Mental Capacity Law Newsletter November 2014: Issue 51

Court of Protection: Compendium

ThirtyNine
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Introduction

Welcome to the November Mental Capacity Law Newsletters. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Newsletter: an update on judicial authorisations of deprivation of liberty and two difficult cases, one involving the MHA and the MCA, and the other capacity to consent and to contact;

(2) In the Property and Affairs Newsletter (this month edited by Kelly Stricklin-Coutinho): the first revocation of a digital LPA and an update on necessaries;

(3) In the Practice and Procedure Newsletter: fact-finding against the odds, the limits of the inherent jurisdiction, an escalation of the legal aid debate and the launch of Alex's guidance on litigation friends in the Court of Protection;

(4) In the Capacity outside the COP newsletter: an important case on capacity and s.117 MHA 1983, an update on the new approach adopted by CQC to the MCA 2005 and a round-up of recent guidance on the MCA 2005, as well as call for best practice documentation, new guidance on DNACPR notices, and the Committee on the Rights of Persons with Disabilities' statement on Article 14.

(5) In the Scotland Newsletter: the hotly anticipated Scottish Law Commission on plugging the *Bournewood* gap, updates on the position relating to powers of attorney, an important case on testamentary capacity and undue influence, and updates on recent reports from the Mental Welfare Commission.

Table of Contents

Hyperlinks are included to judgments; if inactive, the judgment is likely to appear soon at www.mentalhealthlaw.co.uk.

Contents

Introduction	1
Judicial authorisation of deprivation of liberty, part 2	3
The MCA crashes into the MHA	5
Sex vs contact	8
Regional variations in DoLS	10
Necessaries revisited	11
Short Note: Digital Misconduct	13
Short Note: departing from the general costs rule in property and affairs cases	14
Fact finding against the odds	15
The limits of paternalism	18
Short note: the legal aid debate escalates	20
(In)equality of arms and legal aid (2)	22
Guidance for Litigation Friends in the Court of Protection	23
Transparency in the Family Court	24
Short note: capacity, s.117 MHA 1983, and the future	25
Short Note: capacity in practice	26
CQC takes steps to ensure compliance with the MCA 2005	27
Capacity guidance round-up and call for best practice materials	28
New guidance on DNACPR	29
Care Act secondary legislation and guidance	30
Safeguarding statistics 2013-4	31
Inclusion Europe supported decision-making website	32
Committee on the Rights of Persons with Disabilities statement on Article 14 CPRD	32
Book Review: Medical Treatment and the Law: Issues of Consent (2nd Edition)	32
Scottish Law Commission Report on Adults with Incapacity	34
Powers of Attorney	40
Damaging illegality of Scottish Social Work Authorities	41
Testamentary Capacity and Undue Influence	41
Mental Welfare Commission for Scotland Reports	44
Smoking ban upheld	45
Comment on Article 14 of the CPRD	46
Mental Health and Disability Sub-Committee	47
Conferences at which editors/contributors are speaking	50

Judicial authorisation of deprivation of liberty, part 2

Re X and others (Deprivation of Liberty) [2014] EWCOP 37 (Sir James Munby P)

Article 5 – Deprivation of Liberty

Summary

The President of the Court of Protection has now expanded on the preliminary judgment handed down on 7th August 2014 (*Re X and others: Deprivation of Liberty* [2014] EWCOP 25).

This new judgment does not answer all the questions which were before the President when he heard this case in June 2014, particularly some relating to the possible extension of urgent authorisations by the court (a further judgment addressing these points is still awaited). It does however expand upon three questions

> *"(7) Does P need to be joined to any application to the court seeking authorisation of a deprivation of liberty in order to meet the requirements of Article 5(1) ECHR or Article 6 or both?*
>
> *(9) If so, should there be a requirement that P … must have a litigation friend (whether by reference to the requirements of Article 5 ECHR and/or by reference to the requirements of Article 6 ECHR)*
>
> *(16) If P or the detained resident requires a litigation friend, then: (a) Can a litigation friend who does not otherwise have the right to conduct litigation or provide advocacy services provide those services, in other words without instructing legal representatives, by virtue of their acting as litigation friend and without being authorised by the court under the Legal Services Act 2007 to do either or both …?"*

The President answered the first question in the negative, primarily using the analogy of wardship proceedings, where wards do not always have to be a party. Turning to the Convention jurisprudence, the President noted P's entitlement to the safeguards of Article 5(4) and the UNCRPD, and concluded:

> "*13. Article 6 requires that P be able to participate in the proceedings in such a way as to enable P to present his case 'properly and satisfactorily': see Airey v Ireland (1979) 2 EHRR 305, para 24. More specifically, referring to Article 5, "it is essential that the person concerned should have access to a court and the opportunity to be heard either in person or, where necessary, through some form of representation, failing which he will not have been afforded 'the fundamental guarantees of procedure applied in matters of deprivation of liberty'.": Winterwerp v Netherlands (1979) 2 EHRR 387, para 60. This may require the provision of legal assistance: Megyeri v Germany (1992) 15 EHRR 584, para 23. There is a margin of appreciation (see, for example, Shtukaturov v Russia (2012) 54 EHRR 962, para 68), but this cannot affect the very essence of the rights guaranteed by the Convention. The Strasbourg court has made clear that deprivation of liberty requires thorough scrutiny and that any interference with the rights of persons suffering from mental illness must, because they constitute a particularly vulnerable group, be subject to strict scrutiny. So the process must meet that demanding standard.*
>
> *14. More generally, P should always be given the opportunity to be joined if he wishes and, whether joined as a party or not, must be given the support necessary to express views about the application and to participate*

> *in the proceedings to the extent that they wish. Typically P will also need some form of representation, professional though not necessarily always legal.*
>
> *15. So long as these demanding standards are met, and in my judgment they can in principle be met without P being joined as a party, there is, as a matter of general principle, no requirement, whether in domestic law or under the Convention, for P to be a party*."

It is perhaps to be noted that the suggestion that P will "*need some form of representation, professional though not necessarily always legal*" does not appear in the first *Re X* judgment.

In the balance of his judgment, the President then drew a number of further conclusions:

1. That there was no obstacle to P could participating and be represented in proceedings in the COP without being a party;

2. If P was a party, there was no reason in principle why the Court of Protection Rules could not be amended to allow P to act without a litigation friend, the real requirement (enshrined in the ECHR) being to ensure that P's interests are properly represented;

3. (Amplifying the 'headline' conclusion in his first judgment), that a litigation friend may conduct litigation on behalf of P without instructing solicitors – but, unless they otherwise have a right of audience, cannot address the court without permission.

The President noted that all matters he had been considering could properly be regulated by the 2007 Rules. "*They are all issues which, as it seems to me, require urgent consideration by the Committee, both as a matter of principle and also to achieve the necessary clarity for which Mr Cragg appropriately called. Some, it may be, might also merit consideration by both the Civil Procedure Rules Committee and the Family Procedure Rules Committee*."

He concluded:

> "*36. It is not for me in this judgment to advise the Committee how to proceed. There is, however, one aspect of the matter to which the Committee will, I suggest, need to give careful consideration. It is essential that where the issue concerns P's deprivation of liberty the Court of Protection's processes are rigorous, so that the circumstances of the individual case are subjected, as they must be, to the strict scrutiny demanded by the Convention. Both our domestic law and the Convention impose demanding standards. But the need to meet this challenge must not be allowed to lead to a system of technical requirements which may, in the real world, operate to deny P the speedy access to a judicial determination which is the very essence of what is required. To speak plainly, the Committee will have to consider how best to craft a process which, while it meets the demanding requirement of the law, also has regard to the realities consequent upon (a) the legal aid regime and (b) the exposure of a litigation friend to a costs risk. There is no point in a system which requires there to be a litigation friend, let alone which requires the litigation friend to instruct lawyers, if the reality is that there is, because of an absence of legal aid and possible exposure to an adverse costs order, no-one willing and able to accept appointment as litigation friend. Indeed, such a system would be self-defeating. And in this connection it needs to be remembered that the Official Solicitor can never be compelled to accept*

appointment. Moreover, as I understand it, he is not funded to act as a litigation friend in deprivation of liberty cases, so he is dependent on external funding which in many cases will not be available in the absence of legal aid."

Comment

We note that, as at the time of going to press, permission had been sought to appeal by two of the protected parties in the proceedings before the President to appeal his conclusions that: (1) (subject to certain conditions) it is not necessary for P to be a party to proceedings for applications for judicial authorisations for deprivation of liberty; and (2) that a litigation friend is not required to act via a solicitor for purposes both of conducting litigation and acting as advocate before the court. The Law Society has also sought permission to appeal on the first of the points above, and also on the President's decision that an oral hearing is not required in all cases. We anticipate that it is likely that permission will be granted given the importance of the issues, and hence we keep the discussion of this case relatively limited at this stage because it is likely not to be the last word on these difficult questions.

Notwithstanding the developments set out above, the new *Re X* procedure is also in the final stages of implementation, and we will keep you posted as and when we can. In the interim, we have updated our guide to judicial authorisations of deprivation of liberty.

The MCA crashes into the MHA

A NHS Foundation Trust v Ms X [2014] EWCOP 35 (Cobb J)

Best interests – medical treatment

Summary

Ms X was a young woman who suffered from an enduring and severe form of anorexia nervosa and alcohol dependence syndrome which had caused chronic and now "end stage" and irreversible liver disease.

She had been trapped for many years in an increasingly destructive revolving door of treatment and recurrent illness: she was treated for the anorexia but on discharge sought refuge in alcohol and sought to undo the weight gains achieved in hospital. At the date of the application she was in extremely poor health: extraordinarily malnourished and consuming in the region of half a bottle of vodka per day. Her BMI of 12.3 – 12.6 kg/m2 would ordinarily provoke further admission to hospital but the doctors who had treated her in recent years regarded it as "clinically inappropriate, counter-productive and increasingly unethical" to cause her to be admitted for further compulsorily feeding".

The NHS Trust sought declarations that:

i) It was not in Ms X's best interests to be subject to further compulsory detention and treatment of her anorexia nervosa, whether under the Mental Health Act 1983 or otherwise, notwithstanding that such treatment may prolong her life.

ii) It was in her best interests, and should be declared lawful, for her treating clinicians not to provide Ms X with nutrition and hydration with which she does not comply.

The Trust contended that Ms X did not have capacity to make a decision as to whether it would be in her best interests to receive treatment for anorexia.

The Trust was not seeking authorisation to withhold treatment. Treatment remained on offer should Ms X wish to avail herself of it. This was, therefore, a case about the lawfulness of not compelling treatment.

Ms X herself supported the application. Her litigation friend, the Official Solicitor, having tested the evidence, did not oppose the application.

Having heard evidence from experts, from a friend of Ms X (Ms Y) and having considered Ms X's own views as expressed in writing, Cobb J concluded that Ms X: (i) lacked capacity to litigate and to make decisions about her eating disorder. He accepted the view of the doctors that she did have capacity to make decisions about alcohol.

Cobb J went on to consider an ADRT in relation to future treatment of her liver disease which Ms X had made in June 2014. He held that she had capacity to make the Advance Decision when she did so and still did have capacity in relation to the matters reflected in the Advance Decision. The ADRT was therefore entitled to the fullest respect.

Cobb J then went on to consider Ms X's best interests. He noted that he was naturally steered to exercise his judgment in a manner which attaches the highest (even if not absolute) priority to the preservation and sanctity of life. As he noted, one might assume therefore that it would be in Ms X's best interests to order that she be forcibly fed:

> *42. Medical treatment is invariably designed to achieve the protection and preservation of life. But there is a paradox in this case: that if I were to compel treatment, I may (and the doctors argue strongly that I would) be doing no more than facilitating or accelerating the termination of her life. I have no jurisdiction to make 'best interests' decisions about Ms X's drinking; that remains wholly within her power. Any treatment for her anorexia (particularly if that is in-patient and compelled) is likely – on past experience – to provoke subsequent increased, sustained and dangerous alcohol consumption which will (in the medical view) hasten Ms X's death.*

The paradox extended further as all the professionals and Ms Y considered that if Ms X retained her autonomy she might access some medical help, even if it were only of a palliative nature. There were also other factors ranged against the compulsion of medical treatment at this stage for Ms X. The process of admitting Ms X and compelling her re-feeding would be highly traumatic (probably requiring restraint).

Articles 3 and 8 ECHR were engaged in repeated forcible feeding over a long period of time against her clearly expressed wishes. There were also hazards. The combination of liver disease and previous nasogastric feeding treatments meant that Ms X now had varicose veins in her throat and the process of inserting the tube could lead to bleeding.

The judge also took into account Ms X's expressed wishes and feelings. She wholeheartedly supported the application. The judge also gave weight to the evidence of Ms X's friend Ms Y who he found had brought "*extraordinary wisdom, compassion, objectivity and insight into the current dreadful situation affecting her closest friend*."

Cobb J concluded that the relief sought by the Trust would be in Ms X's best interests. Whilst he described the evidence as unanimous, the decision was clearly not an easy one and he recorded that he was reassured by the fact that it was not just those who knew Ms X well who had concluded that it would be in her best interests but that it was also the view of the independent and jointly instructed Dr Glover (who had advised the court in 3 similar cases in the past).

Cobb J concluded:

> "*This is an unusual and desperately sad case. I believe that I speak for all those who have had to grapple with the issues – medical professionals and lawyers alike – in expressing the hope that Ms X does indeed access some medical treatments which will have the effect of prolonging her life. I have, faithful to the guidance offered by Baroness Hale in the Aintree case, considered the welfare of Ms X "in the widest sense"; I have reflected on what treatment would mean for her, not just medically but socially and psychologically. So far as I can do so, I have endeavoured to put myself in the place of Ms X, and guided by what she has directly told me and others, I have considered what her attitude to the treatment is or would be likely to be. Having fully reviewed the circumstances of this case, and for the reasons discussed above, I have reached the clear conclusion that I should not compel treatment for Ms X's anorexia.*
>
> *I hope that Ms X will nonetheless realise that it would be of enormous benefit to her to access treatments (at least in the form of palliative care, nursing support and dietetic guidance) which may improve the quality of the limited life she has left to her, if not to render more dignified its passing.*"

Comment

This is in many ways a text book example of a thoughtful and meticulous best interests decision. It does indeed draw on *Aintree* to consider Ms X's welfare in the widest sense and gives clear weight to Ms X's wishes and feelings against the background of what Cobb J described as a judicial instinct to preserve life.
It is against that context that we raise the issue (a little hesitantly) that we struggle to see how Cobb J could grant a declaration as a CoP judge that the MHA 1983 could not be used. The decision whether or not to detain Ms X under the MHA 1983 is not a best interests decision (it is, ultimately, a public law decision by an AMHP whether an application is necessary and proper – see s.13 MHA 1983). Further, the Court of Protection has no jurisdiction to make any decisions in relation to forced treatment under the provisions of Part IV of the MHA 1983 (s.28 MCA 2005). It is therefore difficult, we suggest, to see how Cobb J could – as a Court of Protection judge – make the declarations that he did.

Procedurally, the proper route (in our view) for Cobb J to do what – substantively – he was entirely correct to seek to do would have been to constitute himself as a judge of the High Court and grant a declaration as to the lawfulness of the approach to be adopted by the Trust. This declaration could have been granted, we suggest, either under the provisions of Part 8 of the CPR or, potentially, by Cobb J simply exercising the inherent jurisdiction of the High Court. A similar route, albeit for different purposes, was adopted by Mostyn J in *Nottinghamshire Healthcare NHS Trust v RC* [2014] EWCOP 1317, another case in which the court properly wished to deploy considerations of capacity and best interests in a sphere governed by the MHA 1983. The eagle-eyed will have spotted that, whilst Mostyn J made the requisite findings in respect of RC's capacity and in relation to the provisions of the ADRT in that case wearing his COP hat, he made the declaration that it would be lawful not to administer blood transfusions (even though they could, in theory, be administered under the provisions of s.63 MHA 1983) as a High Court judge.

Some readers might wonder whether these procedural points are not on the arcane side. We venture to suggest not because Parliament has sought – albeit in a horribly messy fashion – to delineate a clear distinction between the functions of decision-makers under the MCA and MHA 1983 (and the factors that are to govern their decisions), and decisions such as the present (and also, arguably, that in *ML*) risk blurring those distinctions. Even if this is for reasons that make sense on the facts, it makes it all more difficult for professionals applying the two regimes to be clear as to when they are to operate one or the other (or, potentially, both in parallel).

We note, finally, that Dr Glover revealed that Ms E (the subject of a hotly contentious decision of Peter Jackson J in 2012) is still alive, receiving treatment as an inpatient in hospital. Whether or not this was information that he could properly impart (which we are not in a position to comment upon), it does provide both a useful corrective to an urban legend that we were aware of that she had died, and also an interesting (and rare) insight into the 'afterlife' of a Court of Protection case.

Sex vs contact

Derbyshire CC v AC, EC and LC [2014] EWCOP 38 (Cobb J)

Mental capacity – contact – sexual relations

Summary

AC was a 22-year-old woman with significant learning disability (IQ of 53), depression, and primary hyperthyroidism. She had a fiery temper and lived with her parents during the week. She spent the weekends with her new boyfriend, described by police as a "serial criminal". With her long history of volatile, abusive and exploitative relationships, an urgent meeting convened by the Local Authority concluded that she required the necessary level of protection she required could only be provided by depriving her of liberty in residential care. At times AC wanted to stay with her family; at other times she indicated a strong wish to leave.

The case is noteworthy for two reasons. The first is that AC was found to lack capacity to decide on contact with others but found to have capacity to consent to sexual relations. Her lack of capacity with regard to contact resulted from her having no real understanding of the consequences of contact decisions. She had limited concept of time and could not therefore process whether something had happened in the recent past or some time ago. She also struggled with the concept of the future and found it difficult to reason or problem-solve. Her consultant psychiatrist, Dr. Milne, opined:

> *"she is clearly unable to judge the intentions of the people with whom she comes into contact and this has led to her being repeatedly exploited and placed in potentially dangerous situations."*

Since May 2014, AC had been in a relationship with a man who had convictions for assault and actual bodily harm against a former partner. The police found them having sex naked in a public park. There were also allegations that he had assaulted her. In fact, only 3 weeks prior to the hearing, she reported to the police that he had struck her in the face, put his hands around her throat and had threatened to kill her. She had also told her family that he had threatened her with a knife. She continued to stay with him.

In 2012, AC had given birth to a girl who was ultimately made the subject of a placement order. Dr Milne found that AC was able to discuss the basic mechanics of sexual intercourse, understood the risk of pregnancy and sexually transmitted disease, but was unable to demonstrate that she would be able to refuse to have sexual relations: "she said that even if she didn't want sex she would have to go along with it as she wants to be 'lovey dovey". Dr Milne concluded that her capacity was probably fluctuating but that she was currently probably capacitous. The Local Authority and the Official Solicitor agreed that she had capacity to consent to sexual relations.

Cobb J. summarised the relevant law, including *IM & LM v Liverpool City Council* [2014] EWCA Civ 37, and noted:

> *"The distinguished line of judges sitting in the jurisdictions of the Family Division and Court of Protection who have opined on the question of what 'relevant information' should inform the test of capacity in this vexed area have not sought to include within the scope of information the understanding of 'P' that she (or he) may at any time change her (or his) mind about consenting to sexual relations. Hedley J. considered that it would be legitimate to ask the question whether "the person whose capacity is in question understand[s] that they do have a choice and that they can refuse.""*

This was important because the evidence suggested that AC might not always fully understand that she did have a choice, and/or that she could change her mind in relation to consent to sex. Given the extent to which she had been exploited, this gave his Lordship considerable anxiety and some misgivings about the consensus of opinion between the parties as to her capacity. However, on the established test, he held that she had capacity but that the issue should be kept under careful review, given its fluctuating nature.

The second feature of the case which may assist capacity assessors concerns the identification of the information relevant to the decision as to residence. On the facts of this case, the salient details were:

- That she would live with other people;

- That she would not live with her parents;
- That she would be supported by workers;
- The location of Pennine House;
- That she had considered the age and gender of the fellow residents;
- That she would need to abide by house rules;
- Whether the placement was envisaged as long-term or short-term; and
- In general terms, that one of the residential options has a therapeutic component.

Comment

Given that sex involves contact, we must confess that we consider it remains a conceptual struggle that P can in law lack capacity to decide on contact with D but yet retain capacity to have sexual relations with D. Whilst the courts' eagerness not to set the threshold for sexual capacity too high is understandable, the facts of this case demonstrate that the current test may be failing to safeguard the vulnerable from sexual abuse. If, because of significant learning disability, P feels unable to say "no" to sex with a serial criminal as she wants to be 'lovey dovey', this does raise serious misgivings as to why the risks posed by D should be relevant to contact decisions but not to sexual decisions.

Regional variations in DoLS

One article in the recent excellent series in *Community Care* on *Cheshire West* caught our attention in particular, namely this mapping of variations in referral rates and timescale breaches. It provides a vivid illustration of the difficulties faced by local authorities.

Necessaries revisited

Aster Healthcare Limited v The Estate of Mr Mohamed Shafi [2014] EWCA Civ 1350 (Court of Appeal (Master of the Rolls, Beatson and Briggs LJJ)

Mental Capacity - Finance

We have previously reported upon the first instance judgment in this case [2014] EWHC 77 (QB)) was reported on in the edition of our newsletter. In this appeal against the High Court's order overturning summary judgment for the claimant, the Court of Appeal unanimously dismissed the appeal.

The Claimant owned six care homes registered under the Care Standards Act 2000. In one of those care homes, Raj Nursing Home ('the Home'), the majority of the referrals were made by Brent Council. Mr Shafi resided at the home from 29 January 2010 until his death on 28 March 2012. Fees of £62,199.94 accrued for his care and accommodation. The Claimant sought recovery of the fees from the estate of Mr Shafi. HH Judge Million granted the Claimant summary judgment for the fees, but this was overturned by Andrews J in the High Court. Permission to appeal to the Court of appeal was granted in limited circumstances.

Mr Shafi was admitted to Park Royal Centre for Mental Health ('the Hospital') on 13 November 2009 for an assessment under s.2 MHA 1983 The Hospital decided that he lacked capacity to make decisions as to his future care and a social worker employed by Brent Council contacted the Home for an admissions assessment. He was assessed as suitable and the admission sheet, completed by the manager of the Home, showed the duration of his assessment as long term and Brent Council as the "funding source." The Claimant wrote to Brent Council in 2010 as to outstanding fees and Brent Council responded as follows:

> *"Mr Shafi had a financial assessment completed and it indicated that he had in line with fairer charging criteria enough money readily available in bank accounts to pay for his care. Mr Shafi is thus considered to be a self funder and as such should be charged for his care accordingly.*
>
> *Should access to Mr Shafi's accounts be frustrated as it appears is the case a member of his family, or indeed on certain occasions a care home can apply to the Office of Public Guardian in respect of an apointeeship (sic). As such management of Mr Shafi's finances can be taken over."*

After this, Andrews J had held in the High Court, the Claimant had tried to get Mrs Shafi to sign an agreement, which she refused to sign, but someone else did, for Mr Shafi. The judge had held that the agreement was obviously backdated and that Mr Shafi lacked capacity on the date of the agreement.

For a reminder of the judgment of Andrews J in the High Court, please see our earlier report.

On appeal, Counsel for the Claimant conceded that Mr Shafi's estate had an arguable defence to the claim for fees up to the period when Brent Council notified the Claimant that Mr Shafi should pay the fees rather than Brent Council, but he argued that there was no defence to the claim for fees after that date, or after a

reasonable period from that date. There were two grounds of appeal. The first was that Brent Council placed Mr Shafi at the home either:

1. on a temporary basis under s.47(5) of the National Health Service and Community Act 1990 (which allows for a local authority to temporarily provide or arrange the provision of community care services without a prior assessment of needs if the person's condition requires urgent services), or

2. under ss.21 and 26(2) of the National Assistance Act 1948 under which a local authority may make arrangements to provide residential accommodation for certain people in need of care otherwise not available to them, and those arrangements may be made with a registered care home.

The second ground of appeal was that the judge had incorrectly proceeded on the basis that the claimant could not rely on s.7 MCA 2005, which provides that:

> *"(1) If necessary goods or services are supplied to a person who lacks capacity to contract for the supply, he must pay a reasonable price for them.*
>
> *(2) 'Necessary' means suitable to a person's condition in life and to his actual requirements at the time when the goods or services are supplied."*

The Claimant's argument was that s.7 MHA 1983 would assist it unless it were held that the services were provided as a gift, which it considered unlikely.

In respect of the first ground of appeal, the Court of Appeal held that there was clear evidence that the contract between Brent Council and the Claimant was a long term contract and there was no evidence that there was a temporary contract. As a matter of contract law, Brent Council's letter amounted at most to a repudiatory breach of the contract, but there was no evidence as to the acceptance of that repudiation or the end of the contract. In terms of statutory provisions, the Court of Appeal held, Brent was at least arguably always under a duty to provide assistance to Mr Shafi, whatever his resources, because he lacked capacity, no one had been appointed as his Deputy and accommodation was not otherwise available to him within the meaning of the National Assistance Act. The Circular LAC98 and paragraph 1.022 of CRAG supported this reading. It was therefore at least arguable that had Brent Council terminated its contract in its letter, it would have been in breach of its statutory obligations. Brent Council therefore remained at least arguably liable for the Claimant's fees after the date of its letter. The Court of Appeal therefore dismissed this ground of appeal.

In respect of the second ground of appeal, the Claimant was refused permission to appeal on the basis that the question is not whether the services were provided as a gift but rather whether it provided services to Mr Shafi on terms that he was not to pay for them. This was a question of fact, and the Court of Appeal held that it could not improve upon Andrew J's reasoning in concluding that this could not be determined in advance of a trial. The Court of Appeal also confirmed that Andrews J had been correct to hold that s.7 MCA 2005 mirrored the common law rule on "necessaries," and (as under the common law) it did not

come into play where it was not intended by the supplier that the recipient should pay for the goods and services.

Comment

The Court of Appeal's decision is unsurprising, and useful in upholding the reasoning of Andrews J as to the operation of s.7 MCA 2005. It follows that where P has no Deputy or LPA and is accommodated by a Local Authority in residential care under the 1948 Act, the Local Authority is under a statutory obligation to pay the care home fees. It can, of course, seek to reclaim against P's estate but the important point to note is that the debt would lie between the Local Authority and P, and not between the care home and P.

Short Note: Digital Misconduct

In *JL (Revocation of Lasting Power of Attorney)* [2014] EWCOP 36, Senior Judge Lush considered an application by the Public Guardian to revoke and cancel the registration of a digital LPA for property and financial affairs. He noted that this seemed to him to be the first occasion on which the court has considered a digital LPA in the context of an application to revoke the appointment of an attorney.

A digital LPA had been executed by the donor (JL) such that her daughter (AS) would be her sole attorney. JL did not receive independent advice about the creation of the LPA, although AS claimed she had fully explained the document to JL prior to it being executed and a friend of the family witnessed the signature and acted as the certificate provider. Senior Judge Lush noted that:

> *"10. ….The function of the certificate provider is to certify that:*
>
> *(a) the donor understands the purpose of the LPA and the scope of the authority conferred under it;*
>
> *(b) no fraud or undue pressure is being used to induce the donor to create the LPA; and*
>
> *(c) there is nothing else which would prevent the LPA from being created by the completion of the prescribed form."*

In making his decision, Senior Judge Lush held that in order to revoke the LPA he had to be satisfied that AS had behaved in a way that contravened her authority or was not in JL's best interests and that JL lacked the capacity to revoke the LPA herself.

Senior Judge Lush considered the particular circumstances arising as to the making of the digital LPA:

> "*23. I shall consider these reasons in a little more detail. First, AS admits that she failed to keep proper records and accounts. At the hearing she said she did not know she had to keep accounts and that she had not read the declaration in Part C of the prescribed form of LPA, which she had signed. It says:*
>
> *'I understand my role and responsibilities under this lasting power of attorney, in particular:*
> *…*

> …
> *I have a duty to keep accounts and financial records and produce them to the Office of the Public Guardian and/or to the Court of Protection on request.'*
>
> *This admission is damning enough, but it gives rise to additional concern about the circumstances in which the LPA was created. If AS failed to read Part C, it makes it hard to believe her assertion that she had carefully read and explained to her mother the contents of Part A of the LPA – the part that the donor is required to complete."*

Senior Judge Lush considered the evidence before him as to JL's living conditions, the application of her funds, and the pressure exerted on her by AS and went on to hold that in addition to AS acting in a way that contravened her authority and was not in JL's best interests, JL also lacked the capacity to revoke the LPA herself.

Short Note: departing from the general costs rule in property and affairs cases

A further example of departure from the rule in property and affairs cases can be found in *BIM & Ors v MD* [2014] EWCOP 39. The brother and sister-in-law of P's husband sought in the context of a major "row" to be substituted as property and affairs deputies in place of P's husband. They persisted in the face of indications that they application was hopeless. They were therefore ordered by Senior Judge Lush to pay their own costs of the proceedings.

Fact finding against the odds

A Local Authority v (1) M by his litigation friend the Official Solicitor (2) E (3) A [2014] EWCOP 33 (Baker J)

Practice and procedure – fact-finding

Summary

This is a mammoth judgment running to 92 pages following a hearing that lasted over 2 weeks. It has been reported predominantly for what Baker J said (or, rather was very careful not to say) about the MMR vaccine and any link with autism, but we do not focus upon that aspect here, not least because Baker J was at pains to say that the MMR vaccine had nothing to do with the case before him.

The case concerned M, a 24 year old man with autism and learning disabilities and charted the difficult relationship which developed between E (M's mother and health and welfare deputy) and the local authority from M's late teens and culminated in the local authority making an application to the COP. The local authority made a series of allegations against E's parenting of M which led to a lengthy fact finding hearing.

At paragraph 253, Baker J summarised the critical facts which had been established in the case as follows (253):

> *"M has autistic spectrum disorder. There is no evidence that his autism was caused by the MMR vaccination. His parents' account of an adverse reaction to that vaccination is fabricated. The mother has also given many other false accounts about M's health. He has never had meningitis, autistic enterocolitis, leaky gut syndrome, sensitivity to gluten or casein, disorder of the blood brain barrier, heavy metal poisoning, autonomic dysautonomia (which, in any event, is not recognised in any classification of medical conditions), rheumatoid arthritis or Lyme disease. As a result of E maintaining that he had these and other conditions, she has subjected M to numerous unnecessary tests and interventions. He did have a dental abscess for which E failed to obtain proper treatment and caused him 14 months of unnecessary pain and suffering. E has also insisted that M be subjected to a wholly unnecessary diet and regime of supplements. Through her abuse of her responsibility entrusted to her as M's deputy, she has controlled all aspects of his life, restricted access to him by a number of professionals and proved herself incapable of working with the local authority social workers and many members of the care staff at the various residential homes where M has lived. This behaviour amounts to factitious disorder imposed on another. In addition, E has a combination of personality disorders - a narcissistic personality disorder, histrionic personality disorder and elements of an emotional unstable personality disorder".*

The main focus of the case was the fact finding exercise (which led to the conclusions above) and the judgment contains a useful summary of the principles which should be applied to a fact finding hearing in the COP (at paragraphs 82 – 90). In short, Baker J held that the legal principles in the COP should be broadly the same as in children's proceedings where a court is investigating that a child has been ill-treated or neglected. Those principles have been summarised by Baker J in a number of cases including *Re JS* [2012]

EWHC 1370 (Fam). The principles which were of particular importance in the instant case (and are likely to be of importance in the majority of COP cases) are set out here for ease of reference:

"83. First, the burden of proof lies with the local authority. It is the local authority that brings these proceedings and identifies the findings that they invite the court to make. Therefore, the burden of proving the allegations rests with them.

84. Secondly, the standard of proof is the balance of probabilities: Re B (Children) [2008] UKHR 35. If the local authority proves a fact on the balance of probabilities, this court will treat that fact as established and all future decisions concerning M's future will be based on that finding. Equally, if the local authority fails to prove any allegation, the court will disregard that allegation completely. In her written submissions on behalf of the local authority, Miss Bretherton contended that the court should apply the principle that

> *'the more serious the allegation the more cogent is the evidence required to overcome the unlikelihood of what is alleged and thus to prove it.'*

This principle, originally stated by Ungoed-Thomas J in Re Dellows Will Trust[1964] 1 WLR 451, was at one time applied by the courts considering allegations of child abuse in family proceedings under the Children Act 1989. In Re B, however, the House of Lords emphatically rejected that approach. Baroness Hale of Richmond, with whose judgment the other four Law Lords agreed, having analysed the case law, stated at paragraphs 70 to 72:

> *'70 I would announce loud and clear that the standard of proof in finding the facts necessary to establish the threshold under s.31(2) or the welfare considerations of the 1989 Act is the simple balance of probabilities - neither more nor less. Neither the seriousness of the allegation nor the seriousness of the consequences should make any difference to the standard of proof to be applied in determining the facts. The inherent probabilities are simply something to be taken into account, where relevant in deciding where the truth lies.*
>
> *71. As to the seriousness of the consequences, they are serious either way. A child may find her relationship with her family seriously disrupted or she may find herself still at risk of suffering serious harm. A parent may find his relationship with his child seriously disrupted or he may find himself still at liberty to maltreat this or other children in the future.*
>
> *72. As to the seriousness of the allegation, there is no logical or necessary connection between seriousness and probability.'*

In my judgment, the same approach must surely apply in the Court of Protection where the court is carrying out a similar exercise in determining the facts upon which to base decisions as to the best interests of an incapacitated adult.

85. Thirdly, findings of fact in these cases must be based on evidence. As Munby J (as he then was) observed in Re A (A Child: Fact-finding hearing: speculation) [2011] EWCA Civ 12:

> *'It is an elementary proposition that findings of fact must be based on evidence, including inferences that can properly be drawn from the evidence, and not on suspicion or speculation.'*

86. Fourth, the court must take into account all the evidence and, furthermore, consider each piece of evidence in the context of all the other evidence. As Dame Elizabeth Butler-Sloss, President, observed in Re T [2004] EWCA Civ 458, [2005] 2 FLR 838, at paragraph 33:

> *"Evidence cannot be evaluated and assessed in separate compartments. A judge in these difficult cases must have regard to the relevance of each piece of evidence to the other evidence and to exercise an overview of the totality of the evidence in order to come to the conclusion whether the case put forward by the local authority has been made out to the appropriate standard of proof."*

87. Fifth, whilst appropriate attention must be paid to the opinion of medical experts, those opinions need to be considered in the context of all the other evidence. The roles of the court and the experts are distinct. It is the court that is in the position to weigh up expert evidence against the other evidence: A County Council v. K, D and L [2005] EWHC 144 Fam, [2005] 1 FLR 851 per Charles J.

88. Sixth, in assessing the expert evidence, which involves a multi-disciplinary analysis of the medical information conducted by a group of specialists, each bringing their own expertise to bear on the problem, one important consideration - and of particular relevance in this case - is that the court must be careful to ensure that each expert keeps within the bounds of their own expertise and defers where appropriate to the expertise of others - see the observations of Eleanor King J in Re S [2009] EWHC 2115 Fam.

89. Seventh, the evidence of the parents is of the utmost importance. It is essential that the court forms a clear assessment of their credibility and reliability. They must have the fullest opportunity to take part in the hearing and the court is likely to place considerable weight on the evidence and impressions it forms of them - see Re W and another (Non-accidental injury) [2003] FCR 346.

90. Eighth, it is not uncommon for witnesses in these cases to tell lies, both before and during the hearing. The court must be careful to bear in mind that a witness may lie for many reasons - such as shame, misplaced loyalty, panic, fear and distress - and the fact that a witness has lied about some matters does not mean that he or she has lied about everything - see R v. Lucas [1981] QB 720. The assessment of the truthfulness is an important part of my function in this case".

Comment

This was a factually dense case with 35 lever arch files of evidence and 32 witnesses giving oral evidence. It was further complicated (and the case substantially lengthened) by the fact that E (M's mother) was acting in person. As he drily noted:

> *"One lesson of this case is that, if parties such as E and A are to be unrepresented in hearings of this kind, be it in the Court of Protection or in the Family Court, the hearings will often take very considerably longer than if they were represented. Denying legal aid in such cases is, thus, a false economy."*

Despite those factors, Baker J applied the principles set out above to make succinct findings of fact (see paragraph 253 quoted above). He set out in detail his assessment of each of the witnesses and the evidence as a whole in a manner which is useful and informative generally as an approach to evidence in such cases. Notably, he did not shy away from a judgment which was highly critical of E whilst acknowledging in the last paragraph of his judgment (paragraph 254) that E and A (M's mother and father)

would have an enormous amount to offer their son if they "*could work in collaboration with the local authority and other professionals in M's best interests*."

The limits of paternalism

Re DM [2014] EWHC 3119 (Fam) (Hayden J)

Practice and procedure – other

Summary

Sunderland City Council sought declaratory relief sanctioning a birth plan in respect of a vulnerable adult which contemplated: (i) interference with the mother/baby relationship following the birth which involved some unspecified level of forced separation and, potentially, removal of the child; and (ii) that the mother should not be informed of key aspects of the plan.

The above orders were sought under the Human Rights Act 1998 and the inherent jurisdiction of the High Court.

The application was made on a Friday. Hayden J adjourned it over the weekend because he did not consider that the evidence had been fully marshalled. On Monday, the local authority sought permission to withdraw its application. Hayden J granted permission to withdraw 'without hesitation' because he was far from persuaded of the necessity for or proportionality of the relief sought.

The expert evidence was that the mother had capacity to make decisions about (i) the contact she had with professionals (ii) the safe management of the birth of her baby and particularly in deciding whether and when to undergo an induction and (iii) to make decisions about the treatment she should receive following the birth of the baby.

The young woman had given birth on 8 previous occasions and each of those children had been removed from her care and placed for adoption. The mother had also gone into hiding late in her last pregnancy. Relevant clinicians had come to the conclusion in this pregnancy that labour should be induced for the mother's own health. The local authority was understandably concerned that the mother might go into hiding again jeopardising her own health, that of the unborn child and that of the child following birth. The local authority sought to protect the mother and to put in place such protective measures as they could on the birth of the child. Hayden J described the instincts of the local authority as 'laudable' but with a 'paternalistic complexion'. He emphasised that the law was vigorous in protecting the fundamental principle of personal autonomy. He noted that individuals are entitled to take their own decisions, both good and bad and are at liberty to make their own mistakes.

The starting point was that the local authority had an obligation to consult parents in the care planning for their children and/or unborn child.

Hayden J reiterated that in UK law a foetus has no rights of its own until it is born and has a separate existence from its mother. It was a principle that infused the whole of the criminal and civil law in the UK. Balcombe LJ in *Re F (in Utero) (Wardship)* [1988] 2FLR 307 had confirmed that the inherent jurisdiction did not extend to the unborn child.

The issue in this case was therefore the future rights of a child, crystallising on birth and the present and existing rights of a pregnant, capacitous woman. In *St George's Healthcare NHS Trust v S and R v Collins & Ors, ex parte S* [1998] 2 FLR 728 Judge LJ in the Court of Appeal concluded that a capacitous adult should be entitled to decline medical treatment even if her life or that of the unborn child depended on it. The 'powerful elucidation of the law' by Buter-Sloss LJ in *Re MB (An adult: Medical treatment)* [1997] 2 FLR 426 remained the starting point in all applications:

> "*… a competent woman who has the capacity to decide may, for religious reasons, other reasons, or for no reasons at all, choose not to have medical intervention, even though … the consequence may be the death or serious handicap of the child she bears or her own death. She may refuse to consent to the anaesthesia injection in the full knowledge that her decision may significantly reduce the chance of her unborn child being born alive. The foetus up to the moment of birth does not have any separate interests capable of being taken into account when a court has to consider an application for a declaration in respect of a caesarean section operation. The [law] does not have the jurisdiction to declare that such medical intervention is lawful to protect the interests of the unborn child even at the point of birth.*"

The application in this case was based on the landmark decision of Munby J (as he then was) in *Re D (Unborn baby)* [2009] 2 FLR 313. In *Re D*, Munby J was not exercising the inherent jurisdiction in relation to an incapacitated adult; he was concerned with the best interests of the baby when born. Munby J emphasised the "*wholly exceptional*" circumstances in which anticipatory relief would be granted. It was necessary to ensure that it was not only "*appropriate and justified', but 'imperatively demanded*" in the interest of safety in the period immediately following the birth of a child. It was always to be regarded as "*highly unusual*" and a "*very exceptional step*."

Hayden J went on the revisit in summary the exceptional circumstances of the *Re D* case which included: the fact that the mother was serving a custodial sentence due to a serious assault on her daughter during a supervised contact session; the mother's continuing extreme distress and challenging behaviour including an attempt to take her own life in highly alarming circumstances in her cell; the fact that the mother had expressed the view that her children would be better off dead than in the care of the local authority. He emphasised tha*t Re D was "a wholly exceptional case*" and reiterated that the courts and local authorities must be vigilant to ensure that the wholly exceptional nature of the relief was never lost sight of.

Hayden J did not consider that any more recent cases had weakened the test set out by Munby J in *Re D*. He did not consider that it would be helpful to set out prescriptive conditions but stated that to invoke the declaratory relief initially sought in this case the facts would require a level of 'exceptionality' and would be characterised by the 'imperative demands' and the 'interests of safety' of the new-born baby in the period immediately following its birth.

Hayden J held that the professional instincts in this case were sincere but they were ultimately misconceived. It was possible to keep the mother and baby together in a manner that respected the mutual need each for the other in the period immediately following birth which would have the effect of maintaining the respective rights of both mother and baby until the Family Proceedings Court could hear the inevitable applications.

Although the judgment had described the application as misconceived the judged observed that professionals involved in these difficult decisions provided a huge service to the woman and babies they dealt with and society more widely. This case, Hayden J, had illustrated the challenges they faced and the debt we all owed to them.

Comment

This case is a useful reminder of the limits of the inherent jurisdiction (albeit as it applies in a rather different context to that jurisdiction as it applies in relation to vulnerable adults) and the wholly exceptional nature of the *Re D* case with its use of an anticipatory declaration in the interests of a child who has just been born.

It is also a useful reminder for local authorities and those who act for local authorities that good intentions and legitimate professional concerns can stray into the realm of paternalism.

Short note: the legal aid debate escalates

In some of his most trenchant comments to date, Sir James Munby P has raised the stakes yet further in the battle (we entirely support) to secure proper funding for representation in proceedings concerning the most vulnerable. In *Re D (A Child)* [2014] EWFC 9, the President was concerned with care proceedings in which:

(1) The father lacked capacity to litigate and therefore required a litigation friend. That litigation friend was the Official Solicitor, who was only prepared to act because the father's solicitor and counsel had agreed to act, thus far, *pro bono* and, indeed, further, the solicitor had agreed to indemnify him against any adverse costs orders;[1]

(2) The mother, although she had learning disabilities, was not a protected party. Because of her "*personal characteristics, intellectual functioning and limitations which affect* [her]," she was in the view of her Counsel (endorsed by the President) "*wholly unable to represent herself in relation to any aspect of* [the] *proceedings*;"

[1] It should also be noted that the solicitor, Rebecca Stevens of Withy King had spent in excess of 100 hours, all unremunerated, working to resolve the issue of the father's entitlement to legal aid. As the President noted, "[t]*his is devotion to the client far above and far beyond the call of duty*."

(3) Neither qualified for legal aid but both lacked the financial resources to pay for legal representation where, as the President put it "*unthinkable that they should have to face the local authority's application without proper representation*."

Sir James Munby set out a number of propositions of equal application – we suggest – to "adult care" proceedings before the Court of Protection where a local authority wishes to remove an adult P from the care of their parents.

He noted, in particular, the decision of the European Court of Human Rights in *RP v United Kingdom* [2008] EWCA Civ 462, drawing attention, especially, to the underlined words in paragraph 67:

> *"67 In light of the above, and bearing in mind the requirement in the UN Convention that State parties provide appropriate accommodation to facilitate disabled persons' effective role in legal proceedings, the court considers that it was not only appropriate but also necessary for the United Kingdom to take measures to ensure that RP's best interests were represented in the childcare proceedings. Indeed, in view of its existing case-law the court considers that a failure to take measures to protect RP's interests might in itself have amounted to a violation of Art 6(1) of the European Convention (emphasis added)."*

The President described the parents' predicament as "*shocking*":

> *"31. Stripping all this down to essentials, what do the circumstances reveal?*
>
> *i) The parents are facing, and facing because of a decision taken by an agent of the State, the local authority, the permanent loss of their child. What can be worse for a parent?*
>
> *ii) The parents, because of their own problems, are quite unable to represent themselves: the mother as a matter of fact, the father both as a matter of fact and as a matter of law.*
>
> *iii) The parents lack the financial resources to pay for legal representation.*
>
> *iv) In these circumstances it is unthinkable that the parents should have to face the local authority's application without proper representation. To require them to do so would be unconscionable; it would be unjust; it would involve a breach of their rights under Articles 6 and 8 of the Convention; it would be a denial of justice.*
>
> *v) If his parents are not properly represented, D will also be prejudiced. He is entitled to a fair trial; he will not have a fair trial if his parents do not, for any distortion of the process may distort the outcome. Moreover, he is entitled to an appropriately speedy trial, for section 1(2) of the 1989 Act and section 1(3) of the 2002 Act both enjoin the court to bear in mind that in general any delay in coming to a decision is likely to prejudice the child's welfare. So delay in arranging for the parents' representation is likely to prejudice the child. Putting the point more generally, the court in a case such as this is faced with an inescapable, and in truth insoluble, tension between having to do justice to both the parents and the child, when at best it can do justice only to one and not the other and, at worst, and more probably, end up doing justice to neither.*

vi) *Thus far the State has simply washed its hands of the problem, leaving the solution to the problem which the State itself has created – for the State has brought the proceedings but declined all responsibility for ensuring that the parents are able to participate effectively in the proceedings it has brought – to the goodwill, the charity, of the legal profession. This is, it might be thought, both unprincipled and unconscionable. Why should the State leave it to private individuals to ensure that the State is not in breach of the State's – the United Kingdom's – obligations under the Convention? As Baker J said in the passage I have already quoted, "It is unfair that legal representation in these vital cases is only available if the lawyers agree to work for nothing."*

The President then threw down the gauntlet in no uncertain fashion, in a fashion presaged in his earlier decision in *Q v Q* [2014] EWFC 7, and directed a further hearing:

> "*at which, assuming that the parents still do not have legal aid, I shall decide whether or not their costs are to be funded by one, or some, or all of (listing them in no particular order) the local authority, as the public authority bringing the proceedings, the legal aid fund, on the basis that D's own interests require an end to the delay and a process which is just and Convention compliant, or Her Majesty's Courts and Tribunals Service, on the basis that the court is a public authority required to act in a Convention compliant manner.*
> *37. Copies of this judgment, and of the order I made following the hearing on 8 October 2014, will accordingly be sent to the Lord Chancellor, the Legal Aid Agency, Her Majesty's Courts and Tribunals Service and the Association of Directors of Children's Services, inviting each of them to intervene in the proceedings to make such submissions as they may think appropriate. If they choose not to intervene, I shall proceed on the basis of the conclusions expressed in this judgment, in particular as I have set them out in paragraph 31."*

(In)equality of arms and legal aid (2)

In *Re H*, an unreported case available (at present) only on Lawtel, HHJ Hallam made some very trenchant comments as to the dangers arising from the inequality of arms in child protection proceedings of equal application (we suggest) in equivalent 'adult protection' proceedings in the COP. In particular, whilst not having legal aid would not prevent an unrepresented mother with evident speech, hearing and learning difficulties from having physical access to a court she had "*undoubtedly been prevented from having intellectual access to* [the] *court*," such that it could not properly be said that her access was "effective."

HHJ Hallam held that the mother was not "*sufficiently disadvantaged to say that she does not have capacity to litigate. She has capacity to litigate but in my judgment that is only with the assistance of a solicitor. She has difficulties in hearing, in speech and intellectual difficulties. She is unable to read or write. They are not fanciful difficulties. In previous public law proceedings there has been a report from Dr Cooper, who is a psychologist, informing the court of the mother's cognitive difficulties and learning difficulties. Having seen the mother in court, I am satisfied that she would not have been able to represent herself in a case as complex as this and therefore, in my judgment, she was, to all intents and purposes, prevented from having access to this court save for, as I say, the extremely fortunate event that someone was prepared to step in and represent her pro bono*."

HHJ Hallam found it "astounding" to say (as did the LAA) that there would be no breach of the mother's Convention rights where she was unrepresented, and both the local authority and the father were (a)

represented; and (b) running cases against her, when she was the party with the least ability and greatest vulnerability. HHJ Hallam "*could not think*" of a clearer breach of Article 6 ECHR, and equally found that Article 8 ECHR was engaged and would have been breached but for the fact that some *pro bono* representation had been arranged.

Guidance for Litigation Friends in the Court of Protection

As many of you will know, Alex has spent a significant part of this year working on guidance commissioned by the Department of Health for IMCAs, RPRs and other advocates (as well as family members and friends of putative 'P's) considering acting as litigation friends in the Court of Protection.

The guidance has now been published, and is hosted by the University of Manchester, available here. As it says in its introduction:

> *Th*[e] *Guidance aims to demystify the Court of Protection generally and the role of litigation friend specifically so as to enable more people to consider taking up the role – thereby ensuring the better promotion and protection of the rights of those said to be lacking capacity to take their own decisions.*

Because of its scope, it guidance may also serve as a useful (free) overview for others wishing to learn more about the Court of Protection.

The guidance is primarily aimed at proceedings relating to health and welfare, and its chapter headings are as follows:

A: Overview
B: An overview of the Court of Protection
C: Who can be a litigation friend for P in proceedings before the Court of Protection?
D: Becoming a litigation friend and instructing lawyers
E: What does a litigation friend do?
F: When is it appropriate to bring a case to the Court of Protection as litigation friend for P?
G: How do cases before the Court of Protection proceed?
H: When would an appointment of a litigation friend come to an end?
I: Practicalities
J: Frequently asked questions
K: Useful sources of information

There are also appendices containing checklists, a template position statement and details of the 'balance sheet' approach.

Alex is very grateful indeed to the very many people who took the time to attend workshops and comment upon drafts, and generally – he hopes – to assist in producing a document that will be of actual use!

Transparency in the Family Court

Sir James Munby, President both of the Court of Protection and of the Family Division, has placed a very high priority on increasing transparency in both courts. In consequence, we have the Practice Guidance issued in January 2014 relating to the publication of judgments in the Court of Protection. As yet, further steps (for example, enabling increased media access to hearings) have yet to be taken in the Court of Protection.

In August 2014, the President issued a consultation on next steps in the Family Court. This has already produced a number of responses, usefully collated by Jordans Family Law website here, and we suggest that the results may well cause us to take stock before any moves are taken to move down the route to further transparency in the Court of Protection.

Short note: capacity, s.117 MHA 1983, and the future

In *R(Worcestershire County Council) v Essex County Council* [2014] EWHC 3557 (Admin), HHJ David Cooke, sitting as a Deputy High Court judge, has held that the rationale for excluding from periods spent under detention under the MHA 1983 does not extend to other situations and, specifically, that periods spent deprived of liberty under the provisions of Schedule A1 to the MCA 2005 are not ignored when deciding where a person is resident for purposes of s.117 MHA 1983. In rejecting the contention that allegedly unlawful periods of detention in a care home in Essex were to be ignored for purposes of deciding where an individual was "resident" (unlawful because the individual in question was said – retrospectively – to have lacked the material capacity and no authorisation had been sought or granted under Sch A1), HHJ Cooke examined the position vis-à-vis capacity thus:

> "*24. What then if the person has no capacity to decide for himself where to live? If he in fact lives eats and sleeps somewhere (and has no other place that may be considered his home) is that not to be taken as his residence? That would be the effect of Essex's argument in this case. In my judgment this too is a question that must be answered in accordance with the context in which it is asked. In the context of s117, Lloyd LJ said this* [in *R (Sunderland CC) v South Tyneside Council* [2012] EWCA Civ 1232]:
>
> > *'27. In terms of the overall policy of MHA and that of section 117 in particular, Langstaff J said [at first instance] at paragraph 23(1) that the section must be construed in the context of Parliament's presumed intention to establish a workable and effective system to provide for after-care in the community for patients released from hospital. That is common ground. In particular, the objective of the provisions is that it should be possible to prepare in advance for the discharge of the patient...'*
>
> *25. Patients liable to detention under the MHA may very often have long term mental health problems and degrees of mental impairment that fluctuate over time and are difficult to assess. Their capacity must of course be assessed in the context of a particular decision, at the time they are called on to make it. It would not be a workable or effective system, or one which enabled responsibility for aftercare to be readily ascertained prior to discharge from a period of detention if it were necessary to examine retrospectively the patient's capacity at a date in the past, particularly if that might involve consideration of a question that was not in fact addressed at the relevant time, or if there was no contemporaneous psychiatric assessment. The present case is a paradigm example of the potential difficulties; Essex seeks to have a retrospective assessment now in which it would challenge the adequacy of assessments that were in fact made at the relevant times, saying they are out of kilter with other assessments for different purposes and at different dates.*
>
> *26. Nor would engaging on that enquiry necessarily result in an allocation of responsibility that would be any less fortuitous or more satisfactory in terms of the policy of the section. For patients with a long term history of capacity and institutional intervention, the conclusion might be that they had no place of residence and accordingly responsibility would fall on the authority for the place to which they were discharged. That would potentially act as a disincentive to an authority to make available a place for a person who still may have long term and expensive needs.*

Conclusion

27. The context and purpose of s117 point in my judgment to an interpretation that is as straightforward as possible, the residence of a person being prima facie the place in which he was in fact living eating and sleeping immediately prior to his detention. There may be reasons to conclude that he has not lost an established residence elsewhere, for example because of imprisonment or because he is only temporarily away from that residence on holiday, but if he has no such other place, and in the absence of some other special factor, his actual place of abode is his residence. This would be so whether he is there voluntarily or involuntarily, and whether any lack of voluntariness is caused by his will being overborne (eg on imprisonment) or because a decision he has in fact made is vitiated by lack of capacity, or if the decision has in reality been taken on his behalf by someone else, with or without lawful authority to do so."

As HHJ Cooke noted, this decision will be of time-limited impact given the changes coming in in April 2015 with the coming into force of s.39(4) Care Act 2014 and the alignment of 'residence' for s.117 MHA 1983 purposes with 'ordinary residence' for other community care purposes.

Note should be had in this regard to Chapter 19 of the statutory guidance that has now been issued to accompany Part 1 of the Care Act. This guidance, in addressing the cases of those who do not have capacity to decide as to residence (at paragraphs 19.15-19.19), is in very short form indeed. Interestingly, and despite the fact the Court of Appeal in *R(Cornwall Council) v SoS for Health & Ors* [2014] EWCA Civ 12 held in terms that *Vale 1* test (in essence equating the ordinary residence of the incapacitated adult with that of their parents) was incorrect as a matter of law, a vestige of it remains at paragraph 19.18:

"19.18. In the case of a person whose parents are deceased, people who have become ordinarily resident in an area and then lost capacity or have limited contact with their parents, the approach known as Vale 2 is appropriate. This involves considering a person's ordinary residence as if they had capacity. All the facts of the person's case should be considered, including physical presence in a particular place and the nature and purpose of that presence but without requiring the person have voluntarily adopted the place of residence."

No doubt the Supreme Court will, in due course, pronounce upon this aspect of the guidance when it determines the appeal of the Secretary of State and Somerset County Council in the *Cornwall* case.

Short Note: capacity in practice

In *Jubair Ali v (1) David Graham Caton (2) Motor Insurers' Bureau* [2014] EWCA Civ 1313, the Court of Appeal considered an appeal against an award made in a personal injury claim following a road traffic accident which left the claimant with a serious brain injury. The original judgment For the purposes of this Newsletter the interesting ground of appeal is the one which challenged the judge's finding that the claimant lacked capacity to manage his property and financial affairs.

This was one of 4 grounds of appeal and was dealt with at paragraphs 51 – 69 of McCombe LJ's judgment (with which the 2 other judges agreed).

The defendant argued: (i) that the judge did not properly apply the provisions of the MCA 2005; (ii) that the judge's conclusions on lack of capacity were inconsistent with his finding that the claimant passed the UK Citizenship Test; and (iii) that the judge could not properly find a lack of capacity without impeaching the material expert evidence.

The Court of Appeal dismissed the appeal, holding that the judge was entitled to conclude that the claimant lacked capacity (notwithstanding the statutory presumption), having regard to the sum total of the evidence.

McCombe LJ rejected the contention advanced by the defendant that the judge was wrong to place reliance on evidence other than that of the neuropsychologists (particularly that of the psychiatrists) in circumstances where all the experts had deferred to the neuropsychologists, finding that the question of mental capacity was ultimately a matter for the court. The evidence from the neuropsychologists was an important facet in the equation but the judge had to weigh that with the evidence from other quarters as to how the claimant presented and how in practice he functioned in day-to-day life. In other words: "[t]*he opinion formed in the consulting room does not dictate what happens on the street or in the home*"

CQC takes steps to ensure compliance with the MCA 2005

The House of Lords Select Committee report on the MCA 2005 recommended that the standards against which the CQC inspects should explicitly incorporate compliance with the Mental Capacity Act, as a core requirement that must be met by all health and care providers. With effect from 1 October 2014, the CQC has now implemented that recommendation by making one of the key lines of enquiry ('KLOEs') followed by inspectors examination of the topics of:

- the MCA 2005
- the deprivation of liberty safeguards;
- consent to care and treatment; and
- restraint.

This KLOE is mandatory, and the place that is assigned in the CQC's investigation and reporting regime means that compliance (or otherwise) with it can effect a services' overall rating.

As explained in all the provider handbooks (covering the different sectors that the CQC inspects):

> *The Mental Capacity Act (2005) is a crucial safeguard for the human rights of adults who might (or may be assumed to) lack mental capacity to make decisions, including whether or not to consent to proposed care or treatment interventions. The Mental Capacity Act (MCA) provides the essential framework for balancing autonomy and protection when staff are assessing whether people aged 16 and over have the mental capacity to make specific decisions at the time they need to be made. The MCA clearly applies where a service*

works with people who may have cognitive difficulties due to dementia, an acquired brain injury or a learning disability. But providers must also recognise that a person may lack mental capacity for a specific decision at the time it needs to be made for a wide range of reasons, which may be temporary, and they must know how they should then proceed.

Any decision taken on behalf of a person lacking capacity must be made in their best interests and be the least restrictive option that can be identified to meet a specific need.

We have a duty to monitor the Deprivation of Liberty Safeguards in all hospitals and care homes in England, and check on their use when we inspect places where they are used. Hospitals and care homes must tell us about the outcome of any application to deprive someone of their liberty using the Safeguards or by an order of the Court of Protection.

Where it is likely that a person lacking mental capacity to consent to the arrangements is deprived of their liberty to be given essential care or treatment, we will look for evidence that efforts have been made to reduce any restrictions on freedom, so that the person is not deprived of their liberty. Where this is not possible we will check that the deprivation of liberty has been authorised as appropriate, by use of the Deprivation of Liberty Safeguards, the Mental Health Act 1983, or by an order of the Court of Protection.

The importance of working within the empowering ethos of the wider MCA is reflected in our inspections. A specific KLOE about consent takes account of the requirements of the Mental Capacity Act and other relevant legislation. During our inspections, we will assess how well providers are using the MCA to promote and protect the rights of people using their services. In particular, we will look at how and when mental capacity is assessed, how mental capacity is maximised and, where people lack mental capacity to make a decision, how that decision is made and recorded in compliance with the MCA.

We will look for evidence that restraint, if used to deliver necessary care or treatment, is in the best interests of someone lacking mental capacity, is proportionate, and complies with the MCA.

Capacity guidance round-up and call for best practice materials

There is a veritable torrent of guidance (of one form another) being published at the moment as to the application of the MCA 2005 in different contexts. Important items to have crossed our desks which may you have missed include:

1. A SCIE report on the MCA and care planning;

2. The Local Government Ombudsman's October Adult Social Care Newsletter, focusing on safeguarding, including a number of case studies drawn in large part from instances in which capacity had either been over or underestimated;

3. "*Making the Abstract Real*" – a report of a number of specialists (of different disciplines) in brain injury prepared for the benefit of the Department of Health in responding to the House of Lord's Select Committee report on the MCA 2005, focusing on the difficulties of using the MCA 2005 on behalf of people with an ABI.

4. NHS England Guidance for CCGs and other healthcare commissioners on commissioning in a fashion compliant with the MCA 2005

Note also that the DH is asking the Department of Health is asking practitioners to send SCIE best practice materials used in relation to the MCA 2005, including information leaflets for service users and their families, guidance for professionals, documents for recording or guiding capacity assessments, and audit tools. The final collection of documents will be placed on a dedicated website for wide access.

Resources can be submitted in any format including, toolkits, guidance, apps etc. When submitting your resources please include details of:

- who the resource is intended for (e.g. registered manager, care worker, etc)
- what setting you work in (e.g. NHS, Local Authority, residential care, etc)
- who your client group is.

Please submit the MCA resources you wish to be included in the review to MCA@scie.org.uk or contact Angela Hatcher on 020 7535 0941. The deadline is 7 November.

New guidance on DNACPR

The British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing) published on 7 October new Joint Guidance on 'Decisions relating to resuscitation'. This guidance, formerly known as the Joint Statement, guidance reflects in significant part the impact of the Court of Appeal's decision in *Tracey* which – rightly or wrongly – was viewed by clinicians as significantly changing the approach to consultation in relation to the imposition of DNACPR notices.

The guidance is essential reading – in full – for all those involved in these intensely difficult decisions, but it is worth noting the particular points of emphasis in the new edition to which the Resuscitation Council draws attention:

"*In particular, the new edition:*

- *emphasises the importance of making anticipatory decisions about CPR as an integral part of good clinical practice: leaving people in the 'default' position of receiving CPR should they die, regardless of their views and wishes, denies them of the opportunity to refuse treatment that for many may offer no benefit and that many may not want;*
- *once again emphasises that every anticipatory decision about CPR must be based on assessment of the person's individual circumstances at that time;*

- *emphasises the importance of involving people (or their representatives if they are unable to make decisions for themselves) in the decision-making process; this often involves a person making a shared decision with their healthcare professionals, but where CPR has no realistic chance of success it may involve informing people of the decision and explaining the basis for it;*

- *emphasises that when CPR has no realistic chance of success it is important to make decisions when they are needed, and not to delay a decision because a person is not well enough to have it explained to them or because their family or other representatives are not available; nevertheless a clear plan should be made to explain and discuss the decision with the person and/or their representatives at the earliest practicable opportunity;*

- *emphasises that, whenever possible, anticipatory decisions about CPR are best made well in advance, when people are well enough and have enough time to consider them carefully and discuss them fully with anyone that they wish to, including their family and members of their healthcare team;*

- *emphasises the increasing recognition that such advance decisions are often best made as part of a broader consideration of the type of care or treatments a person would wish to receive (as well as the type of care or treatments they would not wish to receive) should their health deteriorate so that they are unable to make choices for themselves*

- *emphasises the importance of careful documentation and effective communication of anticipatory decisions about CPR*"

Care Act secondary legislation and guidance

In a positive flurry of activity, the majority of the secondary legislation (both 'affirmative' and 'negative') accompanying Part 1 of the Care Act has been published on the DH website, alongside the Care and Support Statutory Guidance and its consultation response.

We, and our sister Community Care Law Newsletter, will be dissecting this secondary legislation and guidance over the coming months (and one point in relation to capacity and ordinary residence is already identified in the first item above).

SCIE has also set up new Care Act website. This includes, giving rather belated effect to a commitment given during a debate during passage of what became s.42 of the Care Act), a Guide to "*Gaining access to an adult suspected to be at risk of neglect or abuse: a guide for social workers and their managers in England*." Alex, for one, remains firmly of the view that this Guide represents a woefully inadequate substitute for a statutory power of entry as exists in Scotland (and, coming soon, in Wales), and would also invite interested readers to read Preston-Shoot and Cornish, "*Paternalism or proportionality? Experiences and outcomes of the Adult Support and Protection (Scotland) Act 2007*" [2014] Journal of Adult Protection 5, which presents a detailed and nuanced picture of how the powers in Scotland are actually being used.

We would, though, note with some relief that the Guide does not suggest – as we were afraid that it might – that the inherent jurisdiction could be used to compel the capacitous but vulnerable in the way (we

submit rather alarmingly) envisaged by Parker J in *NCC v TB* Rather, it limits itself to the entirely correct (we suggest) proposition that:

> *"The important thing to remember when considering applying to the Court to use its jurisdiction to grant an access order is that its purpose is not to overrule the wishes of an adult with capacity, but* ***to ensure that the adult is making decisions freely****. In the context of this guide, constraint, coercion or the undue influence of a third party may be preventing the adult's ability to make free decisions, and recourse to the Court's jurisdiction may be used to assist professionals in gaining access to assess the adult."* (emphasis in original)

Safeguarding statistics 2013-4

The Health and Social Care Information Centre has recently published findings from the first Safeguarding Adults Return ('SAR') data collection for the period 1 April 2013-31 March 2014. As it replaces a different dataset (the Abuse of Vulnerable Adults), it is not possible to draw comparisons year on year.

The key findings were as follows:

- Safeguarding referrals were opened for 104,050 individuals during the 2013-14 reporting year. 60 per cent of these individuals were female and 63 per cent were aged 65 or over. Just over half (51 per cent) of the individuals had a physical disability, frailty or sensory impairment.

- For referrals which concluded during the 2013-14 reporting year, there were 122,140 allegations about the type of risk. Of these, the most common type was neglect and acts of omission, which accounted for 30 per cent of allegations, followed by physical abuse with 27 per cent.

- There were 99,190 allegations made about the location of risk in concluded referrals. The alleged abuse most frequently occurred in the home of the adult at risk (42 per cent of allegations) or in a care home (36 per cent of allegations).

- The source of risk was most commonly someone known to the alleged victim but not in a social care capacity, accounting for 49 per cent of allegations. Social care employees were the source of risk in 36 per cent of allegations and for the remaining 15 per cent the perpetrator was someone unknown to the alleged victim. These figures are based on a total of 99,190 allegations recorded for concluded referrals.

- There were a total of 56 serious case reviews (SCRs) for concluded referrals. A serious case review takes place when an adult or adults have suffered serious harm. The 56 SCRs involved a total of 100 adults at risk, of which 46 per cent suffered serious harm and died and 54 per cent suffered serious harm but survived.

Although the report advises caution as regards data relating to the mental capacity (to decide as to what is not stated) of individuals, of concluded referrals, 28% of individuals were found to lack capacity while 44% did not lack capacity. The individual's capacity was unknown in 29% of cases. Perhaps unsurprisingly, younger adults

aged 18-64 were the least likely to lack capacity (24%), while adults aged 75-84 were the most likely (31%). Overall, just under half of those lacking capacity were supported (by an advocate, family friends) were supported in a referral.

Inclusion Europe supported decision-making website

Inclusion Europe have launched a new website on supported decision making, with lots of practical examples from different jurisdictions (both inside and outside the EU).

Committee on the Rights of Persons with Disabilities statement on Article 14 CPRD

With thanks, as ever, to the eagle-eyed Lucy Series for bringing this to our attention, the Committee on the Rights of Persons with Disabilities has very recently issued a statement on Article 14, unpacking the jurisprudence on this article (providing for the right to liberty and security of the person). The statement is uncompromising in tone, emphasising the "*absolute prohibition of detention on the basis of disability*" and makes it clear that when it starts its scrutiny of the United Kingdom's compliance with the CRPD, it is very likely indeed that it will find that the MHA 1983 to be problematic. As the Committee note:

> "*There are still practices in which state parties allow for the deprivation of liberty on the grounds of actual or perceived disability. In this regard the Committee has established that article 14 does not permit any exceptions whereby persons may be detained on the grounds of their actual or perceived disability. However, legislation of several states party, including mental health laws, still provide instances in which persons may be detained on the grounds of their actual or perceived disability, provided there are other reasons for their detention, including that they are dangerous to themselves or to others. This practice is incompatible with article 14 as interpreted by the jurisprudence of the CRPD committee.*"

Although we understand that the process of scrutiny of the UK by the Committee has been delayed, this statement only suggests that the dialogue when it comes will be frosty and, on the part of the Government (and of the various constituent parts of the UK) will not proceed on the basis of an uncritical acceptance that the "jurisprudence" of the Committee is of the equivalent status to the jurisprudence of a domestic or international court.

Book Review: Medical Treatment and the Law: Issues of Consent (2nd Edition)

Medical Treatment and the Law: Issues of Consent (2nd Edition): Richard Harper (Jordans, 2014, £54)[2]

[2] Full disclosure: Alex is very grateful to Jordans for providing him with a copy of this for purposes of this (unpaid) review. We are always open to reviewing books in the area of mental capacity law and policy (broadly defined) – contact one of us with your suggestions and, ideally, a copy of the book!

This book, subtitled "*The Protection of the Vulnerable: Children and Adults Lacking Capacity*" is the second edition of a work first published in in 1999. The author, an experienced District Judge, comments in his introduction that the substance of the book is intended to be of assistance beyond lawyers and the judiciary to those working with the welfare and protection of the vulnerable. To this end, it is written in a deliberately simple (but far from simplistic) fashion and is (some might say blessedly) free from footnotes.

The book goes very far beyond simple consideration of issues of consent (although the first chapter on medical treatment and consent is worth the price of the book alone, as it provides an extremely clear outline of this often overly-complicated issue). It is divided into four parts: (1) general principles in relation to medical treatment and the law; (2) the right to life and the 'right to die'; (3) jurisdiction and procedure in medical treatment cases concerning incapacitated adults and children; (4) other specific areas in relation to medical treatment and the law (covering such topics as non-consensual treatment and medical treatment other than for purely medical reasons. Each of the sections provides a clear and above all practical guide to the key principles and to the case-law.

Whilst not providing (nor, in fairness, pretending to provide) a substitute for detailed procedural guides such as the Serjeants' Inn (now slightly elderly) work on *Medical Treatment: Decisions and the Law* (Bloomsbury, 2010) or for textbooks on medical ethics such as Mason and McCall Smith's *Law and Medical Ethics* (OUP, 2013), the book would – and indeed – should sit on the bookshelf not just of 'generalist' lawyers needing a reliable introduction to the key issues involved in medical and healthcare decision-making but also of doctors seeking to ensure that they comply with the demands of the law. In this regard, it is perhaps of particular importance in breaking down the component parts of the crucial decision of the Supreme Court in *Aintree v James* so as to ensure that its import is properly recognised by both lawyers and clinicians.

All books such as this are at the mercy of developments and, whilst it is commendably up-to-date, I should perhaps note that to the chapter on jurisdiction and procedure should be added reference to the case of *NHS Trust v FG*, with its vitally important guidance on when (and how) applications relating to serious medical treatment should be brought to court, guidance going far beyond the obstetric interventions with which the case was ostensibly concerned. I would also note that the discussion relating to PVS and MCS needs to be read subject to the new guidance issued by Royal College of Physicians on *Prolonged Disorders of Consciousness*. Finally, I might also suggest that it would have been desirable to include a passing mention of the Convention on the Rights of Persons with Disabilities; whilst – at present – it remains a convention more hotly discussed in the abstract than applied on the ground, it is increasingly being referred to in the context of domestic decisions, and some of the most dramatic challenges that it poses to practitioners (of all kinds) lie in the fields of medical treatment.

These are but minor quibbles, though, speaking more to the need for the speedy production of a third edition than anything else, and overall this relatively modestly priced work is a soundly reliable primer for all those concerned with areas where, almost more than any other, the consequences of getting the law wrong can have severe and irreversible consequences.

Alex Ruck Keene

Scottish Law Commission Report on Adults with Incapacity

Introduction

The Scottish Law Commission published its Report on Adults with Incapacity[3] on 1 October 2014, making 45 recommendations and attaching a draft Bill amending the Adults with Incapacity (Scotland) Act 2000 (AWIA). The report seeks to address possible incompatibilities between Article 5 ECHR and the AWIA following the Strasbourg B*ournewood*[4] ruling, namely (1) what constitutes a deprivation of liberty engaging Article 5 in situations other than psychiatric hospitals and prisons; and (2) how to lawfully authorise such deprivation of liberty and provide the necessary legal and procedural safeguards required by Articles 5(1) and (4).

The task of the Commission, as was the case for the Supreme Court in *Cheshire West*,[5] was not assisted by the fact that there is little guidance to date from Strasbourg on these issues. However, until such time as there is clearer direction from the European Court of Human Rights we at least have the Cheshire West interpretation of deprivation of liberty engaging Article 5 which is influential, if not binding, in Scotland.

Overview of recommended legislative changes

The report proposes amendments to the AWIA to allow for measures to prevent an adult with incapacity leaving hospital, the authorisation of significant restriction of liberty and orders to cease the unlawful detention of adults. Moreover, rather than defining "deprivation of liberty" the draft Bill introduces the concept of "significant restriction of liberty" to encompass all potential deprivation of liberty situations. The precise provisions can be found in the draft Bill, and are also described by Adrian Ward here. See also his comments on immediate practical consequences in his items on powers of attorney and the *Smyth* judgment elsewhere in this Newsletter. The following are some initial observations arising from the suggested legislative amendments, although it they are not exhaustive and inevitably at this stage ask more questions than they answer.

Hospitals: Prevention of adults with incapacity receiving medical treatment, or being assessed as to whether medical treatment is required, going out of hospital or some part of an NHS or private hospital (s.50A draft Bill)

[3] Scot Law Com No 240, 2014.

[4] *HL v UK* (2005) 40 EHRR 32

[5] *P (by his litigation friend the Official Solicitor) (Appellant) v Cheshire West and Chester Council and another (Respondents); P and Q (by their litigation friend, the Official Solicitor)(Appellants) v Surrey County Council (Respondent)* [2014] UKSC 19 ("*Cheshire West*").

The assessment of the adult's capacity and the means employed to prevent them from leaving hospital, including use of any medication or use of force, must be in accordance with the definition of "incapable" in s.1(6) AWIA and the Act's principles such as benefit, necessity and least restrictive alternative.

Moreover, there are review and appeal provisions of the authorisation to implement the measure. The medical practitioner who authorised the preventing of the person from going out of the hospital is under a duty to review this authorisation "from time to time"[6]. It is also possible for the patient or anyone claiming an interest in their personal welfare to apply to the sheriff for an order setting an end date for such a measure[7] or to review any action taken in reliance on the authorising certificate[8]. Additionally, administration of medication for confining the person to hospital can be brought under s52 AWIA (i.e. an appeal against medical treatment).

That being said, several aspects of the recommendations require further consideration.

Scope of authorisation process – immobile patients

It is the Commission's view[9] that the authorisation process will only be required where it is necessary to retrain the patient but that "in many cases it may not be necessary because of the state of their health"[10]. It is interesting that this view has been taken because Strasbourg and English jurisprudence indicate that even where the person does not try to leave if those responsible for them are clear that they will be prevented from leaving then this amounts to a deprivation of liberty[11].

Duration of authorisation – end dates and suitable alternative accommodation

In assessing whether or not to grant the order for an end date to be set, the sheriff is required to be satisfied that the treatment or assessment has ended, and that the patient is ready to return home or that suitable accommodation is available elsewhere. The Commission considers that[12], on balance, the advantages of including the provision regarding the suitable alternative accommodation outweighed the disadvantages of the court not being able to set an end date. It states:

> *"..we envisage that in its application, local authorities will be expected to provide full information to the court regarding the availability of suitable alternative accommodation or provision of care in the person's own home and to account for the performance of their statutory duties regarding these matters."*[13]

[6] s.50B draft Bill.

[7] s.50C draft Bill.

[8] s.50A(6) draft Bill.

[9] Report, para 5.3.

[10] Report, para 5.3.

[11] *HL v UK*, para 91, *JE v DE* [2006] EWHC 3459(Fam), per Munby J at 77 and *Cheshire West*, per Lady Hale at 48-49.

[12] Report, para 5.23.

[13] Para 5.23.

However, this does mean that if no such alternative accommodation exists then the adult may remain in hospital for an extended period where there is no therapeutic justification for this, which may not met the AWIA's requirements regarding benefit, necessity and least restrictive alternative. It this connection is perhaps worth noting that in *G(AP) v Scottish Ministers*[14] the Supreme Court noted that the objective behind the patient right in s.264 of the Mental Health (Care and Treatment)(Scotland) Act 2003 (relating to detention in conditions of excessive security at the State Hospital) was to actually drive forward the provision of sufficient medium-secure facilities.

Lack of automatic judicial oversight of authorisation and subsequent review

Whilst the Commission is not convinced that implementation of the authorisation automatically requires judicial approval, it is perhaps questionable whether the absence of such approval in light of the fact that the recommendations relate to vulnerable adults who may not be able to instruct someone to apply to the court on their behalf or there may not be anyone who is able or willing to do this. The European Court of Human Rights has after all referred on several occasions to the right to liberty being too important a right to be taken away simply because an incapacitated person appears to have given themselves up to detention[15].

Absence of welfare attorneys and guardians in authorisation process

The recommendations have deliberately not allowed guardians and attorneys to be involved in authorisation process, determined by a medical practitioner, because they may undermine the very purpose of the process[16] although they can apply to the sheriff as a person with an interest in the patient's welfare (see above). Again, given the importance placed on the right to liberty, should those who may be able to provide support to the adult be excluded at this early stage?

Community: Authorisation of significant restriction of liberty in relation to (1) placement in a care home or accommodation arranged by an adult placement service[17]; and (2) short term care (s.52 draft Bill)

In each case, the adult must again be assessed to be incapable in terms of the AWIA and the Act's principles must be applied. The "relevant person", being the manager of the material premises, failing which the adult's social worker, determines whether a significant restriction of liberty is required. The adult's welfare attorney and guardian will then authorise such significant restriction of liberty (or a sheriff if they do not exist or do not agree) and this will be deemed to be the consent of the adult with incapacity. Indeed, it will be assumed that with effect from commencement of the provision it will be assumed that this is included within their powers unless the contrary is expressly indicated[18].There are also review and appeal provisions.

[14] *G(AP) v Scottish Ministers* [2013] UKSC 79.

[15] *De Wilde, Ooms and Versyp v Belgium (No 1)* (1971) I EHRR 373, paras 64-65, *Storck v Germany*, para 75 and *HL v UK*, para 90.

[16] Report, para 5.31.

[17] By reason of vulnerability or need resulting from infirmity, ageing, illness, disability, mental disorder, or drug or alcohol dependency.

[18] s.52E(3) draft Bill.

The concept of "significant restriction of liberty" is substituted for deprivation of liberty and is intended to be clearer and easier to apply but will cover all situations involving deprivation of liberty in relevant care homes or placements without falling within the realms of a restriction of the right to liberty of movement[19]. If two of the listed factors are present then there is a significant restriction of liberty.

Once more, several observations can be made.

Objective factors constituting a "significant restriction of liberty"

A: Lack of social contact

The Commission decided not to include a lack of social contact as a factor when assessing what will constitute a significant restriction of liberty although it acknowledged that Supplementary Code of Practice on the Mental Capacity Act 2005 for England and Wales[20] includes this and that it has featured in Strasbourg jurisprudence[21]. It justifies its approach on the basis that to include it "is tantamount to creating a formal process for restriction of contact and communication"[22] and notes that all care arrangement standards encourage contact with family and friends, that to restrict access with others may have implications for those other people's Article 8 ECHR rights, and that there may be situations where contact with others may be legitimate for the adult's protection[23]. It is, however, submitted that it should be possible to distinguish between normal healthy contact situations that should be permitted and situations where it would be legitimate to restrict contact thus meaning that it can be included as an identifying factor.

Purpose and isolation

As in *Cheshire West*, the Commission rejects purpose as forming a factor to be taken into account when assessing significant restriction of liberty[24] although acknowledges that the context of the restriction may potentially be relevant[25].

Additionally, it does not consider that isolation[26] should be included as a factor because it cannot envisage that this would form part of a care arrangement. This approach is also to be welcomed because it is arguable that to include isolation as a determining factor in care placement situation may affirm the

[19] Article 2, ECHR Protocol No.4.
[20] Report, paras 6.17-6.20.
[21] *HL v UK*, para 91, and *HM v Switzerland* (2004) 38 EHRR 17, para 45.
[22] Report, para 6.21.
[23] Report, paras 6.22-6.24.
[24] See, for example, report para 6.55.
[25] Report, paras 6.56-6.57, referring to *Austin v UK* (2012) 55 EHRR 14, paras 58-59.
[26] In *Chosta v Ukraine* (35807/05) judgment 14 January 2014, the European Court of Human Rights stated "Relevant objective factors to be considered include the possibility to leave the restricted area, the degree of supervision and control over the person's movements and the extent of isolation." (para 1). However, this case did not relate to a care placement situation.

'normality" approach, with its paternalistic and possibly discriminatory overtones, suggested by Lord Justice Munby in the Court of Appeal *Cheshire West* judgment[27].

Substituted consent: welfare attorney or guardian authorisation of implementation of a significant restriction of liberty

Given that welfare attorneys or guardians will be considered to have consented to the significant restriction of liberty on behalf of the adult, Article 5 will not be engaged and there is no independent oversight of, or protective framework for, such restrictions.

Whilst it is arguable that in most cases any suggested and authorised significant restriction of liberty will be made in good faith and for the benefit of the adult concerned this, occasionally and very sadly, will not always be so. It is precisely in these minority of cases that human rights are so important.

The Commission justifies[28] such surrogate decision-maker authorisation on the basis of a passage in *Stanev v Bulgaria*[29] which states that:

> *"…there are situations where the wishes of a person with impaired mental faculties may validly be replaced by those of another person acting in the context of a protective measure and that it is sometimes difficult to ascertain the true wishes or preferences of the person concerned…"*[30]

It is suggested, however, that it may not be entirely safe to rely too heavily on this statement. For example, the paragraph continues:

> *"However, the Court has already held that the fact that a person lacks legal capacity does not necessarily mean that he is unable to comprehend his situation…"*[31]

and refers to *Shtukaturov v Russia*[32] in which it stated:

> *"…the applicant lacked de jure legal capacity to decide for himself. However, this does not necessarily mean that the applicant was de facto unable to understand his situation…"*

and in both cases, as well as in *Storck v Germany*[33] (referred to in *Shtukaturov*), it was noted that it was very clear that the applicant did not wish to be placed in the circumstances in which they found themselves (including, in *Stanev* and *Shtukaturov*, objecting to being subject to guardianship). In light of this, the aforementioned weight given by the Court to the right to liberty and the current direction from the

[27] *Cheshire West and Chester Council v P* [2011] EWCA Civ 1257 per Munby LJ at 83 And 86.
[28] Report, para 6.42.
[29] (2012) ECHR 46, para 130
[30] *Stanev*, para 130.
[31] *Stanev*, para 130.
[32] *Shtukaturov v Russia* (2008) ECHR 228, para 108.
[33] *Storck v Germany* (2005) ECHR 406, para 144.

Committee on the Rights of Persons with Disabilities on legal capacity[34] it does seem debatable whether such substituted consent would avoid Article 5 engagement and thus Article 5(1) and (4) legal and procedural safeguards are required.

Lack of automatic judicial oversight of authorisation, subsequent review and variation

As with the hospital measures, there will be no automatic authorisation or reviews by a court of the lawfulness of a restriction of liberty (although a sheriff will have to provide such authorisation where there is no welfare attorney or guardian or they refuse to give the authorisation). It should also be noted that, for the reasons already given, it may be that where welfare attorney or guardianship consent has been obtained it is possible to renew restriction arrangements indefinitely.

Moreover, the "relevant person" (defined as the manager of the premises or, failing this, the adult's social worker) may vary the significant restriction of liberty and implement such variation pending the outcome of any appeal against this by the adult, their welfare guardian or attorney and/or named person (if any), their primary carer and nearest relative, all of whom must be told about the variation[35] and why it is being made and are entitled to make such an appeal. It is, of course, possible that the level of restriction may be increased by these means and, again, there is no judicial authorisation of this.

Ability to apply to the sheriff in relation to an unlawful detention of an adult with incapacity (S.52J draft Bill)

Modelled on s.291 of the Mental Health (Care and Treatment)(Scotland) Act 2003, the draft Bill also provides for the sheriff to order that an adult who is, or may be, incapable is being detained in accommodation provided or arranged for by a care home service or an adult placement service is unlawful and that those detaining the adult must cease to detain the adult. The order may be applied for by the adult or any person claiming an interest in the adult's personal welfare. The report and explanatory notes accompanying the draft Bill indicate that this provision will operate alongside s.3(1) AWIA to ensure that where the adult with incapacity will not be left unsupported where the detention ceases but they still have care needs that mean they cannot live independently.

However, Article 5 requires proactivity and it is therefore important to emphasise that the state, medical staff, care managers and social workers cannot adopt a reactive approach and simply wait for the adult to mount such a challenge.

[34] Committee on the Rights of Persons with Disabilities, General Comment No. 1 (2014) *Article 12: Equal recognition before the Law,* adopted 11 April 2014, and UN Committee on the Rights of Persons with Disabilities Statement on Article 14 of the Convention on the Rights of Persons with Disabilities (right to liberty and security). Although the CRPD is not incorporated, and thus legally enforceable, within the UK, the UK nevertheless has a duty under international law to comply with its requirements and it should also be noted that devolved Scottish legislation and actions of the Scottish Ministers may be set aside if incompatible with the UK's international obligations (ss35 and 58 Scotland Act 1998). Moreover, the European Court of Human Rights must have regard to the requirements of the CRPD it being a higher source of international law.

[35] The Mental Welfare Commission for Scotland must also be informed (s.52I draft Bill).

Conclusion

As already mentioned, the Commission was not been helped by a lack of Strasbourg direction on the specific questions that have arisen post-*Bournewood*. Whilst acknowledging that the right to liberty is a fundamental right, the Commission also points out that it is considering the care of extremely vulnerable people and therefore that it has to be mindful that recommending legal procedures that are in excess of what is required for ECHR compliance this may take resources away from the care of individuals without providing an equivalent benefit[36]. It promotes what it considers to be a "common sense" approach to assessing what constitutes a significant restriction of liberty and endeavours to keep resource heavy bureaucracy and formality to a minimum. Moreover, it seeks to balance the Article 5 right to liberty, and reflecting the *Winterwerp* criteria, with the state's protective obligations in Articles 2 (the right to life) and 3(freedom from torture and inhuman or degrading treatment or punishment)[37].

If the report's recommendations are adopted and reflected in legislation it remains to be seen whether its approach will ultimately be compatible with ECHR requirements or be found to be too pragmatic affording too much deference to, and faith in, doctors, care managers and substitute decision-makers, as well as concern for the public purse, and not enough emphasis on the individual's autonomy and liberty, particularly in light of the approach adopted recently by the Committee on the Rights of Persons with Disabilities to capacity and liberty.

Jill Stavert[38]

Powers of Attorney

The case which we described as *B and F v B* last month has now been reported on the Scotcourts website as *B and G v F*. Following upon the uncertainty originally arising from *NW*, the Public Guardian has confirmed that she will make "*an application to the Inner House to afford us a definitive outcome*."

We previously reported on a case in the Court of Session identified as *DC*, a judicial review application in which it was asserted that the applicant, placed in a nursing home by his daughter acting as his attorney, had been unlawfully deprived of his liberty. The applicant asserted *inter alia* that an attorney could not be empowered to authorise deprivation of liberty, and that in any event the attorney in that case was not so authorised. The case attracted considerable interest, with both Mental Welfare Commission and Equality and Human Rights Commission entering the process. That case has now been abandoned, after certain undertakings were given, clearing the way for the focus to return to the applicant, his own wishes and needs, and his family. A few days before that case was thus resolved, Scottish Law Commission published its Report on Adults with Incapacity (see the article above by Jill Stavert). The Report, and appended draft Bill, recommend that welfare attorneys and welfare guardians should be empowered to authorise a significant restriction of liberty "*unless the Power of Attorney or Guardianship Order expressly provides otherwise*". Hitherto, those who considered that principles of autonomy and self-determination should be

[36] Report, para 1.21.

[37] Report, para 6.58

[38] The assistance of Rebecca McGregor, Research Assistant with the Centre for Mental Health and Incapacity Law, Rights and Policy, Edinburgh Napier University, in the preparation of this article is gratefully acknowledged.

respected so as to allow granters of Powers of Attorney to specify how any possible need for deprivation of liberty should be regulated, took the view that that should be expressed fully and clearly, and in a manner seeking to meet the requirements of Article 5 of the European Convention on Human Rights, in the power of attorney document. In doing this they looked to the principle enunciated, for example, in *McDowall's Executors* v IRC [2004] STC (SCD) 22 that anything contrary to the presumed purpose of granting a Power of Attorney should be expressly authorised. In *McDowall*, gifts for tax-planning purposes were held to be invalid because the presumed purpose of granting a financial Power of Attorney is to manage and conserve the granter's estate, not to give it away. From now on, it would appear that instructions should be taken as to whether power to authorise a significant restriction of liberty should be expressly excluded. Granters will have to be advised that this is a proposal only. They will also have to be advised that in the meantime the existing law remains unchanged, and some may opt to continue expressly to provide a mechanism for authorisation of deprivation of liberty.

Adrian D Ward

Damaging illegality of Scottish Social Work Authorities

We previously reported in July, August and October on the failure by local authorities to comply with the requirements of the Adults with Incapacity (Scotland) Act 2000 that reports by mental health officers for welfare guardianship applications should be prepared within 21 days of notification to the Chief Social Work Officer of intention to make such an application. The position appears to have worsened. The Newsletter would be interested to hear how many local authorities in Scotland still consistently comply with the 21-day limit. Provisions of the Mental Health (Scotland) Bill currently before the Scottish Parliament and of the draft Adults with Incapacity (Scotland) Bill proposed by the Scottish Law Commission in its Report on Adults with Incapacity discussed in the first item in this Newsletter will substantially increase the total workload for mental health officers. There are insufficient mental health officers to meet current requirements. There is accordingly an urgent need for Scottish Government to facilitate and resource the recruitment and training of substantially more mental health officers. That is already necessary to meet current requirements, and should be implemented immediately on a scale to ensure adequate provision when proposed new requirements come into force.

Adrian D Ward

Testamentary Capacity and Undue Influence

On 16th October 2014 Lord Glennie issued a decision, *Smyth v Rafferty and others*, in an action in which the pursuer sought production and reduction of a new Will, and a Codicil to a previous Will, made very shortly before her death by the pursuer's sister, on grounds of (i) lack of testamentary capacity, (ii) undue influence and/or (iii) facility and circumvention. The testator died without issue and divorced from her former husband. She was survived by the pursuer and other siblings, and by nephews and nieces. Under her previous Will, the pursuer stood to benefit substantially. Within a fortnight before her death she altered this radically by creating a substantial preferential provision in favour of a discretionary trust, with the intention that the trustees could if need be use those funds to support a family company in which the trust held a substantial shareholding derived from the testator, and of which the testator was managing

director up until her death. The new arrangements substantially disadvantaged the pursuer compared with the position under the testator's previous Will. Shortly before the testator's death, her former husband returned from abroad. There was much unpleasantness. It was clear that the pursuer was justified in feeling suddenly excluded from contact with the testator and whatever was happening, and had understandable grounds for the concerns reflected in the conclusions of the action which she brought.

Up until close to death the testator had sought to conceal, even from those closest to her, that she was terminally ill, and suffering extreme pain and nausea, and the side effects of medication.

Lord Glennie's lengthy and meticulous decision is not ground-breaking in legal terms. It sets out the relevant law, applies it to a careful examination of complex facts, and reaches the conclusion that the pursuer's claim must fail. It is however worthy of attention because of the contemporary relevance of many of the points made by Lord Glennie in his judgment, and the clarity with which they were made. The following comments are no substitute for reading the judgment:

1. With reference to the characteristics of intellectual capacity which a testator must have, Lord Glennie commented: "*These requirements will be absent if the testator suffers from some disorder of the mind preventing him exercising his natural faculties. But the testator does not have to have an actual understanding of the nature of the act, the extent of the property and the claims of those who might expect or be expected to benefit. The question is whether he was capable of understanding such matters, not whether he actually understood them on the occasion in question*" (paragraph 40);

2. As regards the so-called "golden rule" that the making of a Will by an old and infirm testator should be witnessed and approved by a medical practitioner who satisfies himself as to a testator's capacity and understanding, Lord Glennie pointed out that this is at most a rule of good practice; that there is no general duty on solicitors to obtain medical evidence every time they are instructed by an elderly client; that such a requirement "*would be both insulting and unnecessary*"; and that it could result in a solicitor being criticised (or even sued) for delaying carrying out instructions if, for example, delay resulted in a Will not being executed before the would-be testator died;

3. Having defined the essence of undue influence as the abuse of a relationship of trust and confidence, Lord Glennie went on to say that: "*The word abuse may tend to give a misleading flavour of what is involved. The person exercising the influence may genuinely believe that the course which he is persuading the other party to pursue is desirable and for the benefit of that party; and, indeed, may even believe that is in accordance with that party's real wishes. The mischief lies not in the act induced by the application of pressure being itself objectionable in some way, but in the fact that it results from the undue exercise of influence by the person in the position of trust*" (paragraph 45) This dictum is particularly relevant in the face of concerns about the controversial promotion by the UN Committee on the Rights of Persons with Disabilities of the fiction that people with impaired capacity or inability to identify and resist undue influence can nevertheless be "supported" to act and decide validly;

4. As to the pressure which might result in a finding of facility and circumvention, Lord Glennie said: "*That pressure may, at one extreme, be direct, forceful and overpowering or, at the other, be more subtle or insidious, working by solicitation or importuning. Fraud is one example of the way in which a facile mind*

maybe subverted but it is not an essential part of the principle. Bullying or browbeating may equally amount to circumvention. A robust individual will usually be able to resist pressure, or at least decide whether or not he wants to resist it. A facile person may not. But facility is a spectrum; it comes in degrees. A deed will only be at risk of being reduced (or set aside) if the pressure applied is unacceptable having regard to the extent to which the person on whom it is exerted is facile" (paragraph 49);

5. As regards all three head of challenge, Lord Glennie stressed the importance of the modern perception that the particular act or transaction at the particular time must be considered. A person may be capable at some times but not others, and facile on some occasions but not others. "*A person suffering from a grave, debilitating and painful illness will have moments when he is able to discuss matters calmly and sensibly and to resist pressure exerted by others, while at other moments he may be in such pain or so tired that, though capable of reasoning clearly, he simply goes along with what is proposed even though it is not what he would otherwise have done. The same applies, to some extent, to the existence of a relationship of trust relevant to the question of undue influence*" (paragraph 51);

6. Further to the foregoing point, Lord Glennie addressed a situation where: "*the testator, being incapable at the time, executes a will which is drafted to reflect what are known to be his wishes. If he was incapable when he executed the document, it cannot stand even if it reflects what he would have done had he been capable*" (paragraph 52). That impliedly supports the approach taken by Sheriff Principal Kerr (prior to his recent retirement) in *Application by Adrian Douglas Ward* discussed in the January 2014 Newsletter;

7. On the subject of expert witnesses, Lord Glennie referred to the duty to the court to give evidence honestly and impartially, without regard to the interests of those by whom he is instructed, but pointed out that there is no requirement in law that an expert witness be wholly unconnected with the parties. He held that there is no reason why a general practitioner should not be an expert witness on matters with which a general practitioner is familiar. He recorded, however, that he had to restrain such a witness from offering opinions "*on legal and other non-medical issues*", such evidence being clearly inadmissible. Lord Glennie pointed out that: "*Ultimately the question of capacity is one for the court and does not depend solely upon an assessment of the expert medical evidence"* (paragraph 73);

8. Lord Glennie rejected a submission from the defenders that if the pursuer's case on incapacity failed, it was bound to fail also on facility and circumvention and undue influence. He pointed out that the latter concepts pre-supposed capacity;

9. Lord Glennie made it clear that difficulty in obtaining clear instructions is not necessarily evidence of incapacity. In the present case, the testator had changed her mind on a number of occasions, often reverting to matters which her solicitor thought had been settled. Lord Glennie however took the view that: "*This suggests an active and vigorous mind, not one which was capable of being easily subverted by undue pressure or undue influence*" (paragraph 135);

10. Lord Glennie's concluding comments are worth quoting in full: "*Many people make new wills towards the end of their lives, often at a time when they are less alert mentally than they were previously. In that*

condition they may be tempted to cut corners, make assumptions which they might otherwise not have made, reach quick decisions when ideally they might have thought about them at greater length and in greater depth, re-assess their priorities, become more hard-nosed on the one hand or sentimental on the other, change their minds and generally make all sorts of decisions that they might not earlier have dreamed of making. In such circumstances it may well be true that the deed or will was to some extent the result of physical, mental or emotional frailty, but that does not matter. Unless there was incapacity, in the sense described earlier, or unless undue pressure or influence was used to procure the deed or will in the form in which it was executed, then the deed or will must stand. There is no basis for setting it aside" (paragraph 137).

It is notable that the pursuer had only a "lay representative". It appears that this situation was managed carefully by Lord Glennie and appropriately respected by the defenders. Perhaps there is scope in Scots law for considering more formalised provisions, such as the introduction of an equivalent of the English "litigation friend". The judgment appears to have lost nothing in being worded in a manner fully comprehensible to a literate lay person.

One final comment is worth making from a reading of the decision, without any other knowledge of the circumstances of this case. It would appear that the legal team acting for the testator devoted great care and effort to identifying and implementing a mechanism to implement the testator's dying wish to ensure that the family company could if necessary receive financial support from her funds after her death. They must have been aware that in doing so they could well find their actions subject to detailed scrutiny and challenge, in the course of cross-examination such as occurred in this case. That they persevered and succeeded shows true respect for the principles of autonomy and self-determination, and for the requirements of Article 12 of the UN Convention on the Rights of Persons with Disabilities for the provision of support to facilitate the exercise of legal capacity. They set a commendable example.

Adrian D Ward

Mental Welfare Commission for Scotland Reports

The Mental Welfare Commission for Scotland has recently published the following reports:

AWI Act Monitoring 2013/14: Statistical Monitoring

This report notes that the number of new and existing welfare guardianship orders continues to rise (during 2013/14 a further rise of 9.6% in new applications granted). This increase was entirely in private applications. Encouragingly, there was another significant reduction in the granting of indefinite private orders (reduced from 45% in 2011/12 and 35% in 2012/13, to 32% during 2013/14) although indefinite local authority approved applications remained moreorless at the same level as the previous year (26%). That being said, there was a lack of uniformity across local authorities regarding indefinite orders.

Welfare guardianship orders granted where the cause of incapacity was dementia fell to 45%, a decrease from 46% during 2012/13. On the other hand, welfare guardianship orders for persons with learning disability increased from 41% to 44% of orders.

During 2013/14 the Commission visited 593 adults on welfare guardianship (39% were living in their own homes, 38% were resident in a care home, 15% lived in supported tenancies and 5% were in hospital). Unfortunately, concerns were noted on a quarter of the visits. Serious issues included:

a. AWIA principles were not being fully respected in relation to 7% (40) of the adults visited.

b. 15 adults were subject to restraint or seclusion without proper authorisation in guardianship powers.

c. 2 adults had visit restrictions without proper legal authorisation.

d. 9 adults needed further assistance with communication.

e. The mobility problems of 13 adults were not being adequately assessed or addressed

f. 112 guardians with power to consent to medical treatment were not consulted about the adult's medical treatment.

Mental Health Act Monitoring 2013/14: Statistical Monitoring

The main findings of this report included that, for the period concerned, short-term detention rates were highest in inner city areas, detention by nurses has increased, there was a significant reduction in the use of police stations as a place of safety, and that CTOs rose slightly.

Visits to Young People in secure care settings: Visit and Monitoring Report

This report highlights the need for clarity and continuing of care for children and young people and makes a number of recommendations in this respect.

Of course, for greater clarity and detail all three reports must be read in their entirety.

Jill Stavert

Smoking ban upheld

In 2013, the Outer House of the Court of Session ruled in *CM (Petitioner)*[39] that the State Hospital's ban on smoking at the hospital was a violation of Articles 8 and 14 ECHR. This decision was subsequently appealed

[39] [2013] CSOH 143. See also *Scolag* "Mental health law Update" November 2013.

by the State Hospitals Board to the Inner House of the Court of Session, which has held (*M v State Hospitals Board for Scotland*[40]) that Article 8 was not engaged.

The court recognised that the notion of private life covering physical and psychological integrity is broad and also that those deprived of their liberty nevertheless continue to enjoy ECHR rights. That being said, it considered that the extent of the respondent's Article 8 right was "*necessarily restricted to protection from interference beyond that which inevitably flows from the circumstances of lawful imprisonment or other detention*"[41], "*lawful*" being detention in accordance with the requirements of Article 5 ECHR (the right to liberty). The decision to ban smoking was compatible with the Board's general management powers[42] of patients detained in accordance with article 5[43]. Referring to and agreeing with *R (on the application of E) v Nottinghamshire Healthcare NHS Trust*[44] - concerning a smoking ban at Rampton Hospital - the court agreed that a comprehensive ban on smoking in an institute such as the State Hospital does not have a sufficiently adverse effect on a person's personal integrity so as to engage Article 8.

The court also commented that, even had Article 8 had been engaged, a limitation of the right in Article 8(1) would have been justified as lawful under Article 8(2) (under the National Health Service (Scotland) 1978 Act), proportionate (given that due consideration had been given to the views of staff and patients as well as to material on the risks of smoking) and in pursuit of a legitimate aim (the promotion of the health of detained patients and staff).[45] Additionally, Article 14 would not have been applied had Article 8 been engaged because to compare detained patients with prisoners (the latter not being subject to such a ban) and conclude that the former have therefore been discriminated against was inappropriate in light of the therapeutic and diversionary objective underlying detention of patients at the State Hospital.[46]

Finally, it should also be noted that the court considered that the principles in s.1 Mental Health (Care and Treatment)(Scotland) Act 2003 were irrelevant to the decision to ban smoking at the State Hospital given that this matter concerned the management powers of the Hospital Board and was not about the care and treatment of the patients.

Jill Stavert

Comment on Article 14 of the CPRD

We cover this elsewhere in this month's issue, but make no apology for noting it here as well.

[40] [2014] CSIH 71, Lady Paton dissenting. However, although she considered that article 8 was been engaged she also considered that its restriction was lawfully permitted under article 8(2) (Lady Paton at 106-107).
[41] Lord Justice Clerk (Carloway) at 88.
[42] Under s.102 National Health Service (Scotland) Act 1978.
[43] Lord Justice Clerk (Carloway) at 89.
[44] Lord Justice Clerk (Carloway) at 93 referring to *R (on the application of E) v Nottinghamshire Healthcare NHS Trust* [2009] EWCA Civ 795, Lord Clarke of Stone-cum-Ebony MR and Lord Justice Moses at 51.
[45] Lord Justice Clerk (Carloway) at 94-96.
[46] Lord Justice Clerk (Carloway) at 97-99.

In September 2014, the UN Committee on the Rights of Persons with Disabilities issued a statement concerning Article 14 CRPD (the right to liberty and security). It appears very much to reinforce the approach adopted in its General Comment on Article 12 CRPD (the right to equal treatment before the law) discussed before in this Newsletter[47].

Essentially, the statement makes the following clear:

1. Detention on the basis of disability is absolutely forbidden.

2. The involuntary detention of persons with disabilities based on presumptions of risk or dangerousness regarding themselves or others that is tied to disability is contrary to the right to liberty.

3. Declarations of unfitness to stand trial and the detention of persons based on such declaration are contrary to Article 14 CRPD because it deprives the person of their right to due process and safeguards to which every defendant is entitled.

4. Where persons with disabilities are sentenced to imprisonment after committing a crime they should be entitled to reasonable accommodation so as not to aggravate incarceration conditions based on disability.

Whilst point 4 above is compatible with Article 5 ECHR requirements,[48] the directions in 1-3 above continue to bring issues such as protection of the other rights and freedoms of vulnerable persons and others and how Scottish law will be regarded when the Committee considers the UK implementation of the CRPD next year.[49]

Jill Stavert

Mental Health and Disability Sub-Committee

Upon her appointment in May 2014 as Tribunal President of the Additional Support Needs Tribunal for Scotland, May Dunsmuir became the Judicial Head of that Tribunal and in consequence has had to resign from her committee appointments with the Law Society of Scotland. Her resignation from the Mental Health and Disability Sub-Committee took effect at its meeting on 29th October 2014. May has been an active and valued member of the Society's Mental Health and Disability Sub-Committee ("MHDC") for 17 years, becoming vice-convener in 2012 and thereafter joint convener with Adrian. She was also a member of the Health and Medical Law Sub-Committee ("HMC") since its establishment in 2013; a consultant to the Criminal Law Committee from 2004 and 2009; and a member of the Mental Health Accreditation Committee. May has made major contributions to the development of Scots law and the development of

[47] Committee on the Rights of Persons with Disabilities, General Comment No. 1(2014) *Article 12: Equal recognition before the Law*, adopted 11 April 2014
[48] *Ashingdane v UK* (Application No.8225/78) (1985) ECHR 8, para 44, *Aerts v Belgium* (Application No.25357/94) (1998) ECHR 64, para 46, *Hadzic and Suljic v Bosnia Herzegovina* (Application No.39446/06) (2011) ECHR 911, para 40.
[49] This article should not be construed as the author either supporting or not supporting the Committee's interpretation of CRPD rights.

practices and procedures to safeguard and benefit vulnerable children and adults. As well as her Tribunal presidency, she continues as an in-house convener with the Mental Health Tribunal for Scotland. In that role her achievements include the development of Child and Adolescent Mental Health Tribunals, and finding new ways to give young patients a voice at hearings. Her past appointments include over a decade as Children's Reporter and Authority Reporter with Scottish Children's Reporter Administration, significantly influencing the development of better responses and interventions for children at risk. Her previous positions included that of Legal and Parliamentary Officer with Scottish Association for Mental Health. As a student she worked a summer placement with Enable, meeting Colin McKay, then in-house solicitor at Enable, who subsequently supervised her traineeship as a solicitor. Like Colin (who is now Chief Executive of the Mental Welfare Commission), she served on the steering group of the major campaign which resulted in the Adults with Incapacity (Scotland) Act 2000 being put to and through the Scottish Parliament. She also played a major role in the law reform process resulting in the Mental Health (Care and Treatment) (Scotland) Act 2003, and through her many years with MHDC was involved in much other law reform and other work supporting improvements in the way in which the law and legal processes deal with vulnerable people.

Following the meeting on 29th October, May was thanked for her contribution to the work of the Law Society at a dinner hosted by Christine McLintock, the Society's vice-president, and attended by members of MHDC and Alison Britton as convener of HMC.

Ronnie Franks, Deputy Chief Executive of Legal Services Agency and a respected author on mental health law, and David McClements of Russell & Aitken, Solicitors, former Council member and treasurer of the Law Society of Scotland, both of them long-serving members of MHDC, have been appointed joint vice-conveners. Adrian remains convener. Alex Ruck Keene has become a member of MHDC, and is thus the first person to be a member of both MHDC and the Mental Health and Disability Committee of the Law Society of England and Wales. Alex has attended MHDC as a guest at earlier meetings this year, and now provides a valuable formal link between the two committees.

Jan Todd, principal solicitor with South Lanarkshire Council, and David Paton, Clerk to MHDC, both became married since the last previous meeting of MHDC.

Adrian D Ward

Milestones

Finally, a short note to mark two important milestones:

1. The fact that 4th November marks the first anniversary of the Centre for Mental Health and Incapacity Law, Rights and Policy, headed by Jill, at Edinburgh Napier. For more details of the Centre's work, see here;

2. Adrian's recent 70th birthday, which he celebrated by running the Jedburgh Half Marathon, which he considers that is likely to be nothing compared to the marathons ahead on the CRPD, the Scottish Law Commission's report, etc. etc.!

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Conferences at which editors/contributors are speaking

Edge AMHP Conference

Neil will be speaking at Edge Training's Annual AMHP conference on 28 November. Full details are available here.

Talks to local faculties of solicitors

Adrian will be addressing local faculties of solicitors on matters relating (inter alia) to adult incapacity law in Aberdeen on 20 November and Wigtown on 10 December.

Borderline Personality Disorder and Self Harm

Jill is chairing a jointly hosted seminar (the Centre for Mental Health and Incapacity Law, Rights and Policy NHS Tayside and Perth and Kinross Council) on "Borderline Personality Disorder and Self Harm" in Perth on 25 November

LSA Annual Conference

Jill is speaking about the Mental Health (Scotland) Bill 2014 at the Legal Service Agency's Annual Conference in Glasgow on 27 November. For details, see here.

Intensive Care Society State of the Art Meeting

Alex will be speaking on deprivation of liberty safeguarding at the Intensive Care Society's State of the Art Meeting on 10 December 2014. Details are available here.

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Victoria Butler-Cole
Neil Allen
Anna Bicarregui
Simon Edwards (P&A)

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Jill Stavert

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 Mind in return for postings for English and Welsh events. For Scottish events, we are inviting donations to Alzheimer Scotland Action on Dementia.

Chambers Details

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

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THE QUEEN'S AWARDS FOR ENTERPRISE INTERNATIONAL TRADE 2013

Contributors: England and Wales

Alex Ruck Keene
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Alex been recommended as a leading expert in the field of mental capacity law for several years, appearing in cases involving the MCA 2005 at all levels up to and including the Supreme Court. He also writes extensively about mental capacity law and policy, works to which he has contributed including 'The Court of Protection Handbook' (2014, LAG); 'The International Protection of Adults' (forthcoming, 2014, Oxford University Press), Jordan's 'Court of Protection Practice' and the third edition of 'Assessment of Mental Capacity' (Law Society/BMA 2009). He is an Honorary Research Lecturer at the University of Manchester, and the creator of the website www.mentalcapacitylawandpolicy.org.uk. To view full CV click here.

Victoria Butler-Cole
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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. She previously lectured in Medical Ethics at King's College London and was Assistant Director of the Nuffield Council on Bioethics. Together with Alex, she co-edits the Court of Protection Law Reports for Jordans. She is a contributing editor to Clayton and Tomlinson 'The Law of Human Rights', a contributor to 'Assessment of Mental Capacity' (Law Society/BMA 2009), and a contributor to Heywood and Massey Court of Protection Practice (Sweet and Maxwell). To view full CV click here.

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

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Anna regularly appears in the Court of Protection in cases concerning welfare issues and property and financial affairs. She acts on behalf of local authorities, family members and the Official Solicitor. Anna also provides training in COP related matters. Anna also practices in the fields of education and employment where she has particular expertise in discrimination/human rights issues. To view full CV click here.

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

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

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Dr Jill Stavert is Reader in Law within the School of Accounting, Financial Services and Law at Edinburgh Napier University and Director of its Centre for Mental Health and Incapacity Law Rights and Policy. Jill is also a member of the Law Society for Scotland's Mental Health and Disability Sub-Committee, Alzheimer Scotland's Human Rights and Public Policy Committee, the South East Scotland Research Ethics Committee 1, and the Scottish Human Rights Commission Research Advisory Group. She has undertaken work for the Mental Welfare Commission for Scotland (including its 2013 updated guidance on Deprivation of Liberty) and is a voluntary legal officer for the Scottish Association for Mental Health. To view full CV click here.