland(CYPCS) called for the regulations to be significantly strengthened, believing they "fall short of providing parity of protection for all children deprived of their liberty in Scotland." The Commissioner's office explains that unlike Scottish children, children on DoLs are usually deprived of their liberty in Scotland in privately owned non-secure facilities. "These facilities are not currently authorised, inspected, or regulated to detain children. The result is that they have been largely invisible to Scottish inspection/regulatory agencies."

The CYPCS considers that the Regulations fall short in a number of ways:

• There are not equivalent legal processes or protections which align with a 'Scottish' child deprived of their liberty

• They do not place any restrictions on which residential units the child may be placed in

• They do not make provisions for the involvement of Scottish public authorities in an assessment of whether the placement meets the child's needs and whether their legal rights are being upheld

In light of this the CYCPS recommend that lawyers representing children in DoLs hearings ask the court to consider and address the following factors before any order is made by the DoLs Court in holding a child in Scotland:

• The placing local authority provides a detailed assessment and plan in conjunction with the public authorities in Scotland, the care home, and the child and family, on how it proposes to fulfil its human rights duties to the child

• Whether the care home is capable of meeting the child's needs and is it appropriate to deprive a child of their liberty there.

• Confirmation from the Head of the care home that the staff have the necessary training and experience to deliver the child's care plan, and to meet the individual child's needs

• Check that there has been consultation with the receiving local authority and Health Board

• Check whether the care home complies with the requirements of the ECHR and UNCRC, provides details of who will be responsible for assessing the needs of the child, who will be responsible for coordinating and delivering services.

• Ensure that within the 22-day period of the initial DoLs, there will be a multi-agency, Team Around the Child meeting with the Scottish local

authority, child and family which will provide a recommendation and report.

• That the placing local authority must support and fund regular visits and contact between the child and their family throughout the duration of the placement. Evidence shows that children from local authorities in England and Wales residing in secure care in Scotland in 2018 and 2019 were an average of 353 miles away from their homes[5]

• That the placing local authority must undertake that the transportation of children to and from care placements is child-centred and trauma sensitive. In particular, handcuffs should not be used.

• That the placing local authority funds independent legal advice and representation on protections under Scots law for the child.

Lawyers for children facing a DoLs in Scotland can ask for a copy of the Scottish Children's Commissioner's briefing note, or raise concerns about the rights of their client, by contacting DOLNotifications@cypcs.org.uk.

Or for further information contact the Child Law Network shauneen@impactsocialjustice.org

Archie Battersbee: the context and the relevance of the Convention on the Rights of Persons with Disabilities

Following a series of judgments, treatment was withdrawn from Archie Battersbee on 6 August 2022. This article does not consider all aspects of this tragic case, but focuses on the interaction of the case with the UN Convention on the Rights of Persons with Disabilities, and specifically on the implications of the so-called 'note verbale' sent by the Committee on the Rights of Persons with Disabilities [6] to the UK Government requesting that life-preserving treatment be maintained whilst it considers the parents' application under the Optional Protocol to the CRPD.

The CRPD: introduction, status before the English courts, and requests for interim measures

The CRPD took a front seat in the last stage of arguments. A number of assertions have been made which require unpicking.

Although ratified by the UK, the CRPD has not been incorporated into English law in the same way as the European Convention on Human Rights. The obligations that it imposes therefore operate at the state level, rather than (for instance) at the level of the discharge by either public authorities or courts of their respective functions under domestic legislation. This means, as Supreme Court made clear in 2021, that the Convention cannot be used before English courts in the same way as the ECHR either to construe domestic legislation, or ground arguments that the UK has violated its provisions.[7] That does not mean that the CRPD is of no relevance at all before English courts: for instance, courts will often have regard to it as part of the wider canvass when considering the approach to disability – as did Lady Hale in *Cheshire West and Chester Council v P; Surrey CC v P* [2014] UKSC 1 when emphasising the universal nature of the right to liberty. But it does mean that – because of a choice made by Parliament, rather than the courts -arguments based upon the CRPD have a very different

[5] What do we know about children from England and Wales in secure care in Scotland? - Nuffield Family Justice Observatory (nuffieldfjo.org.uk)

[6] This is not available on the UNCRPD website, but the text is contained at paragraph 8 of the decision of the Court of Appeal of 1 August 2022.

[7] See *A Local Authority v JB* [2021] UKSC 52, applying the approach to the UN Convention on the Rights of Children (another unincorporated convention) in R (SC, CB and 8 children) v Secretary of State for Work and Pensions and others [2021] UKSC 26.

nature before English courts than do arguments based upon the ECHR.

As noted above, the UK has ratified the Optional Protocol to the CRPD, which means that it recognises (under Article 1) the 'competence' (i.e. power) of the Committee on the Rights of Persons with Disabilities – the treaty body overseeing the CRPD – to "*receive and consider communications from or on behalf of individuals or groups of individuals subject to its jurisdiction who claim to be victims of a violation by that State Party of the provisions of the Convention*." Article 5 of the Optional Protocol provides, in turn, for the Committee to examine the communication (if it is admissible) in a closed meeting and to "*forward its suggestions and recommendations, if any, to the State Party concerned and to the petitioner*." The use of this language is deliberate – and deliberately different to language relating (say) to the European Court of Human Rights, which is a court, and can pass judgments which are binding on the state in question.[8] The powers of the Committee are therefore, in effect, moral powers, which it can use to place pressure upon a state which has signed the UNCRPD to bring itself into alignment with the Convention.[9]

The Committee has powers under Article 4(1) of the Optional Protocol to send to the state "*for its urgent consideration a request that the State Party take such interim measures as may be necessary to avoid possible irreparable damage to the victim or victims of the alleged violation*." This is what happened in this case; the Committee also making clear at the same time (as is also made clear under Article 4(2)) that this implied no determination on admissibility or the merits of the application to it.

The third decision of the Court of Appeal (of 1 August 2022) and the second decision of the Supreme Court (of 2 August 2022) both turned, in part, upon precisely what the United Kingdom is required to do when it receives a request under Article 4(1) of the Optional Protocol. Both the Court of Appeal and the Supreme Court were clear that, given the status of the CRPD in English law, any such request could not (in effect) override the operation of English law. It is also clear that both were troubled that it appeared that the CRPD Committee's consideration of the application might be prolonged, the Court of Appeal noting that the Committee requested a reply from the United Kingdom some two months from the date of the letter, and the Supreme Court noting that "*to give effect to the application for a stay in the circumstances of this case would be to act unlawfully in conflict with the court's duty under domestic law to treat Archie's best interests as paramount as the Committee envisages a procedure for its consideration of the application which will extend into 2023*."

All of this may seem extremely technical; at one level it is.[10] It is a matter which the Committee may comment further upon in due course, but it is perhaps relevance (although not noted in any of the judgments in Archie Battersbee's case) that the Court of Appeal and Supreme Court have taken a similar approach to the French Cour de Cassation (the equivalent of the Supreme Court) in the case of Vincent Lambert, where a request

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[8] I am ignoring for present purposes the British Bill of Rights Bill currently before Parliament which may seek to alter the status of such judgments within the United Kingdom (although it could not do so as between the United Kingdom and the European Court of Human Rights).

[9] For more on the status of the Committee, including in relation to the 'General Comments' that it issues to set out its interpretation of the CRPD, see Essex Autonomy Project (2014) Achieving CRPD Compliance: Is the Mental Capacity Act of England and Wales compatible with the United Nations Convention on the Rights of Persons with Disabilities? If Not, What Next?, and (2017) Three Jurisdictions Report: Towards Compliance with CRPD Art. 12 in Capacity/Incapacity Legislation across the UK.

[10] One technicality is the difference between requests under the Optional Protocol and the indication of interim measures under Rule 39 of the rules of court of the European Court of Human Rights, as happened in Charlie Gard's case.

had also been made by the CRPD Committee that life-sustaining treatment not be withdrawn in respect of an adult. In that case, a lower tier court had held that the French doctors were under an obligation to comply with the request; the Cour de Cassation overturned this decision; life-sustaining treatment was withdrawn.[11] It appears, at least from materials publicly available, that the Committee never proceeded to a substantive consideration of the application made. Nor did the Committee make any reference to this case or to the approach taken to life-sustaining treatment decisions in relation to adults in its 2021 Concluding Observations on the initial report of France upon its compliance with the CRPD.

The CRPD and life-sustaining treatment

Moving beyond the technicalities, as important as they are, I suggest that it is very important that those who are commenting upon or campaigning in relation to the case are on thin legal ice in asserting that the Committee on the Rights of Persons with Disabilities (if it ever considers the substantive application) would necessarily conclude that the CRPD requires the continuation of life-sustaining treatment in a situation such as this. With Annabel Lee, I have written previously about this in the context of decisions about the continuation of life-sustaining treatment in respect of adults who are incapable of making the decision to consent to or refuse such treatment.[12] I reproduce the relevant section below.

For present purposes, of greatest importance is to understand that the CRPD Committee asserts (an assertion not universally accepted[13]) that Article 12 requires states to replace legislation which provides for substitute decision-making for incapacitated adults based 'on what is believed to be in the objective "best interests" of the person concerned, as opposed to being based on the person's own will and preferences'.[14] The CRPD Committee also contends that the Convention requires that "decisions relating to a person's physical or mental integrity [i.e. medical treatment] can only be taken with the free and informed consent of the person concerned."[15]

Two further articles of the CRPD are of relevance:

1. Article 10, which provides that "States Parties reaffirm that every human being has the inherent right to life and shall take all necessary measures to ensure its effective enjoyment by persons with disabilities on an equal basis with others;"

2. Article 25, which provides that "States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall: […] (f) Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability" (emphasis added).

Given the historic treatment of – and judgments about – disabled people, one might have expected that the CRPD Committee to have expressed clear views about the nature of the right to life and the obligations that follow. The way in which the Committee has sought to grapple with this issue is, we suggest, revealing. To date, the Committee

[11] For a discussion of this case, and also of the status of requests for interim measures under the Optional Protocol to the CRPD, see this article (in French) by Paul Véron and Marie Baudel.

[12] Withdrawing life-sustaining treatment: a stock-take of the legal and ethical position. 2019 Journal of Medical Ethics, 45(12), 794-799.

[13] The most accessible guides to this issue can be found in the work of the Essex Autonomy Project, available at https://autonomy.essex.ac.uk/crpd/.

[14] Committee on the Rights of Persons with Disabilities, 'General Comment on Article 12: Equal Recognition before the law' (CRPD/C/GC/1, adopted 11 April 2014), paragraph 27.

[15] Committee on the Rights of Persons with Disabilities, 'General Comment on Article 12: Equal Recognition before the law' (CRPD/C/GC/1, adopted 11 April 2014), para 42, referring to the interaction of Article 12 with Article 17 (the right to personal integrity).

has not specifically addressed this question in any of its overarching general comments or guidelines, nor has it referred to Article 25(f) in any of its concluding observations.[16] *However, in 2011, in its concluding observations on the initial report of Spain on its compliance with the Convention, the Committee:*

29. […] regret that guardians representing persons with disabilities deemed "legally incapacitated" may validly consent to termination or withdrawal of medical treatment, nutrition or other life support for those persons. The Committee wishes to remind the State party that the right to life is absolute, and that substitute decision-making in regard to the termination or withdrawal of life-sustaining treatment is inconsistent with this right.

30. The Committee requests the State party to ensure that the informed consent of all persons with disabilities is secured on all matters relating to medical treatment, especially the withdrawal of treatment, nutrition or other life support.

It is not entirely clear what the Committee meant by asserting that the right to life is absolute. It might, on one view, be taken as asserting a vitalist[17] *position that all must be done to save the life of the person, regardless of the cost, effectiveness and physical burden on the patient of the intervention in question.*

The 2011 concluding observations, however, stand alone and at odds with the Committee's other concluding observations and other reports. The Committee did not repeat its comments in its concluding observations on Spain's next reports. It has scrutinised other states in which withdrawal of life-sustaining treatment is permitted,[18] *and has only commented on one further state, the United Kingdom. In the advance unedited version of its concluding observations*[19]*, the Committee:*

26 [….] observe[d] 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.***

However, in the final version,[20] *the Committee made a subtle but important change in its recommendation, dropping the assertion in the first sentence:*

27. The Committee 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" and recognizing persons with disabilities as equal to others and part of the diversity of humankind. It also recommends that the State party ensure access to life-sustaining treatment and/or care.

It is speculation, but it is just possible that this came about as a result of commentary from one

[16] This issue has also been the subject of surprisingly little commentary, barely being touched upon in the most comprehensive commentary: Bantekas, I. et al. The Convention on the Rights of Persons with Disabilities: A Commentary. Oxford Commentaries on International Law: Oxford, Oxford University Press 2018.

[17] This is sometimes linked to Catholic teaching, but is not necessarily driven by a religious perspective. For a useful discussion of the evolving Catholic position, see: Zientek DM. Artificial nutrition and hydration in Catholic healthcare: balancing tradition, recent teaching, and law. InHEC forum 2013 Jun 1; 25(2);145-159.

[18] Including, amongst others, Australia, Denmark, Germany and Sweden. See, for a comparative review of different jurisdictions (including discussion of when recourse to court is required)[11].

[19] Although not available on the UN website, it can be found at https://mhj.org.uk/wp-content/uploads/sites/192/2017/09/Concluding-Observations-CRPD-Committee-UK.pdf

[20] CRPD/C/GBR/CO/1 (3 October 2017).

of the present authors on the unedited advanced version which noted that the assertion of an absolute right to life took the Committee into some very difficult territory. In particular, this assertion could be read as requiring treatment to be continued even where this was contrary to the best interpretation of the will and preferences of the person, the standard the Committee consider should govern decision-making where the person is not in a position to make their own decision (even with support).

Further, the Committee's own General Comment on Article 12 CRPD (promulgated after the concluding observations in relation to Spain) provides that "[f]or many persons with disabilities, the ability to plan in advance is an important form of support, whereby they can state their will and preferences which should be followed at a time when they may not be in a position to communicate their wishes to others" at paragraph 12. This simply could not square with the assertion of an absolute right to life in Article 10 if such is intended to mean that there are no circumstances under which life-sustaining treatment could be withdrawn – or, indeed, by the same logic, withheld.

The reality, we suggest, is that:

1. the Committee do not, in fact, think that the right to life is absolute, if this is to mean that all steps can and must be taken at all times to keep a disabled person alive.[21] We are reinforced in this view not just by the analysis set out above, but also by the fact that the Committee could not take this position and yet make no reference in their concluding observations upon Belgium to the fact that euthanasia is permitted there, or, in considering the position in Canada, in which euthanasia is also permitted, limited themselves to emphasising that "persons who seek an assisted death have access to alternative courses of action and to a dignified life made possible with appropriate palliative care, disability support, home care and other social measures that support human flourishing;"[22]

2. the obligation is, rather, to ensure that individuals are not arbitrarily deprived of their lives, as it is in Article 6 of the International Covenant on Civil and Political Rights to which the CRPD gives effect in the context of disabled people;[23] and therefore that

3. even viewed through the prism of the CRPD, the lex specialis of human rights as they relate to disability, there is a balancing act to be undertaken which does not always come down in favour of the preservation of life. As Penelope Weller has observed in the context of Article 25(f), "the CRPD steers a middle path between the argument that everything be done to save the lives of people with disabilities on the one hand, and 'quality of life' arguments that see the lives of people with disability as 'undignified, futile or over-burdensome' on the other."[24]

At the time of writing, the CRPD Committee is considering the case of Vincent Lambert, and, assuming that finds the complaint admissible, it we will have in due course an express set of observations from the Committee concerning his position and, by extension, others in a PDOC being kept alive by artificial means. In particular, the Committee will have to grapple with precisely what it means to construct the will and preferences of a person in a PDOC – in other words to grapple with precisely the same dilemma as confronted Mr Justice Charles in Briggs v Briggs (No 2). We would suggest that the calibrated approach taken in that case represents – albeit in different statutory language – exactly the approach mandated by the CRPD. The CRPD

[21] For a detailed discussion of the use of the term 'absolute' by the CRPD Committee in other contexts, see Martin W, Gurbai S. Surveying the Geneva impasse: Coercive care and human rights. International Journal of Law and Psychiatry. 2019 May 1;64:117-28.

[22] CRPD/C/CAN/CO/1 (8 May 2017), para 24(a).

[23] See also the UN Human Rights Committee's General Comment 36 on Article 6, CCPR/C/GC/36.

[24] In her commentary on Article 10 in Bantekas, I. et al. The Convention on the Rights of Persons with Disabilities: A Commentary. Oxford Commentaries on International Law: Oxford, Oxford University Press 2018, at page 733.

undoubtedly suggests an expansive view must be taken of a person's ability to communicate their will and preferences – not limited by considerations of whether they have or lack capacity to do so – but English case-law equally adopts the same perspective.[25] *There will undoubtedly be difficult cases in which what it is unclear whether the person in a PDOC is communicating a reliable set of will and preferences (or a set of preferences to be set against their will, if 'will' is taken to be something more stable and enduring than 'preferences'*[26]*) or whether they are, in fact, not communicating anything at all. But what the CRPD – as interpreted by the Committee – requires is no more than (but no less than) the "best interpretation" of the person's will and preferences, which ultimately requires an evaluative judgment. Where that interpretation is that the person does not wish treatment to be continued, then (assuming that sufficient safeguards are in place) that interpretation should be taken as representing the exercise of their legal capacity to refuse, even if the consequence is their death.*

We therefore suggest that the CRPD confirms that:

1. it can never be correct to make the decision to withdraw (or indeed withhold) life-sustaining treatment on the basis of generalised assumptions about the quality of life enjoyed by disabled people as a whole.

2. as is already required in England & Wales in decisions about life-sustaining treatment, the intense focus must be upon the "will and preferences" of the individual person in question.

Since this article was published, further concluding observations have been published by the CRPD Committee, including upon France (in 2021) where no comment was made upon the Lambert case and Switzerland (in 2022) where no mention was made of the approach taken in that country to medical assistance in dying. There is therefore nothing to suggest that the CRPD Committee's approach has changed.

Although the record of the arguments advanced on behalf of Archie Battersbee's parents appeared to rely upon the approach to adults,[27] it is, of course, important to recognise that this case concerns a child. Disabled children equally benefit from the provisions of Article 10 CRPD. However, the CRPD Committee has never to my knowledge made any suggestion that a process of individualised, focused, decision-making which might lead to withdrawal of life-sustaining treatment from a child is contrary to the provisions of the Convention. In its recent (March 2022) joint statement with the Committee on the Rights of Children, the CRPD Committee was silent as to this issue. Importantly, however, both Committees urged (at paragraph 4):

[25] See, for instance (in the context of termination) the decision of the Court of Appeal in *Re AB (Termination of Pregnancy)* [2019] EWCA Civ 1215.

[26] Szmukler, G. "Capacity","best interests","will and preferences" and the UN Convention on the Rights of Persons with Disabilities. World Psychiatry 2019 January 18(1): 34-41.

[27] See paragraph 26(iv) of the second judgment of the Court of Appeal:
The parents' counsel's submission is that 'a decision to remove [life sustaining treatment] from someone who previously had capacity, can only be made on the basis of the person's will and preferences and failing this then according to the "best interpretation of will and preferences"'. These submissions, in the context of a person who is so disabled that they have no free-standing capacity for life without artificial and intensive medical intervention, appear to stretch the parameters of this convention beyond its intended boundaries. Be that as it may, it is clear from paragraphs 39 and 45 of Aintree and elsewhere that the approach in domestic law does afford due respect to wishes and feelings in a manner that would be compatible with the principles of CRPD, Arts 10 and 12.

the States parties to apply the concept of the "best interests of the child" contained in article 3 of the CRC and 7 of the CRPD to children with disabilities with a careful consideration of their evolving capacities, their circumstances and in a manner that ensures children with disabilities are informed, consulted and have a say in every decision-making process related to their situation.[28]

It bears emphasis, and consideration by those commenting upon the case, that best interests is precisely the test followed by the courts in England & Wales in determining these agonising cases. The CRPD does not, it should perhaps further be added, dictate that only a parent can determine where the child's best interests lie: rather, and as reinforced in the joint statement, it dictates an individualised focus on the interests of the child. In light of the analysis of Article 10 CRPD above, showing how it does not afford an 'absolute' right to life, I would suggest that it is clear that the focus, in cases such as this, must be on whether life-sustaining treatment is in the child's best interests: a question which must, on a proper analysis, afford the potential answer that it is not.

Alex Ruck Keene KC (Hon)

[28] The CRPD Committee are strongly opposed to reliance upon this context in relation to adults, but the term appears in Article 7 of the CRPD, which requires that "in all actions concerning children with disabilities, the best interests of the child shall be a primary consideration."

SCOTLAND

IN MEMORIAM: ELIZABETH REGINA

Personal memories from one contributor to the Report

I was here once before. Back over that long bridge of time, the headmistress walked into the classroom with a wireless. Solemn music. The only words were those of the ancient formula: "The King is dead, long live the Queen!". In those days none of us needed to be prompted to stand rigidly to attention whenever the National Anthem began.

A few months later my brother and I stood, late one evening, at the entry to Euston Station. The Queen arrived for her journey north to receive the Crown of Scotland. With the combination of dignity and warmth that became her hallmark, she spotted us, leant forward in the car, and waved – just as a neighbour might do on seeing a friend's children. Next day we followed her north on the Royal Scot, as our family made its migration to live in Scotland.

It was the same 40 years later. I and others entered Buckingham Palace tensely ready for a formal event, only to find that we were welcome guests of the Queen in her home, and treated that way. You can't fake the warmth, human interest, and valuing of every human being for what they are, that imbued more real engagements with others than any other person has ever accomplished, or probably ever will.

Not only those personal values were carried throughout the long journey across that bridge. It is timely to remember that they were formed at a time when our country, like our continent and elsewhere, devastated by war, did not wallow in self-pity, but tackled with energy and enthusiasm a transformation towards a truly just and caring society. My father's dearest possession from those times was not from the memorabilia of war, but the copy of the Beveridge Report that he gave to me shortly before his death. And all of us inherited the fundamental human rights instruments created in those times, followed by – in our continent – the creation of the Council of Europe with the role of safeguarding them.

The Queen of course remained non-political, but the life that we now mourn and celebrate was the embodiment of those fundamental values that led to the creation of all that we have inherited, now passed into the safe hands of her successor. Particularly at this time, they are values that we not only should, but must, defend from all threats, external or internal.

As for Scotland, let us never confuse the previous such moment in 1603 when two lineages of sovereignty were conjoined on the next bridge, with debate as to whether the quite different union of 1707 should be dissolved. So long as we aspire to live in the certainties of a free and democratic society, with equal respect for all human beings, embedded in the enduring timescales of a constitutional monarchy, we should never jump off that bridge.

Adrian D Ward

Functions of nearest relative – application under AWI s4

A decision remarkable for what it did not contain, rather than what it did, was issued in a Note by Sheriff Brian Mohan, sitting at Paisley, on 19th August 2022 in an application for "nearest relative" status in Application for Welfare Guardianship by Renfrewshire Council ("the Council") (in respect of the Adult HS), [2022] SC PAI 24. The principal application was for appointment of a welfare guardian to the adult HS, aged 95, suffering from dementia and resident in a care home. Two of the adult's three daughters entered the process. The need for guardianship, and the proposal to appoint the Council as guardian, were uncontested. An application by the adult's second daughter to have conferred upon her the functions of nearest relative was supported by the eldest daughter but contested by the youngest daughter.

The background to the dispute was a rift in relationships among the daughters. The second and youngest daughters had not spoken to each other for eight years. The sheriff heard evidence by affidavits, demonstrating an adverse impact by the hostility between the daughters upon the adult's care, and those caring for her. Having narrated the tenor of formal reports and other evidence as to the impact of the feud, the sheriff noted that it had spilled into everyday decisions within the care home in which the adult had resided since late 2021. One sister left a kettle in the adult's room, leading to a complaint by another. One wanted the adult's room painted in one colour, resulting in objections by another and a request to staff to change the paint. A rug was placed in the adult's room by one sister, apparently to provide a more homely atmosphere, but this was objected to by another, who reported it as a trip hazard. The sheriff concluded that: "*It is not appropriate that either the care home where the Adult resides, or the social work department which carries out the duties of welfare guardian, should be used as a platform for the Adult's daughters to continue to air their mutual grievances. Neither the passage of time, the deterioration in their mother's capacity, nor even the observations of numerous professionals about the impact which their dispute is having on the arrangements surrounding their mother's care, has enabled the sisters to put aside their differences.*"

An original intention by the daughters to apply for appointment of all of them as joint guardians was abandoned in the face of evidence and opinions that such guardianship would be unworkable. The Council applied by agreement of all concerned, was appointed under an interim order in October 2021 (to facilitate the adult's move to a care home), and thereafter under a final order for a period of three years. The application by the second daughter in relation to the functions of nearest relative narrated that the oldest daughter had a number of health problems which prevented her effective participation in decision-making. The application by the second daughter was supported by a letter from the eldest daughter, who (according to the Note) wanted the second daughter "*to take care of her [the mother's] affairs*" because the eldest daughter's own health difficulties meant that she was unable to fulfil the role of nearest relative. In the face of opposition by the youngest daughter, the second daughter suggested the alternatives of her own appointment as nearest relative in addition to the eldest daughter; or alternatively that the eldest daughter should remain sole nearest relative but that the sheriff direct that the second daughter be consulted in accordance with section 1(4)(c)(ii) of the Adults with Incapacity (Scotland) Act 2000 ("the Act"). The youngest daughter submitted that no-one should have the functions of the nearest relative, and that it was unnecessary to direct the local authority to consult any of the daughters formally.

The sheriff first addressed and rejected the proposition that two persons could hold the position of nearest relative jointly. "*That does not appear to be contemplated anywhere in the legislation. I was offered no authority or commentary which supported that position. There is a careful order of priority within the list of persons identified as 'the nearest relative' in section 254 of the Mental Health (Care and Treatment) (Scotland) Act 2003: that mechanism was adopted in section 87 of the 2000 Act (as amended). That background, together with the straightforward grammar of the term 'the nearest relative' (using the definite article, the superlative form of the adjective and the singular noun) indicate that it is a position to be held by one individual only. I therefore reject the submission that LM could be appointed as a joint or additional nearest relative*."

The sheriff did not agree that it would be appropriate to give the suggested direction under section 1(4)(c)(ii) of the Act. That, he considered, could lead to confusion about the roles and could duplicate the work of those involved in the day-to-day care of the adult. He accordingly concluded that his options were to

make no order, leaving the eldest daughter as nearest relative; appoint the second daughter as nearest relative in place of the eldest; or make an order that no-one should exercise the functions of the nearest relative. These options were all available to him under section 4 of the Act. As regards the last option, he noted that he was not able to make that or any other order *ex proprio motu* but that, an application such as the second daughter's having been made, he could under section 4(1)(c) order that no person should exercise the functions of the nearest relative. It should be noted that these provisions relate only to the exercise of those functions under the 2000 Act. Having considered all of the evidence before him and the submissions made to him, the sheriff decided that no person should exercise the functions of the nearest relative during the period of the guardianship order.

What, then, was remarkable about the sheriff's decision? The sheriff narrated the role of the nearest relative under the 2000 Act, including in particular the requirement to take account of the views of *inter alia* the nearest relative in relation to any intervention in the affairs of an adult (section 1(4)(b) of the Act). He noted that "intervention" was not defined in the Act, but quoted with apparent approval my suggestion in "Adult Capacity" (2003), para 4-3, that it covered any decision, act or deliberate omission within the broad scope of the Act's provisions in any way affecting (or intended or having the potential to affect) the welfare, affairs, interests or status of an adult. He narrated some of the provisions of the Act which explicitly required involvement of the nearest relative, to which others such as consenting to research under section 51, could be added. In describing a situation in which many matters decided by the guardian would require consultation with the nearest relative, the sheriff did not address the extent to which the burden of doing so might be restricted by the qualification in section 1(4)(b) "in so far as it is reasonable and practicable to do so".

More significantly and surprisingly, however, the sheriff appears to have overlooked the obligation incumbent upon him to take account of the views of the (then) existing nearest relative under section 1(4)(b) in relation to the decision at which he arrived. He had before him a letter accepted as indicating the eldest daughter's agreement to appointment of the second daughter. He appears to have had no information before him as to the views of the eldest daughter on the proposition that her mother should be left with no-one exercising the functions of the nearest relative.

A subsidiary but also significant point arises if I was correct in my article "Two 'adults' in one incapacity case? – thoughts for Scotland from an English deprivation of liberty decision", 2013 SLT (News) 239–242, that the words of section 1(1) of the Act mean what they say and require compliance with the principles in relation to any adult (defined simply in section 1(6) as a person over the age of 16) subject to any intervention in terms of an order made under any proceedings under the Act. The intervention in relation to the eldest daughter was to remove from her the status of nearest relative to her mother. She had apparently consented to that for the purpose of appointing the second daughter, but not for the purpose of leaving her mother with no-one exercising the functions of nearest relative. So far as I am aware, the proposition in that article has never been challenged in any decision or published material. On the basis of that proposition, the section 1 principles should have been satisfied in relation to the eldest daughter, in addition to the requirement to consult her in relation to her mother under section 1(4)(b). On the face of it, there would also seem to be a question as to whether the eldest daughter's rights under Article 8 of the European Convention, and in that context her rights under Article 6, have been violated. The points in this paragraph are of course matters for the eldest daughter herself, rather than the other parties, though one would suggest that they do have a legitimate interest in ensuring that what took place is properly intimated to the eldest daughter. The sheriff's failure to comply with section 1, and in particular section 1(4)(b), of

course goes to the heart of his decision and would appear to be a matter of legitimate interest to the other parties.

We understand that an appeal has been lodged, but we do not know what are the grounds of that appeal.

Adrian D Ward

Financial guardians' remuneration – update by the Public Guardian

(Note: We have followed the topic of changes to the remuneration of professional financial guardians through several issues: see the May 2022, April 2022, March 2022, February 2022, and November 2021 reports. Initially, professional financial guardians expressed concerns about reduction in their remuneration with a change to effectively deducting VAT from their authorised charges, when this had previously been allowed as an addition. That was carried forward positively at the initiative of the Public Guardian into working with professional financial guardians on the process for sanctioning uplifts to fees above the standard scale figures. We are grateful to Fiona Brown, Public Guardian, for providing us with the following note, with permission to publish it. We would mention at the same time that the fees payable to the Public Guardian were increased with effect from 1st July 2022.)

"Throughout the course of 2022, OPG Scotland has been working with a group of professional financial guardians to agree a straightforward, transparent process, via which financial guardians can request an uplift in remuneration.

"Remuneration is currently set on a standard scale, based on the value of the Adult's moveable estate. There will be no change to the scale remuneration.

"The uplift process allows financial guardians to request an additional payment, where the routine financial guardianship work has been excessive, or where there has been an element of non-routine work within that accounting period. Any uplifted sum is then added to the scale remuneration due.

"To ensure the process is as straightforward and transparent as possible, the working group has developed a pro forma "Uplift Application Form", with embedded guidance, hourly rates and an uplift rate cap. The application will be completed by the financial guardian and submitted along with relevant evidence, with the Annual Account. It will thereafter be considered at the same time as the Annual Account, during the account review process. Any uplift sums will be added to scale remuneration, and totalled on the Audit Certificate.

"In addition, as we recognise that in year one of some cases, there may not be adequate funds to cover an uplift in remuneration (usually whilst heritable property is being sold, and where moveable estate value is low), any uplift can be taken over a two year (accounting) period.

"This process will be offered by way of a pilot in the first instance, to members of the Professional Guardian Scheme, throughout the remainder of 2022.

"It is hoped that full roll out and implementation can take place in the new year."

Fiona Brown
Public Guardian & Accountant of Court
Office of the Public Guardian and Accountant of Court
Tel: 01324 678323
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Adrian D Ward

PKM litigation ends, leaving loose ends

As with the preceding item, we have followed what is generally known as "the PKM litigation" through several issues of the Report: see the May

2022, March 2022, February 2022, and December 2021 reports

Originally there were two cases. One did not proceed beyond a decision of the Sheriff Appeal Court: *RM and SB as joint guardians of the adult PKM (Appellants) v Greater Glasgow Health Board (Respondent)*, 2021 SAC (Civ) 33. The other concluded on 1st August 2022, with what can only be described – as regards the important points of law raised by the litigation – as an inconclusive conclusion.

The factual issue at the heart of the first case was that the adult PKM did not want to receive kidney dialysis. His welfare guardians determined that he should receive dialysis. Doctors considered that his refusal was competent, and on ethical grounds were not prepared to force treatment upon him that he did not want. The case proceeded as a contest between the guardians and the medical practitioners, as to whose view should prevail. It concluded with an agreed disposal, agreed – that is to say – by the parties represented in the proceedings, including a safeguarder who had been appointed. The decision of the Sheriff Appeal Court is remarkable in a number of ways, mostly as to matters upon which it would appear that the court was not addressed.

In the second action, the guardians sought an order requiring the Health Board to revoke and remove from PKM's health records (including computer records) any Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) "directions". At first instance the sheriff initially refused to grant an interim order in those terms, then at a subsequent hearing granted the interim order. The Board appealed that decision to the Sheriff Appeal Court, which in turn acceded to a request to remit the matter to the Court of Session. The Inner House refused the appeal and confirmed the grant of the interim order. PKM wished the DNACPR notice to remain on his record, but did not participate in the appeal proceedings. One has to conjecture that the Inner House anticipated that final disposal would bring the matter back there, as the appeal against the interim order was issued in the form of a "Statement of Reasons", not publicised in the usual way, though I was able to access a copy. It was not published on the scotcourts website.

Following the hearing before the Inner House, the second case went back to the sheriff. In the meantime, PKM sustained a choking fit and collapsed. We understand that this was not directly related to his kidney condition. However, following that episode he told his doctors that he now does wish to be resuscitated in the event of a cardiac arrest.

That left outstanding conclusions on behalf of PKM's guardians for directions under section 3 of the 2000 Act, firstly declaring that the medical practitioners did not have authority to put the DNACPR in place, and secondly a direction to them that they should not do so again in the future. Those points, we understand, were resolved by the guardians' agent seeking an undertaking from the NHS Board that they would not put in place any further DNACPR note without prior consultation with the guardians, which undertaking was given. Thereupon the case was dismissed, with no expenses due to or by any party.

The Mental Welfare Commission ("MWC"), an interested party in these proceedings, appeared at the procedural hearing where the joint motion of the health board and guardians was heard. Counsel for MWC advised the court that there were legal points arising which remained unresolved, and MWC would consider the best way in which to take these forward in light of the conclusion of the present proceedings.

Disappointingly, unless MWC indeed finds a way to have relevant issues judicially addressed, the outcome will leave without final resolution the important issues already identified in previous Reports, including in particular the extent to which section 67 of the 2000 Act allows guardians to override any apparently competent decisions of the adult; the extent to which section

67 applies beyond "transactions" in the normal sense of that word to other acts and decisions, including those in relation to healthcare and other personal welfare matters; whether medical practitioners have authority to act where appointees with relevant powers have refused consent and the matter has not been referred for determination under section 50 of the 2000 Act; and what in law are the consequences of doing so as regards potential civil and/or criminal liability of those medical practitioners (having regard to the omission of persons acting under Part 5 of the 2000 Act from the protections otherwise afforded to persons acting under the Act by section 82). Also unaddressed is the appropriateness of the long timescale over which these evidently serious and urgent matters were before the courts.

Adrian D Ward

MHTS project: a report of major national and international significance

After five years of work, on Monday 5th September 2022 the Centre for Mental Health and Incapacity Law at Edinburgh Napier University launched the final report of the MHTS project, the full title of which is: "The Mental Health Tribunal for Scotland: the views and experiences of Patients, Named Persons, Practitioners and Mental Health Tribunal for Scotland members". The joint principal investigators for the project were Professor Jill Stavert of Edinburgh Napier University and Professor Michael Brown of Queen's University, Belfast. It should be noted that Professor Brown, despite that academic location, is a General Member of MHTS. The report was launched at a well-attended invitation seminar on 5th September, at which the speakers included both Professors Stavert and Brown. The project was supported by Nuffield Foundation, also represented at the seminar.

If one attempts to step back from the wealth of carefully researched detail and rigorous evaluation in the report, the overall impression is of a piece of work of the highest importance and significance, shining a piercingly rigorous light into the workings of Scotland's Mental Health Tribunals, which although it has kept strictly to its remit nevertheless contains challenging insights relevant to questions of access to justice, and delivery of justice, across the whole field of Scotland's courts and tribunals; and at the same time making a groundbreaking contribution towards international study and concerns about the functioning of such tribunals worldwide. The report comes at a time when psychiatric compulsion rates, which vary across the world, are rising in Scotland; when there are increasing imperatives to give full effect to the United Nations Convention on the Rights of Persons with Disabilities, and resulting requirement for a much more proactive, holistic and non-discriminatory approach to realising the rights of persons with mental disorders. The report additionally comes at a time when MHTS is shortly to move from being a free-standing tribunal to being a chamber within the Scottish tribunal system, with understandable accompanying concerns about the potential for dilution of its specialist competence and role. Significantly and importantly, the report also comes shortly before the Final Report of the independent Scottish Mental Health Law Review due by the end of this month. For those who might query how the SMHLR Report at the end of this month can take full account of the work of the MHTS project published less than four weeks earlier, one may reasonably expect that the realistic answer is to point to the major involvement of Professors Stavert and McKay of Edinburgh Napier University in the work of SMHLR.

The aims of the MHTS project were:

- To find out the views and experiences of a purposive sample of stakeholders of the MHTS, including patients, named persons, MHTS panel members, and health and social care professions.
- To evaluate the extent to which the MHTS currently gives effect to the Millan Principles

and existing and evolving international human rights standards.
- To find out the profile and scope of applications and work undertaken by the MHTS.

The impact of the report has been achieved not only by comprehensively fulfilling its remit, but also by being careful not to stray beyond the bounds of that remit, so that the project did not assess MHTS decisions or whether compulsion was necessary. It was about evaluating experiences and making recommendations to improve experiences, if necessary. It also did not enter the debate on the appropriateness of psychiatric compulsion.

From the data collected from participants, a sample across all stakeholder groups, the project identified good practice as well as areas where improvements can be made, but the shortfalls were striking. While it was felt that the principles of benefit, least restrictive alternative, and reciprocity were fundamental, obstacles such as limited resourcing prevent their full implementation. At times patients disputed whether the care and treatment offered in fact provided benefit. A lack of supported accommodation and of resourcing in the community was felt to delay discharge and to act as a barrier to fulfilling the principle of least restrictive option. Participants highlighted the importance of informal care, but patients reported that they did not recall informal care being ruled out before compulsory treatment was authorised.

Participants across various groups contributing to the study identified various facilitators to patient participation, including conveners adjusting their approach to suit patient needs; reductions in formality and in the use of complex and legalistic language; and tribunals visiting on wards patients unable to attend hearings. There were however negative counterparts to these, with perceptions of obstacles in practice including tokenistic participation and the perception of a hearing as a foregone conclusion; formality, and use of complex and legalistic language; an unhelpful order of speaking; and the effect of clinicians' perceptions of patient risk. It was felt that the potential of independent advocacy was restricted by resource limitations and varying quality of performance, the latter concern also being directed at quality of legal representation.

At a time when the world is waking up to the significant potential of "unilateral voluntary measures", equating to the broad definition of "advance directives" by Council of Europe[29]. It is disappointing to read of perceptions that advance statements under current mental health law are rare, and frequently overridden.

Other major topics revealing significant concerns include perceptions of fairness, and of the power of the "medical domain"; and issues around effective provision of support for patients at hearings.

The report lists ten recommendations for action within the remit of MHTS; seven which it proposes should be included in the Final Report of SMHLR and reflected by Scottish Government in subsequent legislative and policy reforms; four further recommendations to Scottish Government; and of particular relevance to much of the readership of this report, a concluding recommendation that Scottish Government should require, and the Law Society of Scotland should ensure, training for solicitors representing patients and named persons on common mental health conditions; on care, support and treatment in hospital and communities; and on related human rights requirements of both the

[29] See Council of Europe Ministerial Recommendation (2009)11 on principles concerning continuing powers of attorney and advance directives for incapacity; and also the recent report of the Law Society of Scotland cross-committee working group on *inter alia* advance choices (advance directives).

European Convention on Human Rights and the UN Convention on the Rights of Persons with Disabilities.

Adrian D Ward

Deprivations of liberty of children

Note: Shauneen Lambe of Child Law Network has provided a guest article for English practitioners (featured in the September 2022 'Wider Context' and 'Compendium' reports) on the topic that we have previously followed in the Scotland section on issues surrounding transfer to Scotland of children and young persons (up to age 18) subject to deprivation of liberty authorisations in England & Wales.

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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 contributor to 'Assessment of Mental Capacity' (Law Society/BMA), 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 ECHR/CRPD human rights, mental health and incapacity law and mainly practises in the Court of Protection and Upper Tribunal. Also a Senior Lecturer at Manchester University and Clinical Lead of its Legal Advice Centre, he teaches students in these fields, and trains health, social care and legal professionals. When time permits, Neil publishes in academic books and journals and created the website www.lpslaw.co.uk. 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 5th edition of the *Assessment of Mental Capacity: A Practical Guide for Doctors and Lawyers* (BMA/Law Society 2019). To view full CV click here.

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

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Steph regularly appears in the Court of Protection in health and welfare matters. She has acted for individual family members, the Official Solicitor, Clinical Commissioning Groups and local authorities. She has a broad practice in public and private law, with a particular interest in health and human rights issues. She appeared in the Supreme Court in *PJ v Welsh Ministers* [2019] 2 WLR 82 as to whether the power to impose conditions on a CTO can include a deprivation of liberty. To view full CV click here.

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Arianna has a specialist practice in mental capacity, community care, mental health law and inquests. Arianna acts in a range of Court of Protection matters including welfare, property and affairs, serious medical treatment and in matters relating to the inherent jurisdiction of the High Court. Arianna works extensively in the field of community care. To view a full CV, click here.

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Simon Edwards: simon.edwards@39essex.com

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

Scotland editors

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

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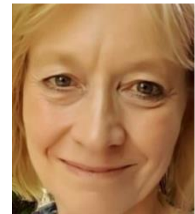

Jill Stavert is Professor of Law, Director of the Centre for Mental Health and Capacity Law and Director of Research, The Business School, Edinburgh Napier University. Jill is also a member of the Law Society for Scotland's Mental Health and Disability Sub-Committee. She has undertaken work for the Mental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

Conferences and Seminars

Forthcoming Training Courses

Neil Allen will be running the following series of training courses:

14 September 2022	AMHP Legal Course Update
16 September 2022	BIA/DoLS legal update (full-day)
30 September 2022	Court of Protection training
13 January 2023	Court of Protection training

To book for an organisation or individual, further details are available here or you can email Neil.

The University of Essex is hosting two events in October:

3 October 4.30pm – 7pm: Evaluation of Court of Protection Mediation Scheme Report Launch
Garden Court Chambers,
57-60 Lincoln's Inn Fields, London, WC2A 3LJ, and online by zoom
Register at: *https://www.eventbrite.com/e/evaluation-of-court-of-protection-mediation-scheme-report-launch-tickets-411843032597*

5 October 1pm – 5pm Mental Capacity Law in Contract and Property Matters
Wivenhoe House Hotel, University of Essex, Colchester, and online by zoom
Register at: https://www.eventbrite.co.uk/e/mental-capacity-law-in-contract-and-property-matters-tickets-365658192497
Speakers include: Clíona de Bhailís, Researcher, NUI Galway, Shonaid and Andy, PA and Support Workers, Outside Interventions
Professor Rosie Harding, University of Birmingham, John Howard, Official Solicitor and Public Trustee Property and Affairs Team, Gareth Ledsham, Russell Cooke Solicitors, Her Honour Judge Hilder, Court of Protection

Advertising conferences and training events

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

Our next edition will be out in October. 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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