

Capacity outside the Court of Protection

Introduction

Welcome to the April 2015 Newsletters. Highlights this month include:

- (1) In the Health, Welfare and Deprivation of Liberty Newsletter: ‘baby Bournemouth?’, an update on the long-awaited Guidance on Deprivation of Liberty, deprivation of liberty at home, the 7th IMCA report and an important ECtHR ruling on the acid test;
- (2) In the Property and Affairs Newsletter: an important decision on the interaction between the CICA and the COP, anonymisation of judgments and changes to LPA forms;
- (3) In the Practice and Procedure Newsletter: details of the first stage of reform of the COP rules, the new Practice Direction on contempt of court, vulnerable witnesses, and funding questions;
- (4) In the Capacity outside the COP Newsletter: an editorial comment on the Care Act and capacity, the House of Lords debates the Select Committee report, recruitment for the chair of the National Mental Capacity Forum, an extremely important decision of the Supreme Court on informed consent, and the publication of the first work on the international protection of adults edited (inter alia) by Alex and Adrian;
- (5) In the Scotland Newsletter: a bumper selection of important material, including news of a new project to consider compatibility of both Scots and NI legislation with the CRPD, the potential for the introduction of designated specialist sheriffs for adult incapacity work, and commentary on recent case-law of relevance to practitioners in the area.

We are also delighted to announce that, as of this month, Beverley Taylor, until recently the Deputy Official Solicitor, will be providing regular guest contributions.

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The Care Act and capacity: Editorial

As our local authority readers will be all too aware, the majority of Part 1 of the Care Act 2014 came into effect on 1 April. The purpose of this Editorial note is identify a number of that our experiences training and advising upon the Act in the period leading up to its implementation have highlighted to us.

Capacity to participate in an individual's pathway through assessment and care planning has – rightly – been emphasised in the Act and, in particular, the Guidance. Further, the introduction of duties relating to the provision of advocacy to support the unbefriended individual in that process where they would have substantial difficulties is to be welcomed (although with the obvious caveat that it is far from clear where these advocates are to be found).

However, there remains a fundamental confusion amongst many between:

1. Public law decisions as to how assessed care needs are to be met, which are, ultimately 'capacity-blind'; and
2. Choices that have to be made between care options that are actually available where the individual in question is not able to make those choices, and a decision must be made on their behalf and in their best interests.

This confusion continues to bedevil too many decisions – an obvious example being planning at the point of discharge from hospital where we have (with respect) seen one too many 'best interests meetings' that are no such thing.

We very much hope that the decision of the Court of Appeal in the appeal against the judgment of Eleanor King J in [ACCG v MN](#) [2013] EWHC 3859 (COP) will provide an opportunity to set this abiding confusion to rest.

A further area where capacity and the Care Act do not necessarily co-exist in happy union is in relation to safeguarding and the duties imposed thereunder. We do not revisit here what Alex at least considers the deeply misguided failure of the Government to include a power of entry to accompany the s.42 duty (a power which is in place in Scotland and will be in place in Wales), but rather would want to emphasise the following points¹ that seem to us absolutely vital if local authorities are to avoid the 'car-crashes' of cases such as [Somerset v MK](#) [2014] EWCOP B25; [Milton Keynes Council v RR](#) [2014] EWCOP B19 and [2014] EWCOP 34 and [Essex CC v RF](#) [2015] EWCOP 1 where safeguarding concerns raised in relation to those who may lack capacity to take material decisions:

1. There will be some circumstances in which a local authority can only discharge its obligations to a person at risk of abuse or neglect in its area by way of an application to the Court of Protection for what will amount, in essence, to an "adult care order";
2. Where such an "adult care order" is required, the local authority must – save in the case of the utmost urgency – make sure that it comes to court armed with the evidence to allow the court to make any relevant findings of fact necessary to justify the substantial interferences with the rights of the individual

¹ Drawn in part from an article co-written by Alex and Kelly Stricklin-Coutinho that will be published in a future edition of the *Journal of Adult Protection*.

(and, in some cases, that of their family) under Articles 8 and – potentially – 5 ECHR that will almost inevitably arise in consequence;

3. Even if there is no equivalent to the s.31 Children Act 1989 threshold in the Court of Protection, it is (at a minimum) good practice for local authorities to proceed as if there were in the collation of their evidence and the preparation of their case. In other words, adopting the rigour that is (or should be) adopted in relation to cases involving children will go some substantial way to ensuring that adult protection cases are formulated and prepared in the correct fashion.

We note in this regard that, as of July and the coming into force of the new Rule 87A proceedings once issued can only be withdrawn with the permission of the Court. This Rule will serve, in part, to identify the clear division of responsibilities between the public authority applicant and the Court of Protection in cases where the public authority can only discharge its obligations to the individual in question with the assistance of the Court (see, by analogy, the discussion of the respective roles of the local authority and the Family Court in relation to proceedings in relation to children in *Re W (Care Proceedings: Function of Ct and LA)* [\[2013\] EWCA Civ 1227](#) [2014] 2 FLR 431.

The emphasis upon empowerment as the first principle of safeguarding in the Statutory Guidance may serve, we hope, further to embed the message of cases such as *Re M (Best Interests: Deprivation of Liberty)* [\[2013\] EWHC 3456 \(COP\)](#) that mere fact of incapacity should not automatically mean that safety becomes the dominant concern. That is fundamentally to subvert (or should that be pervert?) both the

MCA 2005 and the principles underpinning safeguarding. We hope that those on Safeguarding Adults Boards will be astute in their strategic oversight role to press home this message to their partners.

Chair for the National Mental Capacity Forum

A recruitment campaign is now underway to find a new Chair for the National Mental Capacity Forum (NMCF).

The Chair will provide leadership for the NMCF and represent the views of the varied Mental Capacity Act (MCA) stakeholders. He or she will provide direction so that members of the Forum work together to drive significant improvements in awareness among other key stakeholders and the general public. The successful candidate will be expected to commit up to 10 days each year to attend meetings which will be held in London and will be expected to read and consider papers outside meetings. More details can be found [here](#).

The deadline for applications is Tuesday 14 April 2015.

[Editorial Note: the creation of the forum is a response to the House of Lords Select Committee recommendation that a body be created to champion the MCA; as will be seen from the report of the debate in the House of Lords upon the Select Committee's report that follows immediately below, it is clear that Lord Hardie, the chair, does not regard it as an entirely satisfactory response].

The Select Committee report – one year on

Lord Hardie, the Chair of the (now dissolved) House of Lords Select Committee that [reported](#) on the MCA 2005 in March 2014, led a [debate](#) in the House of Lords on 10 March on the Report and its consequences. As with the debate on DOLS on 16 March (covered in our Health, Welfare and Deprivation of Liberty Newsletter), the contributions of the peers was of universally high quality (and not just because they name-checked 39 Essex Chambers!). We do not attempt to summarise the debate here, but would urge those who wish to understand why the MCA matters, and why implementation remains so difficult, to read it for themselves. We note, though, that Lord Hardie (rightly, in our view) emphasised that it was a “grave disappointment” that the Government did not accept the Committee’s key recommendation that responsibility for oversight of the MCA’s implementation be given to a single independent body. As Lord Hardie noted:

“The reasons for rejecting our recommendation seem to be related in part to the breadth of sectors covered by the Act and the associated difficulty of the task in designing a single body, coupled with a fear that such a body would result in people involved in the Act failing to accept personal responsibility for its implementation. I note that in their response the Government do not suggest that the task is impossible. Many tasks are difficult but well worth the effort if they achieve a successful outcome. In this case a successful outcome would be the restoration to many thousands of vulnerable people rights conferred on them 10 years ago, but denied to them because of failures of professionals in different sectors to implement this Act.”

Lord Hardie was underwhelmed by the creation of the Forum (as welcome as it was a first step) because *“it is not a solution to the widespread problems, across all sectors, of failure to implement the Act, and to give vulnerable people the voice and empowerment that Parliament conferred upon them in 2005. In short, it will not bring about the quiet revolution in public attitudes and practice promised 10 years ago. That will only be realised if the Select Committee’s recommendation is implemented in full.”*

We cover the position in relation to deprivation of liberty in the coverage of the DOLS debate.

The patient as agent: the Supreme Court and informed consent

Montgomery v Lanarkshire Health Board [\[2015\] UKSC 11](#) (Supreme Court (Lord Neuberger, President, Lady Hale, Deputy President, Lord Kerr, Lord Clarke, Lord Wilson, Lord Reed, Lord Hodge))

Other proceedings – civil – mental capacity – medical treatment

Summary

This Supreme Court judgment is required reading for all medical professionals, because the Supreme Court has made clear that the doctrine of informed consent is now part of English (and Scottish) law.

The issue arose in the context of whether a doctor was negligent in not informing a pregnant diabetic woman that there was a 9-10% risk of shoulder dystocia during vaginal delivery (the baby’s shoulders being too wide to pass through the mother’s pelvis). The doctor’s policy was not routinely to advise diabetic women about shoulder dystocia as, in her view, the risk of a

grave problem for the baby was very small, but if advised of the risks of shoulder dystocia women would opt for a caesarean section, which was not in the maternal interest.

In the Court of Session (this being a Scottish case), the woman's claim for damages on behalf of her son for the injuries he suffered as a result of shoulder dystocia during his birth was rejected, on the grounds that the doctor was not negligent, and on the basis that any negligence did not cause the injuries as the woman would have not elected to have a caesarean section even had she been told of the risks. In relation to the question of whether the doctor had been negligent, the Court of Session had applied the decision of the House of Lords in *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871, holding that whether a doctor's omission to warn a patient of risks of treatment was a breach of her duty of care was normally to be determined by the application of the "Bolam test" (*Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 i.e., whether the omission was accepted as proper by a responsible body of medical opinion, which could not be rejected as irrational. Expert evidence was before the Court of Session advanced on behalf of the Health Board was to the effect that the doctor's policy was proper.

The decision of the Court of Session was upheld by the Inner House. Mrs Montgomery appealed to the Supreme Court.

Lords Kerr and Reed gave the lead judgment (Lords Neuberger, Clarke, Wilson and Hodge agreeing with them), and undertook a comprehensive review of the jurisprudence both in England and elsewhere. Their conclusions were that *Sidaway* reflected a paradigm of the doctor-patient relationship that had ceased to

reflect the reality and complexity of the way in which healthcare services are provided, or the way in which the providers and recipients of such services view their relationship:

"75. [...] One development which is particularly significant in the present context is that patients are now widely regarded as persons holding rights, rather than as the passive recipients of the care of the medical profession. They are also widely treated as consumers exercising choices: a viewpoint which has underpinned some of the developments in the provision of healthcare services. In addition, a wider range of healthcare professionals now provide treatment and advice of one kind or another to members of the public, either as individuals, or as members of a team drawn from different professional backgrounds (with the consequence that, although this judgment is concerned particularly with doctors, it is also relevant, mutatis mutandis, to other healthcare providers). The treatment which they can offer is now understood to depend not only upon their clinical judgment, but upon bureaucratic decisions as to such matters as resource allocation, cost-containment and hospital administration: decisions which are taken by non-medical professionals. Such decisions are generally understood within a framework of institutional rather than personal responsibilities, and are in principle susceptible to challenge under public law rather than, or in addition to, the law of delict or tort.

76. Other changes in society, and in the provision of healthcare services, should also be borne in mind. One which is particularly relevant in the present context is that it has become far easier, and far more common, for members of the public to obtain information about symptoms, investigations, treatment options, risks and side-effects via such media as the internet (where, although the

information available is of variable quality, reliable sources of information can readily be found), patient support groups, and leaflets issued by healthcare institutions. The labelling of pharmaceutical products and the provision of information sheets is a further example, which is of particular significance because it is required by laws premised on the ability of the citizen to comprehend the information provided. It would therefore be a mistake to view patients as uninformed, incapable of understanding medical matters, or wholly dependent upon a flow of information from doctors. The idea that patients were medically uninformed and incapable of understanding medical matters was always a questionable generalisation, as Lord Diplock implicitly acknowledged by making an exception for highly educated men of experience. To make it the default assumption on which the law is to be based is now manifestly untenable.”

The judicial tour d’horizon continued with a review of the developments brought about under the stimulus of the HRA 1998 and the Oviedo Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine. As they noted:

“82. In the law of negligence, this approach entails a duty on the part of doctors to take reasonable care to ensure that a patient is aware of material risks of injury that are inherent in treatment. This can be understood, within the traditional framework of negligence, as a duty of care to avoid exposing a person to a risk of injury which she would otherwise have avoided, but it is also the counterpart of the patient’s entitlement to decide whether or not to incur that risk. The existence of that entitlement, and the fact that its exercise does not depend exclusively on medical considerations, are important. They

point to a fundamental distinction between, on the one hand, the doctor’s role when considering possible investigatory or treatment options and, on the other, her role in discussing with the patient any recommended treatment and possible alternatives, and the risks of injury which may be involved.

83. The former role is an exercise of professional skill and judgment: what risks of injury are involved in an operation, for example, is a matter falling within the expertise of members of the medical profession. But it is a non sequitur to conclude that the question whether a risk of injury, or the availability of an alternative form of treatment, ought to be discussed with the patient is also a matter of purely professional judgment. The doctor’s advisory role cannot be regarded as solely an exercise of medical skill without leaving out of account the patient’s entitlement to decide on the risks to her health which she is willing to run (a decision which may be influenced by non-medical considerations). Responsibility for determining the nature and extent of a person’s rights rests with the courts, not with the medical professions.

84. Furthermore, because the extent to which a doctor may be inclined to discuss risks with a patient is not determined by medical learning or experience, the application of the Bolam test to this question is liable to result in the sanctioning of differences in practice which are attributable not to divergent schools of thought in medical science, but merely to divergent attitudes among doctors as to the degree of respect owed to their patients.”

Lords Reed and Kerr therefore held that the decision in *Sidaway* was unsatisfactory (and acknowledged that the courts in England and Wales had in reality departed from it). They

held that the correct position in relation to the risks of injury involved in treatment is that:

“87. [...] An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient’s position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.

88. The doctor is however entitled to withhold from the patient information as to a risk if he reasonably considers that its disclosure would be seriously detrimental to the patient’s health. The doctor is also excused from conferring with the patient in circumstances of necessity, as for example where the patient requires treatment urgently but is unconscious or otherwise unable to make a decision. It is unnecessary for the purposes of this case to consider in detail the scope of those exceptions.”

At paragraphs 89-91, their Lordships noted that three further points arose in consequence:

1. The assessment of whether a risk is material cannot be reduced to percentages. The significance of a given risk is likely to reflect a variety of factors besides its magnitude: for example, the nature of the risk, the effect which its occurrence would have upon the life of the patient, the importance to the patient of the benefits sought to be achieved by the

treatment, the alternatives available, and the risks involved in those alternatives. The assessment is therefore fact-sensitive, and sensitive also to the characteristics of the patient.

2. The doctor’s advisory role involves dialogue, the aim of which is to ensure that the patient understands the seriousness of her condition, and the anticipated benefits and risks of the proposed treatment and any reasonable alternatives, so that she is then in a position to make an informed decision. This role will only be performed effectively if the information provided is comprehensible. The doctor’s duty is not therefore fulfilled by bombarding the patient with technical information which she cannot reasonably be expected to grasp, let alone by routinely demanding her signature on a consent form.
3. It is important that the therapeutic exception should not be abused. It is a limited exception to the general principle that the patient should make the decision whether to undergo a proposed course of treatment: it is not intended to subvert that principle by enabling the doctor to prevent the patient from making an informed choice where she is liable to make a choice which the doctor considers to be contrary to her best interests.

Lords Kerr and Reed noted that there would be arguments against the approach that they set out: (1) that some patients would rather trust their doctors than be informed of all the ways in which their treatment might go wrong; (2) that it is impossible to discuss the risks associated with a medical procedure within the time typically available for a healthcare consultation; (3) that the requirements imposed are liable to result in defensive practices and an increase in litigation;

and (4) that the outcome of such litigation may be less predictable. However, they rejected these arguments:

*“85. The first of these points has been addressed in para 85 above. In relation to the second, the guidance issued by the General Medical Council has long required a broadly similar approach. It is nevertheless necessary to impose legal obligations, so that even those doctors who have less skill or inclination for communication, or who are more hurried, are obliged to pause and engage in the discussion which the law requires. This may not be welcomed by some healthcare providers; but the reasoning of the House of Lords in *Donoghue v Stevenson* [1932] AC 562 was no doubt received in a similar way by the manufacturers of bottled drinks. The approach which we have described has long been operated in other jurisdictions, where healthcare practice presumably adjusted to its requirements. In relation to the third point, in so far as the law contributes to the incidence of litigation, an approach which results in patients being aware that the outcome of treatment is uncertain and potentially dangerous, and in their taking responsibility for the ultimate choice to undergo that treatment, may be less likely to encourage recriminations and litigation, in the event of an adverse outcome, than an approach which requires patients to rely on their doctors to determine whether a risk inherent in a particular form of treatment should be incurred. In relation to the fourth point, we would accept that a departure from the Bolam test will reduce the predictability of the outcome of litigation, given the difficulty of overcoming that test in contested proceedings. It appears to us however that a degree of unpredictability can be tolerated as the consequence of protecting patients from exposure to risks of injury which they would otherwise have chosen to avoid. The more fundamental response to such points,*

however, is that respect for the dignity of patients requires no less.”

Applying this approach, Lords Kerr and Reed held that Mrs Montgomery should have been told of the risks of shoulder dystocia, and, further, that had she been told that she would probably have elected to have had a caesarean section. Her appeal therefore succeeded.

Lady Hale, expressing her complete agreement with Lords Kerr and Reed, added what she described as a footnote in relation to the particular issue of pregnancy and childbirth. She noted that it appeared that the doctor’s approach to disclosure was based, at least in part, upon a value judgment as to whether a caesarean section is the maternal interest and that:

*“115. [...] once the argument departs from purely medical considerations and involves value judgments of this sort, it becomes clear, as Lord Kerr and Lord Reed conclude at para 85, that the Bolam test, of conduct supported by a responsible body of medical opinion, becomes quite inapposite. A patient is entitled to take into account her own values, her own assessment of the comparative merits of giving birth in the “natural” and traditional way and of giving birth by caesarean section, whatever medical opinion may say, alongside the medical evaluation of the risks to herself and her baby. She may place great value on giving birth in the natural way and be prepared to take the risks to herself and her baby which this entails. The medical profession must respect her choice, unless she lacks the legal capacity to decide (*St George’s Healthcare NHS Trust v S* [1999] Fam 26). There is no good reason why the same should not apply in reverse, if she is prepared to forgo the joys of natural childbirth in order to avoid some not insignificant risks to herself or her baby. She cannot force her doctor to offer treatment which he or she considers futile or*

inappropriate. But she is at least entitled to the information which will enable her to take a proper part in that decision.”

Comment

In some ways, this case does no more than recognise social and, indeed, professional realities and to remove what had become an increasingly obvious tension between those realities and the venerable decision in *Sidaway*. However, the ringing terms in which Lords Kerr and Reed identified the basis upon which doctors are required to engage with their patients (and the counter-arguments that they set down to the propositions that ‘doctor knows best’ as regards disclosure) make clear that we are indeed a world where both doctor and patient are active agents.

As regards the question of how clinicians are to engage in discussions with those of impaired capacity, we suggest that

1. What is required of the patient remains as set out clearly by Peter Jackson J in [Re JB](#) [2014] EWHC 342 (COP), namely that they should understand the nature, purpose and effects of the proposed treatment, the last of these entailing an understanding of the benefits and risks of deciding to have or not to have the proposed treatment, or of not making a decision. Further, and crucially, as Peter Jackson J made clear, what is required is a broad, general understanding of the kind that is expected from the population at large;
2. What is required of the doctor is as set out in *Montgomery*, with a particular emphasis upon the injunction of Lords Kerr and Reed in *Montgomery* against bombarding the patient with technical information which

she cannot reasonably be expected to understand. How the information is to be made comprehensible is self-evidently a task that must be calibrated to the patient in question. If not, the doctor will not be able to say that they have complied with the injunction in s.1(2) MCA 2005 to take all practicable steps to enable the person to take the decision.

Short Note: Capacity and Housing

R (MT) v Oxford City Council [2015] EWHC 795 (Admin) (as yet only available on Lawtel) concerned an incapacitated adult who had sought housing from his local council pursuant to its obligations under the Housing Act 1996, rather than under community care legislation. The adult lived with his father, who was his financial deputy and who provided care to him. His father, it was proposed, would continue to provide care for him if he lived in his own property. The Council refused his application to go on the general housing register on the basis that he lacked capacity to make the application or to take up any offer of housing that was made. The Council relied on the 22 year old case of *R v Oldham Metropolitan Borough Council ex parte Garlick* [1993] AC 509 in support of its position. Unsurprisingly, the claimant argued that things had moved on in respect of the treatment of mentally incapacitated adults, and that the Council’s approach offended against Article 14 ECHR.

The Claimant’s application for judicial review was dismissed, the court considering that it was bound by the decision in *Garlick*, and holding that there was no discrimination since the Claimant could have accommodation provided to him under s.21 NAA 1948 if he satisfied that statutory test.

Comment

This judgment is peculiar and unsatisfactory in a number of respects. First, it does not address the various ways in which accommodation and care (whether together or separately) might be provided to an incapacitated adult, but seems to proceed on the basis that s.21 NAA 1948 was the only relevant community care provision. It is not clear that the court has fully understood the relevant legislation and the obligations of the relevant statutory bodies towards the Claimant. Secondly, there is little analysis of the Claimant's submissions as to the effect of the MCA 2005 on the position, or the discrimination point. The editors understand that permission to appeal has been sought. This may raise further complexities, since by the time of any appeal, the new regime under the Care Act 2014 will be in force.

End of Life Care

The Health Select Committee has published its [report](#) looking at the state of end of life care following the Neuberger review of the Liverpool Care Pathway. Various of the Committee's recommendations relate directly to the MCA 2005, with a particular focus on advance care planning and advance decision-making.

The Committee found that "[t]oo often [...] staff feel that they lack the confidence, skills and training needed to raise end of life issues with patients, let alone understand the mechanisms available to patients and carers under the Mental Capacity Act 2005 which allow people to make their wishes clear."

Specific recommendations include:

- Further consideration by the Government about raising awareness of mechanisms available under the MCA 2005 to make ones wishes about end of life care clear, including ADRTs.
- Training for all staff who provide palliative and end of life care to people with life-limiting conditions about advance care planning.
- A review of the cost of making an LPA, and the simplification of the LPA process.

No Right Ignored Consultation

The Department of Health has issued a [consultation paper](#) this month entitled "*No voice unheard, no right ignored - a consultation for people with learning disabilities, autism and mental health conditions.*" The consultation runs until 29 May 2015. A summary of the responses to the consultation will be made available and placed on the consultations website at www.gov.uk after the responses have been considered.

The scope of the consultation primarily focuses on:

- The assessment and treatment in mental health hospitals for people of all ages with learning disability or autism;
- Adult care and support, primarily for those with learning disability but also for adults with autism;
- All those to whom the Mental Health Act currently applies (including children and young people).

The paper does not cover further proposals for children and young people to prepare for adulthood because DH considers the legal framework in part three of the Children and Families Act 2014 combined with the Care Act 2014 already exists to support successful transition to adult services. Nor does it seek to make any proposals for further changes to the Mental Capacity Act 2005.

The consultation is termed an 'exploratory consultation'. It sets out the case for change and seeks views on which of the proposed ideas and measures contained in the consultation document would be likely to have most impact. The next Government will determine in the context of a spending review what happens as a result of the consultation.

DH believes that all people should have the right to the same life chances, to make choices and be in control of their own life as far as possible. However evidence and data collected by DH show that it is proving hard to make this happen for everyone:

"We know that some people still have concerns about how much people are listened to, People have told us that the default is set the wrong way round. Statutory agencies and professional should have to justify why, against the wishes of individuals or families, they are doing things like sending people away or keeping them away from their communities, home, families or friends, whether to an inpatient or residential care setting." (2.6)

The consultation sets out a series of measure that could both strengthen the rights of people to live independently and to be included in their community and make choices about their own lives.

Many of the suggestions and measures are designed to help people exercise their rights and choices. For example, by providing individuals and their family/carer or nominated advocate with clear, easy read or accessible information by a named professional setting out a personalised summary of their rights; by simplifying the Mental Health Act (MHA) criteria for detention so that there is one set of criteria for detention for both assessment and treatment under the MHA.

Other measures are aimed at enabling people to make decisions for themselves (where they have capacity to do so) and to challenge others. A welcome example of this is the proposal that Local Authorities and NHS bodies have to seek explicit and documented approval or consent from a person to admit them to an inpatient or residential care settings, and giving individuals, or their families or advocates the right to subsequently change their mind and to request a move, transfer or discharge.

A more controversial proposal is that restricted patients be discharged from hospital onto a new type of order which could contain conditions imposed by the Secretary of State for Justice or a Tribunal and which would authorise deprivation of liberty in the community.

The paper also includes proposals to give individuals with learning disability and/or autism in certain circumstances the right to have a personal health budget.

The paper contains an interesting proposal to change the definition of 'mental disorder' contained in the MHA. The paper proposes three possible options (paragraphs 3.8) for change designed to ensure that the MHA is applied to people with learning disability and/ or autism

appropriately and asks consultees to select which one of the options they prefer.

This is a wide-ranging paper with laudable aims. DH seeks responses from individuals, health and social care bodies, organisations, charities, professional bodies, the police and emergency services and any other party with an interest in improving the rights, health and wellbeing of people of all ages with disability. The consultation will only be useful and effective if people read and respond to it.

Beverley Taylor

Indirect payments and mental capacity

Following a [research project](#) into how 'indirect payments' for those lacking the relevant mental capacity are working in practice, a new web guide to such payments has been developed and is available [here](#).

Mental Health Act 1983 reference guide

The new reference guide to accompany the Mental Health Act 1983 is now available [here](#). It has very much less detail about (in particular) Schedule 1A to the MCA than does the new [Code of Practice](#).

New neglect/ill-treatment offences

The provisions of the Courts and Criminal Justice Act 2015 providing for care worker/care provider offences of ill-treatment or willful neglect (covered [here](#)) will come into effect to cover offences committed on or after 13 April 2015.

Dementia challenge website

DH has launched a beta version of its [Dementia Challenge](#) website which, as yet, is distinctly underpopulated, but may in time provide a useful gateway into resources to assist in the still woefully inadequate understanding of dementia and its challenges for the delivery of dignified care and treatment.

Guardians for missing persons

Although not, strictly, a matter relating to capacity, we note that it is overwhelmingly likely that the next government will introduce a new legal role and status of guardian of the property and affairs of a missing person.

As outlined in the consultation response [here](#), the key features of the proposed scheme will be:

- a guardian will be required to act in the best interests of the missing person and in this respect will be subject to duties similar to those of a trustee;
- the guardian will be supervised by the Office of the Public Guardian and will be required to file accounts in much the same way as a Deputy appointed under the Mental Capacity Act 2005;
- a guardian will be appointed by a court on application by a person with a sufficient interest in the property and affairs of the missing person;
- the appointment will be for a period of up to 4 years with the possibility of applying for an extension for up to another 4 years.

Which court will have the responsibility for appointing and scrutinising such guardians has yet to be determined (and we do not understand that it will necessarily be the Court of Protection, as suggested in some coverage of this).

Book Review: *Judicial Review: Law and Practice* (2nd edition)

Judicial Review: Law and Practice (2nd Edition):
General Editors: The Hon Mrs Justice Patterson DBE and Sam Karim (Jordans, 2015, £89).²

We make short note of the second edition of this book because of the very useful chapter (written by Simon Burrows) that it includes on judicial review and mental health, which also includes coverage of the issues that arise in relation to judicial review and the MCA 2005.

The book is the second edition of a practitioners guide to judicial review. It covers, in the first half, the principles and procedures relating to judicial review applications before in the second half turning to the questions that arise in specific contexts.

It is a very comprehensive work, but I am duty bound to say that it is let down by the fact that there appears to have been something of a delay between the submission of the text and publication because there is – for instance – no reference in the chapter on community care to the Care Act (which was passed into law in May 2014), and there are, in general, very few references to cases decided after the early part of 2014. In such fast-moving areas of the law, it is

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!

inevitable that there will always be points in which matters move on between writing and publication, but the gap here is particularly unfortunate.

That having been said, however, the chapter on mental health and mental capacity is less affected than others (and the decision in *ACCG v MN*, outlining the division between the COP and Admin Court will hopefully be out by the time of the third edition!), and the book in general, clear, straightforward and helpful. It would make a useful reference work for those who do not necessarily have to engage with the Administrative Court on a day to day basis but need to have an understanding of the approach that will be taken.

Alex Ruck Keene

The International Protection of Adults

Alex hopes that readers will forgive the shameless plug for the book that he has written, together with Adrian, Richard Frimston and Claire van Overdijk, on the International Protection of Adults. Available [now](#) from Oxford University Press, the book represents the first comprehensive attempt to address questions of capacity across borders.

As OUP note, increasing numbers of people have connections with one country, but live and work in another, frequently owning property or investments in several countries. People with lifelong or subsequently developed impairments of capacity move cross-border or have property or family interests or connections spread across different jurisdictions. This new work fills a gap in a specialist market for a detailed work advising lawyers on all the considerations in these situations.

The book provides a clear, comprehensive, and unique overview of all relevant capacity and private international law issues, and the existing solutions in common law and civil law jurisdictions and under Hague Convention XXXV (or, as practitioners before the COP know it better, the 2000 Convention). It sets out the existing law of various important jurisdictions, including detailed chapters on the constituent parts of the UK, Ireland, Jersey, the Isle of Man and the states parties to the Convention; and shorter chapters on 26 Non-Hague states and those within federal states, including coverage of the United States, several Australian and Canadian states, and a number of other Commonwealth jurisdictions. Containing a number of helpful case studies and flowcharts, the book draws upon the expertise of the editors in their respective fields, together with detailed contributions from expert practitioners and academics from each relevant jurisdiction.

Conferences at which editors/contributors are speaking

Socio-Legal Studies Association

Alex is presenting a paper on “(Re)presenting P before the Court of Protection” and Jill a paper on “Addressing the *Bournewood* gap in Scotland” at the SLSA 2015 Annual Conference at the University of Warwick 1-2 April.

Commonwealth Legal Education Association

Jill will be presenting (with Rebecca McGregor) a paper on “Access to equal recognition before the law for persons with mental disabilities through supported decision making in Scotland” at the Commonwealth Legal Education Association 2015 conference in Glasgow 9-10 April.

Elderly Care Conference 2015

Alex will be speaking at Browne Jacobson’s Annual Elderly Care Conference in Manchester on 20 April. For full details, see [here](#).

Medical Issues and the Mental Capacity Act 2005

Tor will be speaking at a conference arranged by Clarke Willmott on 24 April, her topic being “The Court of Protection and medical treatment disputes: avoiding court and what happens if you can't.” Full details of the conference are available [here](#).

‘In Whose Best Interests?’ Determining best interests in health and social care

Alex will be giving the keynote speech at this inaugural conference on 2 July, arranged by the University of Worcester in association with the Worcester Medico-Legal Society. For full details, including as to how to submit papers, see [here](#).

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Alex Ruck Keene
Victoria Butler-Cole
Neil Allen
Annabel Lee
Simon Edwards (P&A)

Guest contributor

Beverley Taylor

Scottish contributors

Adrian Ward
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.

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

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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, 2015, 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.**



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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.**



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



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.**



Adrian Ward
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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.**