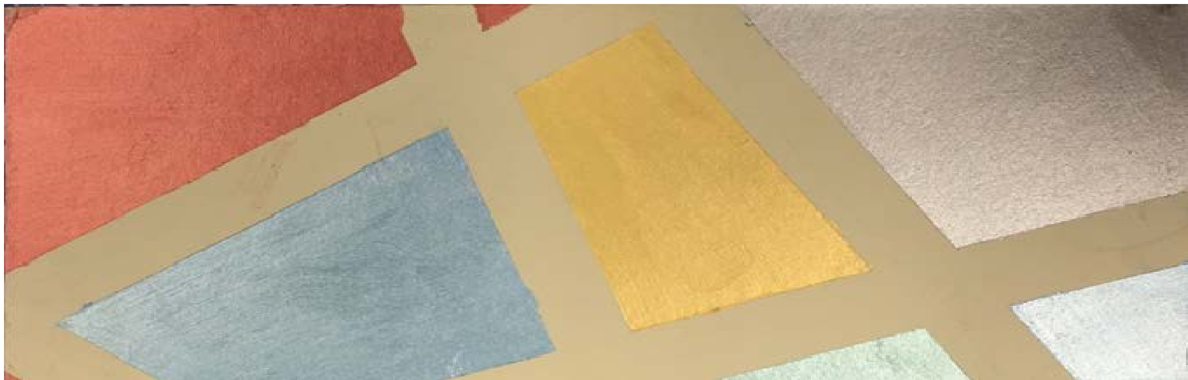

Welcome to the September 2023 Mental Capacity Report, which we think is our largest ever, thanks to judicial hyperactivity over what is usually the (relatively) quiet summer period. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: the MHA/MCA interface revisited; belief, diagnosis and capacity, and questioning an independent spirit;

(2) In the Property and Affairs Report: the SRA looks at law firms providing LPA / deputyship services, OPG guidance on completing LPA forms and a shedinar on the MCA and money;

(3) In the Practice and Procedure Report: transparency in committal hearings and on death, and why belief is not the same as proof when it comes to capacity;

(4) In the Wider Context Report: the wider MHA context within which many MCA matters arise, the limits of autonomy in medical settings; litigation capacity under the spotlight in both civil and family courts; and the second of our reports from Ireland as the new Act beds in;

(5) In the Scotland Report: Articles 3 and 2 ECHR in play in the capacity context

You can find our past issues, our case summaries, and more on our dedicated sub-site here, where you can also sign up to the Mental Capacity Report.

We also take this opportunity to bid farewell and thank you to Stephanie David, whose commitments mean that she has to take a step back from the editorial team.

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

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# HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

## The MHA/MCA interface revisited – Theis J rolls up her sleeves

*Manchester University Hospital NHS Foundation Trust v JS & Others (Schedule 1A Mental Capacity Act 2005)* [2023] EWCOP 33 (Theis J)

*Mental Health Act 1983 – interface with the MCA*

### Summary

Theis J has rolled up her sleeves and waded into the thickets of Schedule 1A, hearing the appeal against the decision of HHJ Burrows in *Manchester University Hospitals NHS Foundation Trust v JS & Anor* [2023] EWCOP 12. In brief terms, she has upheld both the first instance judgment and the test set by Charles J in *GJ v The Foundation Trust & Anor* [2009] EWHC 2972 (Fam) to be applied by decision-makers to determine whether a person could be detained under the MHA 1983. Whilst much of the judgment turned on an analysis of whether HHJ Burrows had applied the test correctly to the facts of JS's case, of wider relevance are the following parts of her judgment.

Theis J agreed (at paragraph 48) that a useful structure for practitioners and judges was to answer – in this order – the 'key questions' of:

(1) Is the person a 'mental health patient'?

(2) Is the person an 'objecting' mental health patient'?

(3) Could the person be detained under section 3 MHA 1983? [or I would add, where relevant, s.2]

Theis J was clear that Charles J's analysis of the meaning of 'could' was correct, namely that the decision-maker should ask themselves whether, in their view, the criteria set by, or the grounds in, s. 2 or s.3 MHA 1983 are met (and if an application was made under them a hospital would detain P). The alternative advanced by the Trust of requiring the MCA 2005 decision-maker to defer to the MHA 1983 decision-maker unless their decision is not logical or rational "*would probably lead to more uncertainty and risk undermining the purpose of the legislation. Such a development would not be welcome in this area, where the legal landscape needs stability rather than further uncertainty*" (paragraph 99)

Theis J identified that a practical step that could be taken in cases where Schedule 1A Case E issues are likely to arise "*is for evidence to be provided to address that issue, utilising the GJ framework. That would not only assist the court and the parties, but also focus the minds on what needs to be addressed both in terms of any decisions to date under the MHA 1983, the basis of the application in the Court of Protection and addressing the key questions outlined above*" (paragraph 116).

Theis J also endorsed 'practical suggestions' put forward by the Secretary of State for Health and Social Care to address 'stalemate' situations, as

follows:

> (1) *The MHA and MCA decision-makers should arrange for discussions between the relevant professionals. They should be undertaken in what Ms Kelly describes as 'the spirit of cooperation and appropriate urgency'. This will ensure the relevant professionals have reviewed and considered relevant evidence and if required further inquiries can be made.*
>
> (2) *If these discussions do not result in a detention being authorised under the MCA the hospital has a number of choices:*
>
> > (i) *It can seek the person's admission under the MHA 1983 to authorise the deprivation of liberty, including on a short term basis while it seeks to advance the person's discharge;*
> >
> > (ii) *It can seek the person to be detained in an alternative setting, such as a care home, in which Case E has no application with consideration being given to what can be put in place to support the person in the community under s 117 MHA 1983 and/or Care Act 2014 duties.*
> >
> > (iii) *It can stop depriving the person of their liberty if it considers the person should not be detained under MHA 1983, even with the knowledge that the person will not be detained under the MCA 2005.*
>
> (3) *If the hospital does not consider that an application for assessment or treatment under MHA 1983 is warranted but does consider it is in the person's best interests to be detained in hospital for treatment of a mental disorder, it should consider carefully its reasons for drawing this distinction. The hospital could apply to the Court of Protection for a determination of whether the person is eligible for detention under the MCA 2005.*

At paragraph 119, Theis J noted in relation to the last point that she could:

> *see the sense in the suggestion of an application to the Court of Protection for a determination being a possible route to resolve these issues, but that is not said with any encouragement for such applications to be made unless it is necessary, and only after all other options have been explored. It will be a matter for each individual judge whether such an application is accepted, depending on the particular circumstances of the case.*

Specifically in relation to those aged 16 or 17, to whom Schedule A1 does not apply (but to whom Schedule 1A does apply in determining whether or not the Court of Protection can make an order depriving them of their liberty), Theis J identified (at paragraph 123) that the following may provide a guide:

> (1) *In any application seeking authorisation to deprive the liberty of a 16 or 17 year old the applicant should carefully consider whether the application should be made in the Court of Protection and, if not, why not.*
>
> (2) *If a Schedule 1A Case E issue is likely to arise any evidence filed in support of an application should address that issue, so the relevant evidence is available for the court, thereby reducing any delay.*
>
> (3) *In the event that the Court of*

> *Protection determines that P is ineligible the professionals should urgently liaise in the way outlined above.*

### Comment

The interface between the MCA and the MHA is a notoriously awful area. Some may find it useful to watch this shedinar where Alex tries to give a way through.

## Best interests, life-sustaining treatment and pain

*Kings College Hospital NHS Foundation Trust v X and Y* [2023] EWCOP 34 (Theis J)

*Best interests – medical treatment*

### Summary

This case concerned an application by Kings College Hospital for permission to withdraw life sustaining treatment from a young man, X, who was 27 years old. The application was opposed by members of his family, with X's father, Y, acting as a family spokesman.

X had been involved in a car accident in January 2023 which had left him with catastrophic brain injuries following a prolonged period of hypoxia. He also sustained damage to his cervical spine and spinal cord. He was resuscitated by paramedics at the scene of the accident, and admitted to ICU. His treating clinicians, and those from whom they had sought second opinions, considered that he was in a persistent vegetative state (PVS). The Trust considered it was not in his best interests to continue to receive treatment, as they did not consider that there was any prospect of his recovery. The judgment summarises that "[h]*e is kept alive by mechanical ventilation, artificial nutrition and hydration and supportive round the clock nursing care involving washing, turning and suctioning of tracheal secretions*" (paragraph 2). The Official Solicitor considered that this was a finely balanced case, but ultimately supported the Trust's application.

Y and other family members wanted X to have more time, and felt that X was responding to stimuli, including opening his eyes and moving his head in response to requests. They felt that X would have wished to continue to have life-sustaining treatment, and would wish to "continue to fight to remain with his family" (paragraph 3). The judgment notes the love of X's family, and their mutual devotion to each other. Family members had been granted leave to seek expert evidence, but had ultimately not been able to obtain it, and did not apply to adjourn the hearing to make further attempts to do so.

The medical evidence was effectively unrebutted, and concluded that X had no function above or below his brainstem. The judgment noted that "there is a limited amount of function which controls his blood pressure and heartrate, but there is no ability for him to regain consciousness, or to move again" (paragraph 14). X had been unconscious throughout his time in ICU, and completely dependent on a ventilator to breathe. He had no response on an EEG to painful stimuli, over a six-week period. His pupils had stopped reacting to light and had become fixed and dilated. His physical state appears to have also been negatively impacted, with medical evidence that "[h]*e is colonized with resistant bacteria. His arms and legs are in contractures. He has lost a lot of muscle mass and is not able to move. His skin is fragile and he has developed skin ulcers which are difficult to heal*" (paragraph 18). He was considered to have a short life expectancy, and be at risk of infection due to ongoing mechanical ventilation. Second opinion evidence from several specialists (including those who had had sight of videos taken by X's family) confirmed the views of the treating team.

X's family felt strongly that X "*would not want to give up on life. He is not the sort of person to let go. Why I say that is because he would say he wants to live for his family, and especially for his children*" (paragraph 31). Y produced four videos taken while X was in ICU in which Y felt demonstrated that "*X moves his head, following requests to do so from his father, and is able to open his eyes. These videos were taken between the end of May to end of June. He confirms that although X was not a practising Christian he was brought up in the Christian faith, which is important to his wider family and that faith does not support the Trust's application as they believe people should go naturally*" (paragraph 32). X's family also felt that he had opened his eyes in response to hearing his grandmother's voice. Y felt that X "*has some level of consciousness and disagrees with the assessment that X's pupils are fixed and dilated, he has observed X look at him*" (paragraph 34). Y's request was that X "*be given more time*" (paragraph 35). The evidence of the medical staff was that what his family had seen was "*reflexive, and consistent with X being in a vegetative state. The movements are not purposeful or discriminating behaviour*" (paragraph 39).

Theis J granted the Trust's application. She accepted the medical evidence that X was in a Persistent Vegetative State, and further accepted the medical evidence that the evidence relied on by X's family were "*spontaneous and reflexive movement which is compatible with a vegetative state, rather than any level of consciousness by X*" (paragraph 48). Theis J accepted the strong presumption of sustaining life, and acknowledged that X would likely have wished to be with his family, and that sustaining life would be in keeping with his Christian religious beliefs. Theis J noted that there was no direct evidence that X was in pain, but considered that

> *51…By definition there are intrinsic burdens to being cared for on ICU and the interventions that are necessary in such care. In this case there is evidence of relative stability in one sense due to the interventions, but there is equally evidence of considerable instability regarding X's condition as part of his care, such as the frequent drops in heart rate.*
>
> *52. I agree with the final analysis of the Official Solicitor that in the light of the evidence regarding the X's medical condition, his lack of awareness and factoring in the likely wishes he would have to be with his family, the strong presumption of sustaining life and the limited evidence of pain, there is, in my judgment, overall no benefit to X in continuing the treatment, due to his lack of awareness and the bleak medical prognosis. In those circumstances, his best interests are met by the withdrawal of treatment.*

### Comment

This tragic case includes a helpful discussion of (1) the perceptions of family members that a person is reacting, and the medical evidence as to why this might be occurring; and (2) where a person's best interests may lie where there is no evidence that a person is in pain (an issue covered in some depth in *Guy's And St Thomas' NHS Foundation Trust v A & Ors* [2022] EWHC 2422 (Fam)). X's family perceived various movements as being reactive to their presence; these were reviewed by a number of specialists, who were consistent in their views that these were spontaneous. The family's evidence (including video evidence) was put before the court, but ultimately (and with the assistance of medical evidence on point) did not persuade Theis J that X was able to react to this surroundings.

## What place diagnosis? Learning Disability, deafness and the Court of Protection

*TW v Middlesbrough Council* [2023] EWCOP 30 (Katie Gollop KC)

*Mental capacity – assessing capacity*

This case raises an important issue about diagnosis in the context of Learning Disability (the term being capitalised for reasons which will become clear) especially in the presence of profound deafness.

For many years, professionals concerned with a man Katie Gollop KC called 'Tony' had supported him on the basis that he had a mild learning disability. However, in the context of an application determining questions of residence, internet and social media,[1] that diagnosis was called into question by expert evidence provided by Dr O'Rourke, a consultant clinical psychologist, in May 2022 after she undertook psychometric testing and identified that Tony's IQ was in the low average range, meaning that he did not meet one of the three mandatory diagnostic criteria. Conversely, she was equally clear that Tony's ability to understand information relevant to the matters in issue, and to comprehend the consequences of his decisions, meant that in relation to the relevant matters, he functioned as if he has a Learning Disability.

As Katie Gollop KC identified at paragraph 3, by the time that the application came before the court in June 2023, the parties had had the benefit of MacDonald J's decision in *North Bristol NHS Trust v R* [2023] EWCOP 5 for some months, explaining why a formal diagnosis of a mental health condition or brain injury is not a necessary prerequisite to a finding that a person lacks capacity to make a decision about a matter for purposes of the MCA 2005. However, at paragraph 4, Katie Gollop KC explained that:

> *that the lack of a formal diagnosis of Learning Disability was actively causing Tony problems in his everyday life. Tony has a long history of using the internet to access images of child sexual abuse. (I am grateful to the Official Solicitor for alerting me to the fact that it is not appropriate to refer to "child pornography", and that this is the preferred and appropriate term.) The latest discovery of such behaviour was in November 2019 when police were involved and removed three internet enabled devices. Tony's care was transferred to the Council's Forensic Disability Service and its Forensic Social Care Team in around February 2021.*

It had been intended that Tony move to 'Placement 2,' a five bedded residential care home exclusively for male adults at risk of coming into contact with the criminal justice system as a result of their offending behaviour. Tony had visited Placement 2 on a number of occasions and expressed a desire to move there. However, Placement 2's registration with the Care Quality Commission required that its service was accessible only by male residents with Learning Disability. In light of Dr O'Rourke's conclusion, Placement 2's position was that it would not accept Tony unless he had a formal diagnosis. Further, Tony's continued access to the Forensic Disability Service was in jeopardy because there was doubt about whether it could properly be said that he has a mental health disability at all.

At the end of the hearing, Dr O'Rourke was asked whether she would endorse a formulation that in the context of having an IQ on the fourteenth

[1] The proceedings initially started as a s.21A challenge by Tony to the restrictions in place upon him at his current placement, but were clearly then reconstituted more broadly.

centile, Tony has a longstanding impairment of the mind or brain, acquired before his eighteenth birthday as a result of prolonged deprivation of communication, education and life experience, which was best termed "a functional learning disability" (it is not entirely clear whether it was one of the parties, the judge or Dr O'Rourke who came up with this term). She said that she would. This, on its face, appeared to satisfy Placement 2, although it is not entirely clear whether it would also satisfy the Forensic Disability Service. The parties all therefore agreed that Tony lacked capacity in the relevant domains, but Katie Gollop KC agreed to give a written judgment because the evidence revealed "some unhelpful differences of approach to the diagnosis of Learning Disability amongst healthcare professionals, and the case concerns the effect of deprivation on mental development in the context of profound deafness."

This meant giving a pen picture of Tony. He was born with cerebral palsy which affected the movements of his head, trunk and hands in particular. He was also born profoundly deaf. In 2017 he fractured his spine and he had been a wheelchair user since then. He deployed a variety of methods of communication including British Sign Language, some Makaton, and other signs of his own devising which he supplemented with occasional written notes. He had some useful speech sounds and lip patterns. He therefore had some communication with hearing people generally, but opportunities for exchange of information and development of understanding were better with someone who had some BSL qualifications, and optimal with a person who was BSL fluent. He had been placed into care of the local authority by his parents when a small baby; and between birth and the age of 20, went to nurseries and schools as far apart as Leeds, Sussex, Kent and Clwyd, Wales. Though he was taught a form of signing, all of these establishments were for hearing children because priority was given to meeting his physical rather than his communication needs. Tony therefore grew up with no exposure at all to his deaf peers. When he went aged 20 to live in a facility for deaf people, he was described as lacking an identity.

Issues around Tony accessing images of child sex abuse started in 2014, and included, in 2021, assessing by a group of professionals from the Adult Learning Disability team, including an interpreter and a social worker who knew him well and who was able to sign, completed an assessment of his capacity to use the internet. The group agreed that he was unable to understand and weigh up the consequences of looking at such images and took the view that functionally he had a learning disability. The police were involved and a COP9 application form recorded in the judgment stated that Tony was served with a Sexual Risks Order[2] and that there were court hearings.

Dr O'Rourke, an expert in the field of mental health and deafness, assessed Tony's capacity in accordance with the 2015 Guidance on the Assessment and Diagnosis of Intellectual Disabilities in Adulthood published by the British Psychological Society ("the BPS Guidance"). As Katie Gollop KC identified at paragraph 17.

> *Of note is the fact that the BPS Guidance deprecates the use of screening tools, and reliance on just one part of the assessment process. Further, it recommends that "a judgement as to whether or not an individual has an intellectual disability should only be*

[2] Parenthetically, it would have been interesting to understand whether there had been consideration of whether Tony could understand the conditions placed on him by the Sexual Risk Order, because they should only be granted where this is the case.

> *made when all three components of the assessment are carried out by an appropriately qualified professional, who is able to justify their opinion in accordance with this guidance. This would reduce confusion for individuals, families and services." The appropriately qualified professional will be a psychologist.*
>
> *The three criteria necessary to an assessment of learning disability are:*
>
> *a) a significant impairment of intellectual functioning; and*
> *b) a significant impairment of adaptive behaviour (social functioning); with*
> *c) both impairments arising before adulthood.*

Dr O'Rourke's conclusions on capacity in her initial report were that:

> *a) Tony's nonverbal skills were within the normal range;*
> *b) however his acquisition of knowledge and skills was poor as a result of deafness leading to lack of access to information and learning;*
> *c) that lack of access is not unusual among deaf people but it had been exacerbated in Tony's case as a result of him being in schools for hearing children in his formative years and thus without access to effective communication with his peers;*
> *d) consequently, he had poor understanding of matters that would be understood by most individuals with his nonverbal skills*
> *e) that inconsistency was explained by educational and experiential deprivation, not organic impairment;*
> *f) the fact that his intellectual potential was within the normal range raised the question of whether the diagnostic test of the MCA was met.*

In July 2022, Dr O'Rourke provided answers to questions put by the parties. By this time, she had had access to additional records and the 2014 WAIS scores. She explained that on proper analysis of the 2014 test results, and when she administered the updated tests in 2022, he scored in the low average range for IQ, on the fourteenth centile, and therefore did not meet the criteria in the BPS Guidance for a diagnosis of Learning Disability. She elaborated on this: "*The fact that he can learn computer skills, adapt his signing to meet my needs, understand humour and answer questions involving 'why?', all support the notion that he does not have a learning disability. However, there are clear deficits in understanding of more abstract and complex matters and impairments in adaptive functioning, most notably a lack of insight into his own needs and matters concerning risk.*" She went on to say that "*this discrepancy and his very obvious difficulties in adaptive functioning are a result of lack of access to formal and incidental learning, lack of opportunity and impoverished linguistic environments which did not afford him the opportunity to develop.*"

As Katie Gollop KC noted, two other clinicians considered that Tony could be diagnosed with a Learning Disability, the first being a GP assessing him as part of the DOLS process (but who then backed down advising that it was not within her expertise to make a diagnosis of Learning Disability), and the second being a psychiatrist, who diagnosed a mild Learning Disability, although with an explanation of how he reached that conclusion. This led Katie Gollop KC to comment that:

> *26. The reported diagnoses of the GP and psychiatrist, in the face of Dr O'Rourke's assessment of IQ, are important because they illustrate the confusion identified by the BPS*

*Guidance, and the pertinence of the recommendations it makes with regard to the need for assessment of Learning Disability to be made by a trained psychologist in accordance with the Guidance. When Dr O' Rourke was asked how she thought it was that a GP and a psychiatrist disagreed with her expert opinion, she said that in her experience most (though not all) psychiatrists are not trained to administer the WAIS tests, and may not be fully cognisant with them or fully appreciate their significance.*

*27. It may be that some healthcare professionals assume an IQ below 70 where the adaptive behaviour criterion is clearly met. Alternatively, there may be a linguistic issue. The term "learning disability" may be being used as a descriptor of functional incapacitous decision making, without an intention to connote a formal diagnosis. Whatever the explanation, the present case demonstrates there will be occasions when P's welfare is compromised if there is confusion about whether all three criteria are met, and a lack of robust evidence supporting any diagnosis. Further, if the practice of referring to a person provided with adult social care as having "mild learning disability" where that person's IQ is properly assessed as being over 70 is widespread, that practice may undermine the validity of the diagnosis. It may mean that the potential of people who have the capability to gain capacity is not being maximised, or that their strengths and weaknesses are not being analysed in the way envisaged by the BPS Guidance (see paragraph 5.7) with deleterious effect. It may perhaps be helpful if healthcare professionals recording that a person has a learning disability (with or without capital letters) go on to state whether that assessment is "within BPS Guidance" or "outside BPS Guidance".*

On the basis of the evidence before her, Katie Gollop KC expressed herself satisfied that Tony lacked capacity in the relevant domains, and in relation to each decision:

> *30.* [...] *the inability exists by reason of an impairment in the functioning of his mind or brain. The impairment, which operates as a functional learning disability, is the result of stunted mental development, occurring before the age of 18 years, as a result of prolonged deprivation of communication, education, social learning and life experience, in combination with institutionalisation. That impairment renders Tony unable to understand why accessing images of child sexual abuse is wrong, the potential consequences for him if the police are involved, and the harm caused to children directly and to wider society indirectly by his actions when he is allowed unrestricted, unsupervised internet access.*

Amongst the orders that Katie Gollop KC made in consequence were:

> *33. [...] interim orders which permit support workers to supervise Tony's access to the internet and social media, and prevent him from accessing images of child sexual abuse, or any other material they consider may be illegal or which may make those viewing or possessing the images liable to criminal prosecution. I declined to accede to the Official Solicitor's application to bring what were described as "crime adjacent" images of children within the ambit of that interim order. I was told that in the past, when Tony has access to a device with software that prevents him from accessing images of child sexual abuse, he may seek out pictures or video of, for example, children in swimming costumes in a paddling pool. It appeared to me that viewing or possession of such images may not be unlawful, that*

> *such a measure could be unduly restrictive, and in any event may be difficult to justify in circumstances where Tony is currently choosing not to use a screen at all whilst supervised. This is a matter that is properly ventilated and determined at the final best interests hearing, where a proposed Care Plan is likely to be available.*

### Comment

Amongst the many troubling issues that the case shines a light on is the 'gatekeeping' function of diagnosis as access to services. Debates about whether or not diagnoses are 'valid' or 'stigmatic' are vigorous and very heated. But for so long as services are diagnosis-based, as this case illustrates, not having a formal diagnosis can be as problematic as having one. And, indeed, it is not entirely clear whether such matters as access to the Forensic Disability Service were going to be solved in Tony's case by the judge's ingenious creation (or endorsement) of a concept of 'functional learning disability.'

The case also highlights the vital, and potentially disabling, role of environment. Had Tony been brought up in an environment which responded to his communication needs, it is likely that the picture before the court regarding his capacity would have been very different – indeed, it may well have been the case that his circumstances would have been sufficiently different that court involvement simply would not have been needed.

## When does disbelieving your doctor shade into incapacity? And what place diagnosis in the MCA test?

*An NHS Trust v ST & Anor* [2023] EWCOP 40 (Roberts J)

*Mental capacity – assessing capacity – medical treatment*

This desperately sad provides an example of how far the courts have come in terms of thinking about capacity since the early days of the MCA 2005, and poses some perhaps challenging questions about its future. ST was 19, and had spent the past year as a patient in an intensive care unit. She had a rare mitochondrial disorder which is a progressively degenerative disease. According to the clinical evidence before the court, there was no cure which might have enabled ST to resume her life outside the clinical setting of the intensive care unit. She was mechanically ventilated through a tracheostomy. She was fed through a percutaneous endoscopic gastrostomy tube and was undergoing regular haemodialysis. Her disease had resulted in a number of related health problems including impaired sight and hearing loss, chronic muscle weakness, bone disease and chronic damage to her kidneys and lungs. The collective view of her treating team was that ST was in, or was fast approaching, the final stage of her life.

Her treating Trust's plan was to move to a treatment plan of palliative care. That path would involve a much less invasive regime for ST. Dialysis would end and there would be no further attempts to resuscitate her in the event of a further major respiratory arrest such as had already occurred twice. As Roberts J identified at paragraph 2 of the judgment:

> *Her treating clinicians are keenly aware of the need to involve ST as far as possible in how she would wish to be cared for and what steps might be taken to ensure that her last days or weeks of life were as comfortable and pain-free as possible. In preserving respect for her personal autonomy to make these choices, they have met with a fundamental obstacle which, on the case advanced by the Trust, is her apparent refusal or inability to accept that her disease will result in her early, if not imminent, death. It is that inability, or*

> *"delusion", which the Trust relies on as rendering her incapacitous to make decisions for herself* [in relation to future medical treatment].

The questions before the court were (1) whether that was the case, and (2) whether ST had capacity to conduct the proceedings.

As Roberts J further identified at paragraph 4:

> *At the heart of the issues in this case is what ST and her family perceive to be a ray of hope in the form of an experimental nucleoside treatment outside the United Kingdom which might offer her hope of an improved quality of life, albeit a life which is likely to end prematurely in terms of a normal life expectancy. She has told her doctors that she wants to do everything she can to extend her life. She said to Dr C, one of the psychiatrists who visited her last week, "This is my wish. I want to die trying to live. We have to try everything". Whilst she recognises that she may not benefit from further treatment, she is resistant to any attempt to move to a regime of palliative care because she wants to stay alive long enough to be able to travel to Canada or North America where there is at least the prospect that she may be accepted as part of a clinical trial.*

Unusually, perhaps, the Trust sought to advance the case that ST lacked capacity in the material domains in the face of evidence from two psychiatrists involved (there being no independent experts instructed). Both the liaison psychiatrist involved in ST's case and a consultant psychiatrist instructed by the Trust considered that ST had capacity to make decisions about her future medical treatment, and neither considered that ST had an impairment of or disturbance in the functioning of her mind or brain. However, the consultant leading her care, Dr A, whilst accepting that he could find no evidence of psychological disturbance or brain damage, was concerned that "*she is unable to weigh up the pros and cons of what he described as 'a dignified death'. As such he believes that she is suffering from a delusion which derives from a false reality in that she cannot contemplate her own death*" (paragraph 31).

As Roberts J identified, the starting point was the decision that ST had to make, and the information relevant to that decision, which at paragraph 77 Roberts J set out as being:

> *(i) the nature of her disease and the fact that her disease is responsible for the deterioration in her respiratory condition;*
> *(ii) the assessment of her medical team as to prognosis;*
> *(iii) the available options in terms of active treatment including the likelihood of that treatment being available and its chances of success;*
> *(iv) the fact that a small insult arising in the course of her care or management or the further development of her disease (such as another respiratory arrest) may cause potentially fatal clinical instability.*

She then made clear that she considered that:

> *78. In terms of the functional test of capacity, a person's ability to understand, use and weigh information as part of the process of making a decision depends on him or her believing that the information provided for these purposes is reliable and true. That proposition is grounded in objective logic and supported by case law in the context of both the common law and the interpretation of MCA 2005.*

The case law Roberts J referred to was *Re MB*

*(Medical Treatment)* [1997] 2 FLR 42, *Local Authority X v MM* [2007] EWHC 2003 (Fam) and *Leicester City Council v MPZ* [2019] EWCOP 64, Roberts J noting at paragraph 83 that:

> *Whilst it is clear that the strict terms of the MCA 2005 omitted a 'belief' requirement from the wording of ss. 2 and 3, it is clear from Local Authority X v MM that the approach taken by Munby J subsumes the requirement for belief within the statutory limbs of understanding, using and weighing as part of the decision-making process. In this context, and in terms of a patient-centred approach, it is important in my judgment for the court to consider the extent to which the information provided to a person is capable of being established objectively as a "fact" or a "truth". The less certain the fact or truth, the more careful the court must be when determining whether the presumption of capacity is rebutted.*

Applying this to the facts of ST's case, Roberts J continued:

> *84. In this case I accept that ST is aware of the nature of her disease in terms of it being a mitochondrial depletion syndrome which is rare. She knows that she is one of few people in the world to have the disease. I further accept that she knows the disease by its nature is progressive and she recognises that, at some point in the future, she may succumb to its effects and die. What she fails to understand, or acknowledge, is the precariousness of her current prognosis. She does not believe that her doctors are giving her true or reliable information when they tell her that she may have only days or weeks to live. She refuses to contemplate that this information may be true or a reliable prognosis because she has confounded their expectations in the past despite two acute life-threatening episodes in July this year and because she has an overwhelming desire to survive, whatever that may take.*
>
> *85. As to the 'truth' or reliability of the information which ST is being given by her doctors, I am quite satisfied on any objective basis from the body of medical evidence before the court that it is the mitochondrial disease which is causing the progressive failure of her respiratory muscles and the general deterioration in her overall condition. It is not the residual after-effects of long-Covid as ST believes it to be.*
>
> *86. Because she clings to hope that her doctors are wrong, she has approached decisions in relation to her future medical treatment on the basis that any available form of treatment is a better option than palliative care which is likely to result in an early death as active treatment is withdrawn. In my judgment she has not been able to weigh these alternatives on an informed basis because (a) she does not believe what her doctors are telling her about the trajectory of her disease and her likely life expectancy, and (b) she does not fully comprehend or understand what may be involved in pursuing the alternative option of experimental nucleoside treatment. Whilst I accept that she recognises that it may not be successful in terms of the outcome which she wishes to achieve, she has failed to factor into her decision-making that there are, as yet, no concrete funded offers of treatment, far less offers which might offer her even the smallest prospect of a successful outcome.*

In the circumstances, Roberts J found:

> *93* […] *ST is unable to make a decision for herself in relation to her future medical treatment, including the proposed move to palliative care, because she does not believe the*

> *information she has been given by her doctors. Absent that belief, she cannot use or weigh that information as part of the process of making the decision. This is a very different position from the act of making an unwise, but otherwise capacitous, decision. An unwise decision involves the juxtaposition of both an objective overview of the wisdom of a decision to act one way or another and the subjective reasons informing that person's decision to elect to take a particular course. However unwise, the decision must nevertheless involve that essential understanding of the information and the use, weighing and balancing of the information in order to reach a decision. In ST's case, an essential element of the process of decision-making is missing because she is unable to use or weigh information which has been shown to be both reliable and true.*

Roberts J accepted the proposition advanced by the Official Solicitor that "*an individual who expresses hope that they will survive, or even a belief based on that hope, does not, without more, become incapacitous simply because they disagree with the medical advice they are given*." However, on the facts of the case before her, Roberts J found that:

> *94.* […] *ST's fundamental distrust in, and refusal to accept, the information she is given by her doctors as to the likely timescales of her deterioration, do not simply operate to impair her ability to make a decision. They prevent her from understanding, using and weighing the information in the context of the options available to her in terms of future care planning. Dr A expressed himself to be entirely open to discussing these options with ST. Indeed, he saw it as an essential part of the care he was providing as her lead treating clinician. She was unwilling to engage with him at all on the subject because she does not trust the information he has given her. Dr D* [the liaison psychiatrist] *did not raise with ST the question of alternative options and what palliative care might look like in terms of an alternative. Dr C* [the consultant psychiatrist] *confirmed in his evidence that ST was unable to weigh up any decision about palliative care because she failed the functional test.*

That then brought Roberts J on to consider whether ST's inability to make the decision was caused by an impairment of or disturbance in the functioning of her mind or brain. Roberts J, relying on the observations of MacDonald J in North Bristol NHS Trust v R [2023] EWCOP 5, reminded herself that:

> *97. That issue is a question of fact for the court to determine. The wording of s.2(1) MCA itself does not require a formal diagnosis before the court can be satisfied as to whether an inability of a person to make a decision in relation to the matter in issue is because of an impairment of, or a disturbance in the functioning of, the mind or brain. This test is not further defined in the Act. As the court made clear in the North Bristol NHS case, to require a specific diagnosis would not only be undesirable, it would constrain the application of the Act. The court, instead, is fully entitled to have regard to the wide range of factors that may act in any individual case to impair functioning of the mind or brain and, most importantly, to the intricacies of the causal connection or nexus between lack of ability to take a decision and the impairment in question (see paragraph 47). There is thus no requirement for the court to be able to formulate precisely the underlying condition or conditions which constitute the impairment.*

It was accepted, Roberts J further reminded herself, that ST did not suffer from any

recognised psychiatric or psychological illness. However, having reviewed the evidence before her, Roberts J continued:

> *103. In my judgment, and based upon the evidence which is now before the court, I find on the balance of probabilities that ST's complete inability to accept the medical reality of her position, or to contemplate the possibility that her doctors may be giving her accurate information, is likely to be the result of an impairment of, or a disturbance in the functioning of, her mind or brain. Her vulnerability has been acknowledged by Dr C. I need no persuading that she has been adversely impacted by the trauma of her initial admission to hospital. That trauma is likely to have been exacerbated by the length of her stay in the ITU unit. Her brother acknowledges that she has been surrounded by patients dying around her on the unit as the months have gone by. Whilst she has been sustained by the near continuous presence of her mother and, to a lesser extent, the other members of her close family, she has endured almost a year of intensive medical and surgical intervention which has been both painful and distressing for her. She is frightened by the prospect of dying and clings to her desire to survive what her doctors have repeatedly told her is an unsurvivable condition. The cumulative effect of her circumstances over such a prolonged period, her profound inability to contemplate the reality of her prognosis, and a fundamentally illogical or irrational refusal to contemplate an alternative are all likely to have contributed to impaired functioning notwithstanding the resilience which ST has displayed in her determination to carry on fighting. It is not necessary for me to seek to further define the nature of that impairment. I am satisfied that it exists and that it operates so as to render her unable to make a decision for herself in relation to her future medical treatment.*

The Official Solicitor was clearly concerned about such an approach, submitting that "*the Trust's reliance on the same beliefs which impair ST's decision-making ability under the first limb of the test in s.2(1) MCA to found the existence of an impairment under that section is circular and undermines the importance of the second question in s.2(1).*" However, Roberts J identified that:

> *104.* […] *In my judgment that is to misunderstand the Trust's position and the basis of my finding that, on the balance of probabilities, the impairment in ST's functioning has been established. It is not simply the failure to believe the advice she is receiving and thus her inability to understand, use and weigh information in the decision-making process which informs the finding of impairment. It is informed by a holistic evidence-based overview of ST's lived experience on the ITU and the trauma she has suffered as a result of the intensive treatment she has required over the past twelve months. That trauma has manifested itself in acute episodes of distress and anxiety and a presentation which suggests a hyper-vigilant state where she is continuously watching for her mother and requiring her constant support on an almost daily basis.*

Roberts J found that she could not see what further steps could be taken to help ST to make a decision, such that future decision-making must take place on a best interests basis.

The second question before the court was as to ST's capacity to conduct the proceedings. ST was represented by the Official Solicitor, but also present in court were leading and junior counsel who were instructed directly by a solicitor on ST's behalf as (as Roberts J described them at

paragraph 9) as her 'informal' legal representatives. They cross-examined the medical witnesses and made final written submissions in relation to ST's capacity to make the substantive decisions required of her and to conduct the proceedings. As matters turned out, the final position of the Official Solicitor and the position of ST's informal representatives were more or less aligned. Given Roberts J's conclusions as to ST's capacity to make decisions about her medical treatment, however, she could not allow the quantum indeterminacy position of representation to continue, and had to make a determination as to whether, in fact, ST had or lacked litigation capacity. Her conclusion was clear:

> *106. Despite the view of Dr C and the position urged on me by Mr Garrido KC and Mr Quintavalle* [ST's informal representatives], *I am satisfied that this is a case where ST lacks capacity to litigate without the assistance of a litigation friend. Capacity to litigate includes not only an understanding of the issues in the case but an ability to understand, use and weigh the arguments on the evidence so as to give instructions in relation to the arguments of other parties who may take an opposing position. Given my findings in relation to subject matter capacity, it is difficult to conceive of circumstances where ST might be said to have full litigation capacity but lack subject matter capacity. I am concerned about the lack of information in which Mr Foster of Moore & Barlow came to be instructed and whether the origin of that instruction was ST herself or her family. I offer no criticism of their involvement in this hearing. They attended at the invitation of the court in order that the court might have the benefit of full argument. In that respect, the attendance of Mr Garrido KC and Mr Quintavalle at this hearing has been of considerable assistance to the court.*

### Comment

It is important to emphasise that the decision in this case was fact-specific, and it should not be read (as the Official Solicitor was clearly concerned that the approach adopted could be read) as equating to the simple formula: "patient believes what doctor is saying => patient has capacity; patient does not believe what doctor is saying => patient does not have capacity." However, Roberts J's observations about the continuing importance of the concept of belief within the structure of the functional test contained in the MCA are of wider relevance: see further here for more on how the language of the MCA maps onto clinical and social work realities.

Some might well be challenged – as it appears was the Official Solicitor – by the approach taken to the so-called (but, as this case shows, entirely inaccurately so-called) 'diagnostic test.' It is entirely understandable that, having reached a conclusion that ST could not – functionally – make the decisions required of her, Roberts J sought then to explain why that was the case within the four walls of the MCA 2005. The alternative (as the liaison psychiatrist, Dr D, appears to have considered) would have been to identify that this was a case falling within the scope of the inherent jurisdiction. At that point, however, very difficult questions would have arisen as to the circumstances under which it would have be legitimate to deploy the inherent jurisdiction of the High Court to make decisions in relation to medical treatment in circumstances where it could not be said (on the face of the material recorded in the judgment) that ST was

subject to undue influence or coercion.[3]

It is therefore entirely understandable why Roberts J sought to bring the case within the scope of the MCA 2005. At that stage, it is one thing to say that there does not need to be a formal diagnosis before the court (or indeed anyone else) can reach a conclusion that someone lacks capacity for purposes of the MCA 2005. However, Roberts J appeared to be (and I would say rightly) aware that she was engaged in a sensitive task of, in effect, having to set out a formulation of an impairment / disturbance[4] in the face of clinical evidence that one did not exist. It would be interesting to speculate whether the involvement of a psychologist would have assisted here in terms of clarifying matters. And, to reiterate, her conclusions were fact-specific, and did not represent a general invitation simply to 'invent' an impairment or disturbance in difficult situations.

More broadly, the case does throw into sharp relief the question of the place of the 'diagnostic' test – a test which has been abandoned by the Republic of Ireland in its newly implemented Assisted Decision-Making (Capacity) Act 2015. Its history and purpose is summarised in section V of this article, but, as the article suggests, revisiting that test must be a matter for Parliament, rather than the courts.

Finally, in relation to litigation capacity, it is very unusual indeed, but on the facts of this case clearly an appropriate exercise of the court's wide case-management powers, to have a situation in which P has both 'formal' and 'informal' representation. One anticipates that this would not have been a step that the court had been taken had there not been evidence before it to suggest that there was at least an arguable case that P had litigation capacity.

## Dialysis and different realities – the Court of Protection has to decide

*Nottingham University Hospitals NHS Trust v JM & Anor* [2023] EWCOP 38 (Hayden J)

*Best interests – medical treatment*

Hayden J has helpfully reminded us of the fact that a person with cognitive impairments may be operating within a very different reality to everyone else does not mean that it is a reality which can simply be ignored.

The case concerned a 26 year old man, JM, who was diagnosed as autistic at the age of 5, but had received very little support for it. His childhood experiences were described by Hayden J as having been characterised by trauma. He was diagnosed with chronic kidney disease in January 2021 and had acquired Thrombotic Thrombocytopenic Purpura ('TTP'). He required regular at least 4 hourly sessions of haemodialysis for a minimum of three times per week. The clinical consensus was that JM would die within 8-10 days if he did not receive treatment.

JM did not accept a diagnosis of chronic kidney disease or his need for dialysis. His mother – who had been diagnosed with schizophrenia – did not accept this either. Hayden J noted in this regard (at paragraph 4) that, "*though they share the same view, which is irrational, Dr C* [the independent psychologist] *is persuaded that they each independently hold the same view and JM's belief structure has not been superimposed upon him*."

[3] Although see here for an examination of how subtle interpersonal influences might be.
[4] At the risk of engaging in remote (and lay) diagnosis, it might be thought that ST's presentation had, on the evidence before the court summarised in the judgment, to have many of the features of 'adjustment disorder.'

In the context of proceedings relating to the future placement of JM, the matter was restored urgently to court, JM having been found in bed at home covered in blood from his dialysis line, there being "very little doubt" that it was JM himself who had cut the line. The line was removed, and JM refused have a replacement line inserted.

Capacity not being in issue, the question was what steps it was in JM's best interests to take. Hayden J's analysis was sufficiently crisp but nuanced that it requires (to use one of the judge's catchphrases) to be set out in full:

> *43. The situation for JM has progressively deteriorated. I remind myself that in early 2023 when JM was clinically stable in hospital, the proceedings were concerned with finding a placement from which he could be encouraged to attend for dialysis three times per week. The situation is plainly now far graver. Restraining JM to reinsert a new dialysis line against his will might in and of itself be justifiable. However, JM's objection is not merely to the reinsertion of the line but to the life sustaining dialysis it would provide. It follows, inevitably, that the restraint required for the reinsertion would be a harbinger for repeated and extensive restraint on a weekly basis and indefinitely. JM's erratic compliance and distorted thinking, now over many months, effectively discounts him, I have been told, from eligibility for a donor organ. Such transplant would need compliance with a fairly rigorous regime of support which is very unlikely to be complied with. Moreover, that too may involve an extensive period of haemodialysis.*
>
> *44. JM's belief system in respect of dialysis is so plainly distorted as to manifestly rebut the presumption of capacity, erected by the MCA 2005. However, even though his reasoning is unsound, JM's confidence and belief in his own judgment is well-established and as the chronology of the case has demonstrated, unmoveable. The fact that an individual's views may be misconceived does not, however, deprive him of the right to hold them. To approach this otherwise would particularly discriminate against the incapacitous, as well as more generally. JM's views on dialysis arise from the complex interplay of his psychological functioning and his life experiences. This is no doubt true for all of us but in JM's case, both are disordered. The nature and extent of JM's autism coupled with the extent of trauma that he has endured, serves to disable him from processing his thoughts and experience in an effective way. Nonetheless, JM's own reality, even though it greatly differs from ours, requires to be respected. It is in this way that the autonomy of the incapacitous is respected. That does not mean that their views prevail but it does mean that they must be afforded weight. As I have set out above [in North West London Clinical Commissioning Group v GU [2021] EWCOP 59], "human dignity is predicated on a universal understanding that human beings possess a unique value which is intrinsic to the human condition".*
>
> *45. For the reasons which I have set out, I am clear that forced restraint either in the face of JM's expressed opposition or at a time when he is no longer able to resist, would compromise his dignity. By agreement and because Roberts J had previously met with JM on a number of occasions, I spoke with him on a private video link from which the public and lawyers were excluded. The solicitor for the Official Solicitor took a note. With outstanding efficiency, the note was available to the parties within 20 minutes of my concluding the meeting.*

> *Judges, I suspect, vary greatly in their approach to meeting with P. Video conferencing platforms have changed the landscape. It seemed to me, ultimately unthinkable, that I should not meet with JM and tell him the important decision I had made. I found him, as has everybody else involved in his care, to be a very pleasant young man. His conversation with me reinforced Dr C's assessment of him. As both Dr F and Dr C have said, JM does not want to die. When I told him of my decision and the fact that he would die, he told me without prompt or question that he did not want to. I formed the impression that he very much wanted to live. Ultimately, all I could do was tell him that the decision was his.*

Hayden J also expressly paid tribute to the doctors and nursing staff, as well as JM's mother and sister, noting in respect of JM's mother that, though she "*struggles to understand the realities of JM's situation due to her own mental health difficulties, she has an impressive and, I sense, strongly maternal instinct that the use of restraint to compel dialysis would be inimical to his welfare. Those instincts, to my mind, are sound and also require to be factored in to this decision*" (paragraph 46).

### Comment

We anticipate that paragraph 44 may well be quoted to and by other judges in the same way as the earlier, pithy observation of Peter Jackson J (as he then was) in the *Wye Valley* case that in some cases "*the wishes and feelings, beliefs and values of a person with a mental illness can be of such long standing that they are an inextricable part of the person that he is. In this situation, I do not find it helpful to see the person as if he were a person in good health who has been afflicted by illness. It is more real and more respectful to recognise him for who he is: a person with his own intrinsic beliefs and values. It is no more meaningful to think of Mr B* [the subject of that case] *without his illnesses and idiosyncratic beliefs than it is to speak of an unmusical Mozart*."

More broadly, the concept of 'best interests' is often challenged, especially by those associated with the Committee on the Rights of Persons with Disabilities, as being code for medical paternalism, as well as a licence (if, indeed, not even a mandate) to discriminate against those with cognitive impairments. It is against this backdrop that calls are made to base all decisions upon the autonomy, will and preferences[5] of those with disabilities. There is no doubt that it is all too easy to point to decisions made up and down the country on a best interests basis that merit the strong criticism leveled against the concept. However, in line with the clear trend in the case-law of the Court of Protection, this decision shows that the concept is capable of being interpreted in a very different way. If the decision is constructed outwards from the person, on the basis of their reality, it is difficult to see how the end result does not comply with the requirement of Article 12 CRPD that it respects their rights, will and preferences.

## When should questioning an 'independent spirit' stop? Capacity, contact and the limits of the inherent jurisdiction

*Re RK (Capacity; Contact; Inherent Jurisdiction)* [2023] EWCOP 37 (Cobb J)

[5] The language used in General Comment 1 on the right to equal recognition before the law contained in Article 12 CRPD. Pedantically, Article 12(4) talks of the need for measures relating to the exercise of legal capacity to respect the rights, will and preferences of the person. It is not obvious that 'autonomy' is synonymous with all the rights that are guaranteed by the CRPD. For more about the CRPD, we strongly recommend the work of Lucy Series.

*CoP jurisdiction and powers – interface with family proceedings – mental capacity – assessing capacity*

### Summary[6]

The case name helpfully captures what this difficult case was about. It concerned RK (identified in the body of the judgment as 'R'), a 30 year old woman with Down's Syndrome, a moderate to severe learning disability (described in the documents as a significant cognitive impairment), who was partially sighted. She had a full-scale IQ of 60, and had some expressive and receptive communication difficulties. She was also an accomplished swimmer, having competed in national and European championships and actor (she had been on national TV in a well-known series). R lived in supported living accommodation called (for purposes of the judgment) 'Castle Hill,' her care needs being provided by a provider identified for purposes of the judgment as 'Signia,' contracted by the relevant local authority, XCC.

Cobb J had previously made determinations that R lacked capacity to litigate, and to manage her property and affairs, but that she had capacity to engage in sexual relations, to make the decision to remain at Castle Hill, and to make decisions about what support she needs on a day-to-day basis with an adequately supported environment. He was now asked by R's family to declare that she lacked capacity to make decisions about contact, that she was susceptible to undue influence, and measures need to be put into place to protect her from this; and that she lacked capacity to revoke the LPA created in respect of property and affairs and health and welfare. In the alternative, if he found that R had capacity to make decisions about contact, he was asked to make an order under the inherent jurisdiction in relation to supporting contact between her and her family. R's family, in essence, wanted to have implemented a supportive framework to encourage R to repair and maintain her relationship with her immediate and wider family and friends.

In support of their application, R's family sought unsuccessfully to persuade Cobb J to embark on a fact-finding inquiry, but 'inevitably' had regard to some of the factual issues set out in a 73-page schedule of proposed facts which they argued required determination. The length of the schedule gives a clue to the long and difficult pre-history of the case, set out in considerable detail in the judgment. To summarise very crudely, R had lived at Castle Hill since 2015 and, between 2015-2020, arrangements had run smoothly and the family were able to work reasonably well with Signia. Matters became problematic when at some point in 2018 or 2019 R formed a relationship with a male resident at Castle Hill, SA (a relationship which was now said to be at an end). As Cobb J noted at paragraph 18:

> *The relationship generated no small amount of anguish for R's family, and their concerns about it led to dispute with Signia. R was clear that SA made her feel happy; whilst she may not have been able to articulate the intricacies of this relationship, she recognised and responded to the emotional value this relationship brought her. Those supporting them believed them to have a loving and nurturing relationship from which they both equally benefited. The anguish focused on whether R had capacity to engage in sexual relations with him.*

The relationship between the family and Signia then broke down entirely during the lockdown,

[6] Tor having been involved in the case, she has not contributed to this summary.

when R could not be persuaded to leave Castle Hill in the face of her family's desire for her to return home to live with them, having spent some time there at the start of lockdown. Matters went from bad to worse, as detailed by Cobb J, but crucially (at paragraph 22):

> *From about this time, R ceased contact with her parents; she left the family WhatsApp group (something which the family do not believe she could have done without help), and rarely (if ever) responded to text or e-mail messages. She initiated no contact with her family, and made herself unavailable if family members or friends called in at Castle Hill unannounced; she cancelled pre-arranged visits. The family say that she missed all of the family birthdays, something which she would generally not have done.*

Contact was never resumed, despite mediation, and – as is sadly often the case – allegation followed allegation about the care provider, as well as R's family raising a safeguarding alert with the police including alleged financial abuse and concerns about sexual abuse, leading to a visit by two police officers to speak to R and SA (a step that it is clear that R's family had not anticipated, and were troubled by). In Autumn 2020, R also stopped the range of activities that she used to enjoy, including 1:1 piano lessons, swimming, a drama group and attending a project which offers a range of activities including drama (the latter two had continued online during lockdowns); the family believed that this – again – was the result of pressure from Signia.

Cobb J identified that he was satisfied that from all that he had read that R "*fundamentally loves her family, and wishes to be a part of the family*" (paragraph 75), but:

> *76. That said, she has for some time (probably since the late summer of 2020) been steadfast – at least in her discussions with Signia staff with whom she has her most regular relationship – that she does not want to see her parents. I find that she is currently highly conflicted in this regard. Dr McKay described her as "ambivalent". R's independent advocate for the Talking Project advanced a similar perspective in an e-mail to PB in October 2022:*
>
>> *"I sense that there are deep rooted issues that the family has with [Signia] that remain unresolved. However, this is an issue they have with [Signia] and not with their daughter although she senses it and I believe this is what holds her back from reaching out to the family." (Emphasis by underlining added).*
>
> *Dr McKay* [the jointly instructed expert psychologist] *went on in her evidence, to demonstrate R's ability to 'use or weigh' the relevant information, to remark that:*
>
>> *"R did not have polarised views of her family. We see many people who only see good or bad but this is not the case with her… she suggested lots of positive attributes in the family".*
>
> *77. I find, having heard all of the evidence, that R feels great empathy towards her family but she is also angry with them because she believes inter alia that they are trying to control her. Ironically, R's parents are firmly of the view that it is the Signia staff who are controlling and coercing R. She senses*

*their anger with Signia, and she does not like being caught in the middle of that.*

*78. The origins of R's anger with her parents and sister, and her strong sense that the family are controlling her or trying to do so, is not entirely clear, but they may well lie in the time when they applied pressure on her in relation to losing weight. This, at least, is what she told the previous social worker, and this was associated in time with the family's stated wish to remove her from Castle Hill (where she was/is happy and has friends) to live at home. Her relatively recent experience of living at home during the early phase of the COVID-19 lockdown in the spring 2020 may have a bearing on this too.*

*79. I am satisfied that her current antipathy towards her family is real; the feelings are, in my judgment, neither confected nor are they the result of pressure (improper or otherwise) from those who currently support and care for R. It is R's view that the family exercise inappropriate control of her in relation to:*

*i) The proceedings, which they initiated and about which she is unhappy; within the proceedings, R has been assessed, questioned and interviewed repeatedly over the same issues. It is possible that her answers in interview for the court have been affected by her unhappiness with the process. The fact that she has been repeatedly questioned may have left her wondering whether her views count for nothing, and this may well have made matters worse;*

*ii) Her money; she wishes them not to know about her spending;*

*iii) Her weight; she senses that they are trying to control what she eats and impose rules around her diet (I was directly aware of her sensitivity about this when I visited her, from comments which she made while we stood together in the kitchen);*

*iv) Her relationship with SA.*

By contrast, Cobb J was not persuaded that Signia had exerted undue pressure on R:

*81. I have seen no evidence which suggests that the Signia staff have acted in such a way as to sap R of her free-choice to meet with them; on the contrary, I was impressed by Ms TB* [the managing director of Signia] *and accept PB's assessment of the quality of care which they offer to R. I accept Dr McKay's persuasive view that if the staff had conveyed to R deeply negative views about R's family, R herself would not hold or communicate positive thoughts about her family. Dr McKay is of the view that R has a desire to reconcile with her family, but lacks confidence that it will be a positive experience; the recent attempt would confirm this. I am satisfied that PB* [R's social worker] *in particular has made concerted efforts to persuade R to see her family, but those efforts have been in vain. In the current circumstances, I am not surprised.*

Importantly – and unusually – Cobb J had before him very clear evidence from R herself as to what she wished from the litigation, set out in a letter that she had sent to him. As Cobb J noted, he found comfort in the letter because it signaled ways in which the situation could improve:

*i) The disclaimer of the LPA* [a matter which Cobb J had identified earlier in the judgment had been agreed to by her parents] *will signal the moment when her parents cannot "make decisions" about her life, particularly*

> *money;*
>
> *ii) R can and should be told that her parents had good reason for referring their concerns to the police about SA and genuinely did not expect the police to visit Castle Hill; R should be told that the mother described to me how she recognised R's upset and distress;*
>
> *iii) It would be possible for R's parents to apologise (again) to SA* [R's former partner]. *If they feel that they have already done this, they could repeat it in such a way that R knows and understands that the apology has been issued;*

As Cobb J noted:

> *84. There is no doubt in my mind that R desperately wants the proceedings to be over. PB expressed it well thus:*
>
> > *"This independent spirit, this determination to set her own store has been continuously undermined and undervalued time and time again. R has been assessed, questioned and interviewed repeatedly over the same issues which have left her feeling that her words and feelings count for little. That her views have been ignored or diminished, her experiences, her feelings and more importantly her own decisions, disregarded".*
>
> *85. It is against this backdrop that Ms TB expressed herself to be "… optimistic that when the Court case is concluded and if [R]'s wishes are respected, that she will feel able to reunite with her family". I cautiously share that optimism.*

Against this context, Cobb J had to decide whether R had capacity to make decisions about contact. He had the benefit of expert reports from Dr Claudia Camden-Smith, a jointly instructed consultant psychiatrist with a particular interest in Neurodevelopmental Disability Psychiatry, and Dr Katherine McKay, a Consultant Clinical Psychologist with a specialism in learning disabilities. Dr Camden-Smith was clear that R lacked capacity; Dr McKay considered that she had capacity. Cobb J preferred the evidence of Dr McKay, noting – amongst other matters – that she had met R on a number of occasions previously, which was a great advantage: she was able to begin her assessment with some pre-existing knowledge and experience of R's abilities and limitations.

Cobb J declared himself satisfied that R:

> *103.* […] *understands the issues, and has been able to use or weigh the information relevant to the decision on contact. She knows her family well and she loves them, but has been hurt by them (for the many reasons which I have discussed above) and deeply so; she feels it very keenly. I do not think that the family see how badly they have hurt R and this is perhaps in part why they cannot accept that she can make a capacitous decision in this regard. R has been clear in saying that she would like to see her family on Zoom initially; this is perfectly understandable. I further sense that she is not saying that she will not want to see her family ever again; she is very clear that a number of impediments to contact need to be cleared first – the disclaimer of the LPAs, and the end of these proceedings being the most important.*
>
> *104. The fact that R has vacillated in recent times (reference 17 November 2022 and June 2023) over seeing the family (or members of them) is perfectly understandable, and utterly predictable;*

> *it is not evidence of inappropriate pressure being applied on her to change her mind. Nor is that that she does not understand the information relevant to a decision on whether to see her family. She does understand that information; she can use and weigh that information; she can retain it, and can communicate her views. But – and this is the key – I find that she is deeply conflicted, very aware that she is caught in the crossfire of the dispute between her family (which fundamentally she loves) and Signia (in whose care she lives, and whose relationship she values). She may say to people that which she thinks they want to hear. That of itself is not an indicator of a lack of capacity; many fully capacitous people do exactly that. Her vacillation is not, or not necessarily, an indicator that she is coming under pressure, let alone undue pressure, from external sources.*

That was not the end of the matter, though, because Cobb J had then to go on to consider whether to make orders under the inherent jurisdiction. He conducted a detailed review of the authorities, "*to demonstrate that while the inherent jurisdiction is available in the right case, it is not 'all-encompassing' and there are clear limits to its applicability*" (paragraph 120). Importantly, he further noted that:

> *119. The burden falls on the Applicant and Third Respondent to prove in this case that R's will has been and/or is being overborne by those who are caring for her, and that she is the subject of constraint, coercion, undue influence or other vitiating factors. It is a serious allegation to make; the more so, it may be thought, when the accusation is made against professional care providers. I have considered the allegations on the balance of probabilities; and I approach my task on the basis that if the party who bears the burden of proof fails to discharge it, the fact is treated as not having happened. If he does discharge it, the fact is treated as having happened (Re B [2008] UKSC 35). I found it useful to reconnect with what Lord Nicholls said in re H (Minors)(Sexual Abuse: Standard of Proof) [1996] AC 563, at 586D-H:*
>
> > *"When assessing the probabilities the court will have in mind as a factor, to whatever extent is appropriate in the particular case, that the more serious the allegation the less likely it is that the event occurred and, hence, the stronger should be the evidence before the court concludes that the allegation is established on the balance of probability".*

Having reviewed the material before him Cobb J reached the following conclusions:

> *133.* […] *As I mentioned above, in Re SA, Munby J declined to define the categories of person for whom the inherent jurisdiction may be invoked, but it is nonetheless clear from his judgment (and from DL which followed) that those for whom it would apply are those who are under constraint, subject to coercion or undue influence or otherwise (for some other reason) deprived of the capacity to make a relevant decision, or disabled from making a free choice (see above). In my judgment, this has not been R's experience in her placement.*
>
> *134. I reject the suggestion by the Applicant that there has been any deliberate attempt at, or actual, alienation of R against her family by members of the Signia staff; I further reject the allegation of 'environmental alienation' – i.e. Signia creating an environment or eco-system in which R is not able to speak positively about her family and/or where all conversation about her family is negative. In my judgment it is likely that, once R's family*

> *started making allegations about Signia and the care it was offering R, Signia staff will have found it difficult actively to encourage R to engage with her family; it may well be that R picked up on Signia's sense of unhappiness at being on the receiving end of a wide range of allegations.*
>
> *135. It is clear that R has recently made free choices, and these are choices which have brought her into contact with her family – i.e., she agreed to take part in the Talking Project [mediation]; she agreed to a meeting with her family in November (albeit that this did not happen), and agreed again to the café meeting on 9 December 2022.*
>
> *136. I view with some sympathy the 'supportive framework' proposals advanced by the parties; indeed in the next section of the judgment I discuss them and actively encourage those with responsibility for R's care closely to consider them. But it is not 'necessary' for me to make orders in relation to them in order to liberate R to make decisions freely, nor is it 'proportionate' ([66] and [76] of DL) that I should. I am conscious of the need to guard against adopting an overly paternalistic attitude to a vulnerable adult who is the subject of the proceedings, and to make orders in (what McFarlane LJ referred to as) the "hinterland" of the MCA 2005 which undermine the very concepts of the MCA 2005 itself.*

As presaged above, this left Cobb J with no "jurisdictional peg" upon which to hang any ruling about R's care arrangements going forward. However, not least because the parties jointly urged him to do so, he gave a number of observations about future arrangements, including an observation that Signia should remain in place providing care for R, and identified some key features of an "impressive" 21 point supportive framework plan put forward by the family as having "particular merit" for incorporation in any plan going forward.

In his conclusions, Cobb J identified that

> *151.* […] *, there is at least one conclusion which it has not been difficult to reach in this case. And that is that these proceedings should now come to an end. R has repeatedly said that she is unhappy by the court's involvement; I am sure that she blames her parents for having initiated the litigation, and that this very issue in itself undermines the efforts which have been made to promote reconciliation. I accept the evidence that R has regularly lost sleep with worry about the court's involvement in her life, and that for a time she was "struggling… crying every night" because of them.*
>
> *152. I agree with PB and Ms TB that R does show a good level of interest in, and empathy for, her family, but she is clearly conflicted; she has feelings of love and obligation towards them, but a strong desire to pursue her own interests and be free from what she sees as their 'control'. I find that she has been relatively steadfast in the last three years in her view on the issue of reconciliation; she has attempted to meet the many demands placed upon her by professionals, and has been frustrated by having to answer repeatedly many similar questions, when she has already made clear her position. I share the optimism of Ms TB that when the litigation has ended, and particularly if R's wishes are respected and hostilities cease between Signia and the family, R will feel freer to explore the options around seeing her family. I also agree that this may take time, and perhaps some third-party help from a personal counsellor for R.*
>
> *153. Other issues raised by the parties at this hearing have not yielded answers*

> *with the same ease. While the Court of Protection is accustomed to making important decisions about an individual's capacity to make decisions, and declarations about their best interests, it is not able to order or declare how people should think, or what they should do to get on better with each other. And that, in large part, is what needs to change in this case for the situation to move on.*

Cobb J also proposed to write a short letter to R to explain that the proceedings have ended, and to set out some key outcomes, and also to give R an opportunity to meet with him again, should she wish to do so.

### Comment

The summary above does not do full justice to the detail and nuance of the judgment, which is noteworthy even by the high standards of Cobb J. Above all, and to sadly still perhaps unusual extent, one gets a sense of the person at the heart of the proceedings, and the deep sense of conflict that troubled her.

As with all decisions, it is fact-specific, but there are undoubtedly patterns which are depressingly familiar to those who work (in whatever capacity) in this area. And Cobb J's observation at paragraph 153 about the inability of the court to declare how people should think or what they should do to get on better with each other is one made with a perhaps weary sense of familiarity with cases of this nature.

Two points of broader relevance perhaps arise from the judgment. The first related to Cobb J's observation about the mediation that took place during the course of the proceedings:

> *50. Although the mediation showed some signs of promise, it was not in fact a success. Signia did not play a significant part in the mediation, having been given a clear expectation (it is said) that they would be expected to participate in the mediation on the basis of full disclosure and open communication. Signia felt that it could not in good faith sign up to this, give the status of R's capacity and her views. R had been very clear with Signia (so it was reported) that she did not wish any information about her service or her personal circumstances to be shared with her family. Signia had understood at that time (from XCC) that R was assumed to have the capacity to make that decision following a capacity assessment undertaken by the previous social worker. A further concern to Ms TB, and a deterrent to successful engagement in the mediation, was that during this period in which mediation was being attempted, the family ignited fresh allegations of fraud which on no account would be amenable to mediation, and which would inevitably complicate the relationships further.*

As important as mediation is, the observation about the position where the subject of the proceedings is understood to have capacity to make decisions about information-sharing is a very important reminder that mediation cannot either lead to a process or a result which might suit everyone else except for that person.

The second is in relation to the inherent jurisdiction, as this case adds to the body of case-law (and, importantly, this time, as an actual decision, rather than 'obiter' comments) pointing towards the limits of the inherent jurisdiction as a tool to coerce – however benignly – a capacitous individual to take steps that they resist.

## DoLS statistics – the crisis continues to deepen

The DoLS statistics for England for the year 1 April 2022 to 31 March 2023 were published on 24 August 2023. They show that, despite heroic

efforts by local authorities up and down the country, they continue to fight a losing battle actually to secure that all those requiring the safeguards are provided with them.

In headline terms:

- There were an estimated 300,765 applications for DoLS received during 2022-23. This is an increase of 11% compared to the previous year, which is closer to the rate of growth seen before COVID-19 (between 2014-15 and 2019-20 the average growth rate was 14% each year) following an interim period of relatively small increases in numbers of applications.
- The number of applications completed in 2022-23 was estimated to be 289,150. The number of completed applications has increased over the last five years by an average of 10% each year.
- However, the reported number of cases that were not completed as at year end was an estimated 126,100, 2% more than the end of the previous year, and the proportion of standard applications completed within the statutory timeframe of 21 days was 19% in 2022-23; this has fallen from 20% in the previous year. The average length of time for all completed applications was 156 days, compared to 153 days in the previous year.

Tellingly, 56% of applications were not granted, but only 3% were not granted because one or more of the DoLS criteria were not met. The reasons for most applications not being granted was due to a change in the person's circumstances, for example being discharged from a short term stay in hospital following an urgent authorisation. And the stark fact is that almost 50,000 people died whilst waiting for a DoLS authorisation to be considered.

The DoLS statistics only tell part of the story, because the framework does not apply where the person is not yet 18, or is deprived of their liberty other than in a care home or hospital. There were 872 applications to the Court of Protection for judicial authorisation of deprivation of liberty in the first quarter of 2023 (down from 1,002 applications the quarter before), but it is very difficult to get a sense of by a factor of how many this number is short of the number of applications that should be made.

The Court of Protection is reviewing the *Re X* application procedure at the moment; Alex would also suggest that there is an urgent need to discuss whether and how it is possible to operate the DoLS framework in a more proportionate fashion – in line with the guidance from the Chief Social Worker for Adults and Principal Social Workers in relation to Care Act assessments. An extremely useful starting point for the discussion – in our view – is this guest post on Alex's website by Lorraine Currie.

# PROPERTY AND AFFAIRS

## SRA review of law firms providing LPA / deputyship services

The SRA has published the result of a 'thematic review' into this area of work, based on visits to 30 randomly selected firms in the summer of 2022. Each one completed a questionnaire about their work in this area, followed by a visit where the SRA investigation team met with the head of the LPA/deputyship team. The team also interviewed a fee earner in the team and reviewed two files - one setting up an LPA and another managing an LPA/deputyship.

In headline terms:

> *We were broadly satisfied with our review of the firms in this area. Reassuringly, we found that firms with roles in managing LPAs or deputyships did so diligently. And there was no evidence of any abuse of the trust placed in them by what are often very vulnerable clients.*
>
> *Firms took their training, supervision and record keeping responsibilities seriously and we did not find deficiencies in the drafting of LPAs. However, neither we nor the profession can afford to be complacent because the impact of poor work for such vulnerable clients is high. And, however small, there is always the risk, that while the overwhelming majority of solicitors do a good job, some could abuse the position of trust that this service provides. As demand increases, so do the risks.*

It is perhaps striking from the report of the review, however, quite how little the voice of those who were the subject of deputyships came through, and it might be though that "all firms were recording best interest decisions" is a rather laconic statement given the sins which can be hidden underneath the recording of a best interests decision.

## OPG guidance on completing LPA forms

The Office of the Public Guardian has published a short guide – aimed primarily at lay readers – as to how to avoid making errors when completing LPA forms.

## Court of Protection P&A User Group

On 12 July 2023, the User Group met and the minutes of that meeting have been published.

The meeting ranged over topics such as backlogs and recovery, P&A digital process, a small payments scheme, Liberty Protection Standards, the LPA bill, consultation re the MCA Code of Practice, a MCA awareness raising toolkit, issues with banks, urgent applications, detailed assessments of costs and complaints about behaviour in court.

Next meetings; General 18 October 2pm (MS Teams); P&A 17 January 2024 (MS Teams).

## The MCA and money

In this shedinar, recorded in August 2023, Alex explains how the MCA applies when thinking about people's money, property and affairs.

# PRACTICE AND PROCEDURE

## New COP3 form

A substantially updated COP3 form is now live on the .gov.uk website. It has been overhauled (amongst other things) so as to reflect the correct ordering of the capacity test, to focus in on the need for clarity as to the relevant information, and to make clear (to paraphrase) that the primary requirement for assessing capacity is competence rather than letters before or after one's name.

Alex has done a walkthrough of the form here; he has also made inquiries in relation to when the old form will no longer be accepted, and the answer is that the new form should always be used now; if it isn't used, the application may be delayed if the court considers that the matter can't progress without the improved information which the new form offers and so makes an order for the evidence to be filed in the new format. There will come a point when the court gives notice that the old form will no longer be accepted. There is no time set yet for the old form not to be accepted.

## Committal hearings in the Court of Protection – publicity and complexity

*Esper v NHS NW London ICB (Appeal: Anonymity in Committal Proceedings)* [2023] EWCOP 29 (Poole J)

*COP jurisdiction and powers – contempt of court – media – anonymity – court reporting*

### Summary

The appellant, Dr Philip Esper, brought an appeal against by a decision of District Judge Beckley to name him in committal proceedings in the Court of Protection relating to his relative, AB.

The contempt and committal proceedings. DJ Beckley had found that Dr Esper had committed a contempt of court by breaching an order restricting his contact with AB (which followed an admission by Dr Esper to doing so). The Respondent ICB made an application to commit Dr Esper to prison; at a hearing in June 2023, District Judge Beckley decided that no sanction should be imposed for the contempt of court where it appeared that Dr Esper's compliance with court orders had improved since the time of the admitted breaches. No appeal was taken against the finding of contempt, the decision not to impose a sanction, or to the decision to hear the contempt proceedings in public. Dr Esper had made an application that District Judge Beckley should recuse himself, which was refused; again, no appeal was taken against this decision.

Poole J noted that the underlying proceedings were subject to a Transparency Order "*which prevents information being published or communicated that identifies or is likely to identify AB, and his relatives who are the other respondents in those proceedings, including Dr Esper*" (paragraph 6). However, this order expressly excludes any committal proceedings from its ambit. DJ Beckley had made "*a further order which applies to the committal proceedings, and which prevents the reporting of the names and some other specific details of AB and two of his relatives identified in his order, but which he did not extend to prevent the identification of Dr Esper. That decision not to prevent the disclosure of Dr Esper's identity is the decision central to this appeal*" (paragraph 6).

The appeal: The appeal related to the following decisions:

i) To publish a judgment naming Dr Esper as a contemnor; and

ii) To permit the publication of Dr Esper's name, while restricting the identification of AB, and two other relatives of AB who are respondents

in the Court of Protection proceedings.

Senior Judge Hilder directed that this matter be considered by a Tier 3 judge in a rolled-up hearing considering both permission to appeal and the substantive appeal. Orders were also made that Dr Esper's anonymity should be preserved pending the outcome of the appeal.

The grounds of appeal were set out at paragraph 4 of the judgment as follows:

> *i) The judge was wrong to decide that he was obliged to permit the publication of the Appellant's details and publish them in accordance with the Lord Chief Justice's Practice Direction: Committal for Contempt of Court - Open Court, March 2015 (as amended in 2020).*
>
> *ii) The judge was wrong to decide that Court of Protection Rule 21.8(5) permitted him to direct the anonymity of the other parties to the application in proceedings for contempt of court but prevented him directing the anonymity of the appellant.*
>
> *iii) The judge was wrong, to the extent that he had a discretion, as to whether he directed the anonymity of the appellant, when he:*
>
> *(a) decided that it was in the interests of justice that a contemnor who had been found to be in breach should be identified, even though no committal order was being made;*
>
> *(b) had indicated by his observations and conduct during the hearing, apparent bias against the appellant.*

In addition to submissions from the parties, the court had submissions from the Press Association and the Open Justice Project.

The legal framework: Poole J noted that the rules governing committal proceedings in Court of Protection, Civil Courts and Family Court had all been amended recently, though there were inconsistencies between the sets of rules. At paragraph 9, Poole J specifically noted that

> *iii) Whereas the COPR provide wide powers to protect the anonymity of P in Court of Protection proceedings, there are only narrow circumstances in which P or any other party's identity will be protected in contempt proceedings arising out of Court of Protection proceedings, namely those set out at COPR r21.8(5).*
>
> *iv) Whereas COPR r21.8(5) requires the court to order the non-disclosure of the identity of any party or witness only if certain conditions are met, the equivalent rule in the CPR, applies to "any person".*
>
> *v) The requirements as to the listing of a committal application in the Court of Protection, and the requirement to publish a transcript of a judgment in committal proceedings are less than clear.'*

Poole J considered both COPR Part 21 and the Lord Chief Justice's Practice Direction: Committal for Contempt of Court - Open Court, March 2015 (PD 2015).

The new COPR 21.8 states that contempt proceedings are to be heard in private if necessary for the administration of justice and one of a range of other factors was met, though the starting position was that all contempt hearings were to be in public. PD 2015 stated that 'all committal hearings' were to be held in public, save for cases with exceptional

circumstances. Poole J also reminded himself of his earlier decision in *Sunderland City Council v Macpherson* [2023] EWCOP 3. He set out his views on the apparent conflict between COPR Part 21.8 and PD 2015:

> 14. […] *There is an apparent conflict between the mandatory requirement in PD 2015 paragraph 13 that a defendant who has committed a contempt of court must be named and their name published, and COPR r21.8(5) which requires the court not to disclose the identity of a party (which would include a defendant) if the two tests of necessity within that rule are met* […]
>
> 15 […] *insofar as it relates to defendants in committal proceedings, which it clearly does, I do not read COPR r21.8(5) as applying only to those who have not, or not yet, been found guilty of contempt of court. Further, in relation to defendants who have been found in contempt of court, I do not agree that PD 2015 takes precedence over the COPR Part 21 such that publication of the name of the defendant is mandatory even if the necessity conditions of COPR r21.8(5) are met. In my view, where they are incompatible, COPR r21.8(5) prevails over PD 2015. COPR r21.8(5) applies to all parties and witnesses in committal proceedings in the Court of Protection, and at all stages – before and after any findings of contempt and/or the making of any committal order…*

Poole J summarised the overall effect of PD 2015 and COPR Part 21 thus:

> *23. In my view, PD 2015, paragraphs 14 and 15, and COPR 21 (11) and (13) as explained or qualified by COP PD 21A(4), are consistent in requiring a reasoned judgment to be given in public at the conclusion of all committal proceedings in the Court of Protection but only to require judgments to be published on the judiciary website in those cases where a committal order has been made. The making of a committal order is, in my view, a "committal decision" for the purposes of PD 2015, paragraph 14. COP PD 21A(4) qualifies COPR r21.8(13), it is not inconsistent with it.*

Poole J considered requirement to give a reasoned judgment is not necessarily a requirement to name the defendant or P or publish that judgment. However, "*COPR r21.8(5) applies to all stages of a committal application and so requires a direction not to disclose the identity of the defendant if and only if the two necessity conditions within that rule are met*" (paragraph 25). Poole J elaborated on when the requirement to name a defendant found to have committed a contempt of court arose:

> *26. Where a defendant is found to have committed a contempt of court there are inconsistencies within PD 2015 paragraph 13 and as between that provision and COPR R r21.8(5). As to the apparent internal inconsistency within PD 2015 (see paragraph 17 above), I am satisfied that, without straining the meaning of the words, it is possible to read paragraph 13 as imposing the requirements to name the defendant in public and to publish their name when they have been found to be in contempt of court, whether or not they have been made subject to a committal order. The explanation in paragraph 13(2) underlines that the court should never withhold the name of a defendant it has made subject to a committal order, but it does not follow that the first and fourth requirements of paragraph 13(1) do not apply when no committal order is made. I reject Mr O'Brien's submission to the contrary. However, the resolution of the internal inconsistency does not resolve the external inconsistency between PD 2015 paragraph 13 and COPR r21.8(5).*

Poole J considered that where there was a conflict between the COP Rules and a Practice Direction, the rules must take precedence. The court took a firmer view than it had in the *Macpherson* case, concluding that:

> *32* […] n*otwithstanding the provisions of PD 2015, judges in the Court of Protection should apply COPR r21.8(5) when considering an order for the non-disclosure of the identity of any party or witness in committal proceedings, including the defendant. Insofar as PD 2015 indicates that there is no power to order non-disclosure of the defendant's name, it should yield to COPR r21.8(5) which requires non-disclosure of the defendant's name if and only if the two tests of necessity set out in that rule are met. COPR r21.8(5) applies at all stages of a committal application in the Court of Protection, it applies to a defendant, any other party or a witness, and it applies to the disclosure of the identity of a party or witness by way of their being named in court, in a judgment and/or in a report of the proceedings.*

Non-disclosure orders: Poole J considered that "*[i]f the court makes a non-disclosure order under COPR r21.8(5), then s.11 Contempt of Court Act 1981 allows the court to make ancillary orders preventing disclosures out of court. In a Court of Protection case those orders might prevent the disclosure of information that would be likely to reveal the identity of the person whose identity is not to be disclosed, such as information about their address or their precise relationship with another person in the case*" (paragraph 33).

Poole J summarised the scenarios in which a party in contempt proceedings would be the subject of a non-disclosure order:

> *36. Accordingly, in my judgment COPR r21.8(5) requires the court to order non-disclosure of the identity of any party or witness if the two necessity conditions within the rule are met. Section 11 of the Contempt of Court Act 1981 allows for ancillary orders to ensure that the purpose of such a non-disclosure order is not defeated. However, it will be a rare case in which the two limb test allowing the court to order non-disclosure of a defendant's identity will be satisfied, and an extremely rare case where they are met in respect of a defendant found to have committed a contempt of court and/or who has been made the subject of a committal order.*
>
> *37. The first test under COPR r21.8(5) is that non-disclosure is necessary to secure the proper administration of justice* […]
>
> *38.* […] *non-disclosure of a party's identity would be a derogation from the principle of open justice which it must be established is necessary to secure the administration of justice. The requirement of necessity means that there must be no lesser measure that will secure that end – only a non-disclosure order will do. Having regard to the authorities, it seems to me that in the case of an order that the identity of a party or witness in contempt proceedings in the Court of Protection should not be disclosed, it would have to be established that,*
>
> *i) Without a non-disclosure order, the application to commit could not effectively be tried or the purpose of the hearing would be effectively defeated; or*
>
> *ii) The purpose of the proceedings within which the committal application was made would be effectively defeated; or*
>
> *iii) The parties seeking justice – which would be the applicant for the committal and any persons on*

*behalf of whom the application was made – would be deterred from bringing their application, or*

*iv) The order is necessary to protect the human rights of the party or witness, having regard to the importance of the protection of the freedom of expression protected by Art 10 of the ECHR and the extent to which the person's identity has, or is about, to become public, and the public interest in publishing their identity pursuant to section 12 of the Human Rights Act 1998; or*

*v) In some other way the proper administration of justice would be undermined.*

*40. The second limb of the test under COPR 21.8(5) enjoins the court to consider whether non-disclosure of the identity of a party or witness is necessary to protect that person's interests. Application of this test will include consideration of the protection of their Convention rights.*

*41. So far as a party who is P in the Court of Protection proceedings is concerned, it might readily be established that ordering the non-disclosure of their identity will be necessary to secure the administration of justice and to protect their interests. Depending on the particular circumstances of each case, an order for non-disclosure might be necessary:*

*i) To protect the integrity of orders made in the Court of Protection proceedings including the Transparency Order.*

*ii) To avoid disclosure of the identity of P defeating the purpose of the Court of Protection proceedings to protect P.*

*iii) To avoid disclosure of the identity of P defeating the purpose of the committal application to enforce the orders of the Court of Protection which will be designed to protect P.*

*iv) To avoid deterring the applicant from bringing a committal application (the naming of P in the committal proceedings would be a deterrent to the application to bring those proceedings).*

*v) To avoid deterring P from giving evidence whether in person or to their Litigation Friend, the police or someone else (if P's evidence were relied upon).*

*vi) To protect the Art 8 rights of P who had not chosen to bring the committal proceedings, without any corresponding significant interference with the Art 10 right of freedom or expression and without any adverse impact on the overall openness of the proceedings and the public interest.*

*vii) To protect P's other Convention rights.*

*42. So far as relatives of P who may be witnesses or parties are concerned, it may often be established that ordering the non-disclosure of their identity will be necessary to secure the administration of justice and to protect their interests. Depending on the particular circumstances of each case an order for non-disclosure might be necessary:*

*i) To protect the integrity of orders made in the Court of Protection proceedings including the Transparency Order.*

*ii) To avoid the likelihood of the disclosure of the identity of P by*

*means of jigsaw identification, thereby defeating the purpose of the Court of Protection proceedings to protect or of the committal application to enforce the orders of the Court of Protection designed to protect P.*

*iii) To avoid deterring the applicant from bringing a committal application (the jigsaw identification of P in the committal proceedings would be a deterrent to the application to bring those proceedings).*

*iv) To avoid deterring family members from giving evidence (if their evidence were relied upon).*

*v) To protect the Art 8 rights of family members who had not chosen to bring the committal proceedings and whose alleged conduct had not prompted committal proceedings, without any corresponding significant interference with the Art 10 right of freedom or expression, and without any adverse impact on the overall openness of the proceedings and the public interest.*

*vi) To protect the other Convention rights of the family members.*

*43. So far as the defendant to committal proceedings is concerned, it will rarely be established that the tests under r21.8(5) are met. Some, but not all, of the same considerations as set out above might well apply but, in most cases:*

*i) There will be a very much greater public interest in knowing the identity of the defendant who may have or has been found to have committed a contempt of court, and who may be, has been, or may have been at risk of being made subject to a committal order.*

*ii) The non-disclosure of the defendant's identity and at least some information about them would be far more likely to render a judgment or reports about the committal proceedings, empty of meaning, thereby undermining the Art 10 right to freedom of expression and the public interest in knowing about committal proceedings in the Court of Protection.*

*iii) A defendant whose conduct has been found to have been in contempt of court, will have brought the contempt proceedings on themselves, a fact which alters the balance between protecting their Art 8 rights and protecting the Art 10 right to freedom of expression. There will be an even greater importance in ensuring freedom of expression about proceedings concerning conduct in contempt of court. There would be less importance given to protecting the private life of a person whose conduct has been in contempt of court. Those made subject to court orders with penal orders attached have been warned that they may be sent to prison if they breach those orders. They must be taken to know that the courts pass sentences of imprisonment in public (or do so save in the most exceptional circumstances) and so if a court sentences a contemnor to prison (whether an immediate or suspended sentence) their names will be made public. It would be going too far to say that they have waived any right to a private or family life by being in contempt of court, but their claim to protection of their anonymity is very much weakened.*

Transparency Orders and Reporting Restrictions: Considering COPR Part 4, Poole J noted a standard Transparency Order does not ordinarily cover contempt proceedings, and committal proceedings are nearly always heard in public. As a result, any reporting restrictions made in committal proceedings would be "different or additional restrictions" for the purposes of paragraph 3 of COP PD 4A (paragraph 47). Unlike other Court of Protection proceedings (which are subject to an order making them be heard in public), no order is required for committal proceedings to be heard in public, "*and the provisions of COP PD 4A in relation to public hearings do not appear to apply*" (paragraph 48). Poole J considered that decisions regarding reporting restrictions in committal proceedings "*must rely solely on COPR r21.8(5) in relation to non-disclosure of the identity of any party or witness in the committal proceedings. Hence, if, and only if, the tests within r 21.8(5) are met, the court will order the non-disclosure of the identity of a party or witness*" (paragraph 49). Poole J noted that:

> *50. It is important to distinguish between different stages of committal proceedings. COPR r21.8(5) applies throughout the proceedings but factors making it necessary for the court to order non-disclosure of a party's or witness's identity may well change during the proceedings. What may be necessary before a finding of contempt, might not be necessary after such a finding has been made. At each committal hearing the court will have to consider whether any r21.8(5) orders must be continued – do the two necessity tests continue to apply? If there has been a finding of contempt or a committal order, does that now mean that no order should be made?*

Listing committal hearings: Poole J also noted that the names of defendants in committal proceedings must be published on listings prior to a judge hearing the relevant case. The court considered 'that COPR r21.8(5) must allow the Court of Protection to make a non-disclosure order regarding the identity of the defendant or any party or witness in committal proceedings in the Court of Protection, even before the first hearing, and regardless of the mandatory terms of paragraph 13 of PD 2015.' [52] The court suggested that as a matter of practicality, 'every committal application in the Court of Protection should be put before the appropriate judge prior to the first hearing so that the question of whether COPR r21.8(5) must prevent the identification of the defendant's name in the public court list can be considered. In the absence of any order to the contrary, the defendant's full name must appear in the list. Court listing offices need to be fully aware of that requirement. However, if the court is satisfied that the necessity tests in r21.8(5) are met, then it must direct that the defendant's name shall be anonymised in the court list. The press should be notified and may make representations at the first hearing.' [53]

Suggestions on committal proceedings: The court stated that given 'the anomalies and inconsistencies identified', further consideration should be given by the Court of Protection Rule Committee on the contempt provisions. At paragraph 54, Poole J offered the following suggestions until such consideration had taken place:

> *i) Open justice is a fundamental principle and the general rule is that hearings should be carried out and judgments and orders made in public. Derogations from the general principle can only be justified in exceptional circumstances when strictly necessary as measures to secure the proper administration of justice.*

*ii) Committal hearings may be heard in private but if the court is considering doing so it must follow the procedures set out at paragraphs 8 to 12 of PD 2015.*

*iii) Immediately upon issue committal applications in the Court of Protection should be referred to a judge to consider prior to the first hearing:*

*a) Whether COPR r21.8(5) requires that the defendant's name should not appear in the court list. In the absence of any such order, committal proceedings should be listed with the full name of the defendant appearing, in accordance with paragraphs 5 or 11 of PD 2015 depending on whether they are to be heard in public or in private. Anonymisation of the defendant on the court list would be a derogation from open justice. Notice of any such decision should be given to the press and the continuation of any r21.8(5) order considered at the first hearing.*

*b) Whether the existing Transparency Order may need to be extended to cover the non-disclosure of the identity of any party or witness in the committal proceedings. A Transparency Order made in Court of Protection proceedings will not extend to committal proceedings unless there is an express order of the court to that effect. COP PD 4C does not apply to committal proceedings. COP PD 4A only applies if a hearing in public is the result of a court order under COP R r4.3 and so does not apply to committal hearings which are heard in public unless otherwise ordered. The court in committal proceedings in the Court of Protection cannot therefore rely on an existing Transparency Order or use COP PD 4A to restrict reporting. COPR r21.8(5) appears to be the only basis for ordering non-disclosure of the identity of the defendant, other party, or witness in a committal application. It applies at all stages of a committal application in the Court of Protection. If the court is considering making a r21.8(5) order, other than in relation to the anonymisation of the defendant in the public list for the first hearing, it should adopt the procedure at paragraphs 3, 4, 8, 9, 10 and 12 of PD 2015.*

*iv) Unless ordered otherwise, the parties in the Court of Protection proceedings are the parties to the committal application within those proceedings. Accordingly, COPR r21.8(5) applies to those parties as well as to any witness in the committal proceedings. Unlike CPR r39.2(4), COPR r21.8(5) does not apply to someone who is neither a party nor a witness.*

*v) COPR r 21.8(5) requires the court to order the non-disclosure of the identity of a party or witness if the two necessity conditions within the rule are met. The Contempt of Court Act 1981 s11 applies to allow ancillary directions to be given if a r21.8(5) order is made. Such ancillary directions may include restrictions on publishing or communicating specific identifying information to prevent the disclosure of the identity of the particular party or witness to whom the r21.8(5) order applies.*

*vi) The court must order that the identity of any party or witness shall not be disclosed if, and only if, it considers non-*

*disclosure necessary to secure the proper administration of justice and in order to protect the interests of that party or witness - COPR r21.8(5). Therefore the non-disclosure of the name of the defendant, or any other party or witness, must be ordered if it meets both those requirements but cannot be ordered if it does not meet them. If a lesser order will suffice, then the order for non-disclosure may not be made. The wording of COPR r21.8(5) reflects paragraphs 3 and 4 of PD 2015, namely that open justice is a fundamental principle, derogations from which can only be justified in exceptional circumstances, when they are strictly necessary as measures to secure the proper administration of justice. It adds a second requirement to be met before the court may order non-disclosure of the name of a party or witness, namely that non-disclosure is necessary to protect the interests of that party or witness. The procedural requirements at paragraphs 3, 4, 8, 9, 10 and 12 of the PD 2015 apply.*

*vii) The court must consider the application of the tests in COPR r21.8(5) separately in respect of P, the defendant, and other parties or witnesses in the committal proceedings. Where P is a party, the court may readily find that the necessity tests in r21.8(5) are met so that it must direct the non-disclosure of the identity of P. In such a case the court may make ancillary orders under s 11 of the Contempt of Court Act 1981 to protect P's identity.*

*viii) If the conditions in COPR r21.8(5) are met in respect of the defendant, then the court must anonymise the defendant in any published judgment and must direct that disclosure of the defendant's identity shall be prohibited. The court may make ancillary orders under Contempt of Court Act s11. A convenient mechanism for making these orders would be by extending the relevant parts of the Transparency Order to the committal proceedings.*

*ix) COPR r21.8(5) is not triggered to prevent the disclosure of the identity of the defendant if the sole purpose is to protect the interests of P. It must be the interests of the defendant that need protecting. In the event of a committal order it will be exceptionally rare for the court to find that the r 21.8(5) conditions are met in respect of the defendant. In the event of a finding of no contempt of court, it will be relatively more likely that the court will find that the r 21.8(5) conditions are met in respect of the defendant, but it will still be an exception for the identity of a defendant to committal proceedings not to be disclosed.*

*x) Subject to an order for non-disclosure of the identity of the defendant being made under COPR r21.8(5), in which case the defendant must be anonymised in any published judgment and reporting of their identity prohibited, the following practice should be adopted in relation to giving judgment and naming the defendant in committal proceedings:*

*a) If the court finds the defendant not guilty of contempt of court, then COPR r21.8(11) requires the court to give a reasoned judgment in public but there is no requirement for that judgment to be published on the judiciary website, nor would the requirements of PD 2015 paragraph 13 apply so as to require the defendant to be named and his name to be published on the judiciary website. Nevertheless, the court may decide to name the defendant and to publish their name by inclusion in a published judgment or otherwise.*

b) *If the court finds the defendant in contempt of court but does not make a committal order, then a reasoned judgment must be given in public and the defendant must be named in court and their name published on the judiciary website, but there is no requirement for a transcript of the judgment to be published on the judiciary website, although the court may choose to do so.*

c) *If the court finds the defendant in contempt of court and imposes a committal order then a reasoned judgment must be given in public, the defendant must be named in court and their name and the judgment must be published on the judiciary website. The requirement to publish the defendant's name will be met by naming them in the published judgment.*

Conclusions on the appeal in Dr Esper's case: Poole J considered the grounds of appeal in turn.

The court did not consider itself bound to name Dr Esper: Poole J concluded that under COPR 21.8, the court was required to give a judgment, but was not obliged to post that on the judiciary website where no committal order was made. Dr Esper's identity was only to be subject to non-disclosure orders if the tests under COPR 21.8(5) were met. The court reviewed the transcript and found that DJ Beckley had recognised that he was not obligated to name Dr Esper publicly, and thus did not fall into error in this way.

The decision not to order non-disclosure of Dr Esper's identity: DJ Beckley considered whether it was in the interests of the administration of justice to order non-disclosure of Dr Esper's identity, and found that it was not. "*The Judge examined the circumstances of the case and determined that COPR r21.8(5) did not apply to require the non-disclosure of Dr Esper's name. He took into account that Dr Esper had been found guilty of contempt of court but had not been made subject to a committal order*" (paragraph 62). The court found that "[t]*here is no doubt that DJ Beckley was entitled in the circumstances to find that the first test in COPR r21.8(5) was not met and therefore that the order should not be made. Indeed, it would have been extremely surprising had he found that one or both tests were met. In the circumstances, he could not order the non-disclosure of Dr Esper's identity*" (paragraph 63). Poole J found that where DJ Beckley "*rightly gave a reasoned judgment in public*," he was not obligated to post this on the Judiciary website, but was free to do so at his discretion.

Permitting the public of Dr Esper's name while anonymising AB and other relatives: Poole J rejected this challenge, and noted that no appeal was taken to the decision to anonymise AB and others. "[T]*he considerations for the court when deciding whether the two necessity tests in COPR r21.8(5) are met in respect of parties other than the defendant, or witnesses, will be different from those that apply to the defendant. There is no logical inconsistency in the decisions made by DJ Beckley. Again, it would have been surprising if he had not found that the tests were not met in respect to AB, and he was clearly entitled to find that they were met in relation to AB's relatives other than the Defendant*."

Poole J also rejected challenges that DJ Beckley had behaved unfairly, and noted that there was no appeal against his decision not to recuse himself. The court also found no error in allowing reporting of Dr Esper's age and profession, noting that "[h]*aving decided that Dr Esper should be named, it seems to me that the judge was entitled to decide that it was not necessary to protect AB to restrict the reporting of Dr Esper's profession. Disclosure of Dr Esper's age would not*

*be likely to lead to the identification of AB*" (paragraph 67).

### Comment

Poole J's judgment is comprehensive in its analysis of the problems that have been caused by the disjointed way in which reforms to the law relating to contempt have been carried out. It undoubtedly lends weight to the timeliness of the Law Commission's contempt project, and, more immediately, to the need for the relevant Rules Committee to consider what can be done in the interim.

## Short note: best interests in the absence of wishes and feelings, and transparency on death

The decision of Poole J in *Hillingdon Hospitals NHS Foundation Trust v IN & Ors* [2023] EWCOP 32 is of wider relevance for two reasons. The first related to observations made in the course of the substantive determination of the application. The second related to the question of anonymity.

A hospital Trust applied for a decision that continued life-sustaining treatment was not in the best interests of a man who had suffered a serious brain injury and had been in a coma for six months. The man's daughter and brother opposed the application, not disputing the medical analysis, but contending that he would have wanted clinically assisted nutrition and hydration to continue so that he could be kept alive as long as possible, on the basis that he was a "fighter" whose Christian faith would have led him to believe that God might perform a miracle to bring him back to consciousness and a fuller life. Applying decisions made in the context of children, Poole J made the important observation at paragraph 34, that, even if "*IN cannot experience pain, it does not follow that continued treatment is not burdensome – see King LJ in Re A (A Child)* [*2016] EWCA Civ 759*, *and Baker LJ in Parfitt v Guy's and St Thomas' Children's NHS Foundation Trust* [*2021] EWCA Civ 362*, *at [61]. IN's condition and the interventions required to keep him alive are burdens even if he is unaware of them.*" Conversely, Poole J continued, "[i]*n like manner, I should also consider the wider benefits to him of continuing CANH even if he is unable to experience pleasure.*" Poole J also joined the growing number of judges who have made clear that they do not find the concept of 'dignity' to be of assistance – at least in isolation - noting at paragraph 36 that: "*I do not find it helpful to co-opt the notion of "dignity" - to suppose that the managed withdrawal of life-sustaining treatment as opposed to continuing such treatment enhances innate human dignity. He would not be in "anguish" as his daughter has said she fears. The plan for palliative care is designed to prevent that. For some, there is dignity in a managed death, for others there is dignity in fighting for life and survival. Human dignity is a very important concept in decisions about end of life care and it is recognised and respected by application of the principles in the MCA 2005 and the authorities, and by an intense focus on IN's best interests. However, based on the evidence I have received about IN's character, I am sure that he would have preferred a peaceful death if only to protect his family from avoidable distress.*" This was also a situation in which Poole J considered that it was not possible to ascertain IN's own wishes and feelings, and – importantly, requiring separate consideration – that his beliefs and values may or may not have led him to discontinue CANH. The ultimate decision was that continuation was no longer in IN's best interests.

In the first reported Court of Protection judgment to do so, Poole J expressly applied the approach set down (in relation to children) by the Court of

Appeal in Abbasi,[7] noting that the decision "applies equally to the Court of Protection where [Transparency Orders] are commonly made to cover a wide range of healthcare professionals and to last 'until further order'" (paragraph 45). Applying the 'intense focus' he considered required to the Articles 8 and 10 ECHR rights engaged, Poole J reached the following conclusions (at paragraph 47):

> *This case has not previously been the subject of reporting. Information is not already in the public domain. The family members have expressed no wish to publicise matters in or arising from this case. However, there is an interest in such Court of Protection proceedings involving end-of-life decision-making. This is not a case where there has been adverse commentary on social media or elsewhere directed to the hospital or healthcare professionals. There are only a few healthcare professionals whose identities are relevant to the proceedings. It is important that those professionals feel enabled to carry out their functions without the fear of hostility. It is a fact that whilst some will regard it as unethical to continue CANH in a case such as this, others will regard the withdrawal of CANH as unethical and deserving of condemnation, including personal condemnation of those responsible. Of course, Judges who make these decisions are named but healthcare professionals are more commonly involved in these difficult decisions and it is important that they are able to make those decisions free from untoward interference. In the present case the Trust invites the court to discontinue the injunction against reporting in relation to the hospital and the identified clinicians at the hospital until after IN's death. I shall direct that those parts of the injunction shall be discharged 7 days after IN's death unless there is a further or other order of the court. The reporting restrictions in respect of IN and members of his family shall remain until further order. AN does not wish IN to be identified. MN was content to leave that decision to the Court. I am satisfied that the continued anonymisation of IN, and therefore of members of his family (to avoid jigsaw identification) will not so adversely affect the Art 10 rights of those who wish to comment or report on this case as to justify what would be a significant interference with the Art 8 rights of IN's family were his and their names to be made public. Accordingly, the TO will remain in place until further order in relation to the identification of IN and family members. I shall delete the reference to "attendees" in the TO – it was not made clear to me who those persons were (beyond the clinicians and the family members). Dr Hanrahan, as an expert, may be named. I vary the TO accordingly.*

Whilst not disagreeing with the decision reached at paragraph 47, it is perhaps important to note that Poole J may not have been on entirely firm ground in aligning himself with the assertion of Mostyn J in *Re EM* [2022] EWCOP 31 that transparency orders are conventional reporting restriction orders, requiring the carrying out – in each case – of the detailed balancing exercise required in the latter cases. As Alex has explained in relation to *EM*, the position in relation to transparency orders made by the Court of Protection is more nuanced, as they do not involve a position where proceedings previously being held in public are being 'shut down' in some way. Rather the operation of the Transparency Practice Direction relates to the application of a general provision guiding judges

[7] Note, the Supreme Court has given permission to the Trusts involved to appeal.

as to the application of the balancing exercise in circumstances where Parliament has decreed that the starting point is that the tap of publicity is off and the court is deciding whether to turn it on. In such circumstances, the making of the 'ordinary' transparency order represents an implicit – and we would suggest sufficient – judicial determination that the appropriate balance remains that set out in the Practice Direction.

That having been said, it is undoubtedly necessary to be careful before allowing a transparency order made at the beginning of proceedings simply to roll on into the future after the end of proceedings (including, as here, the death of the person) without fresh consideration.

## The Court of Protection faces an agonising dilemma (and why belief is not the same as proof)

*Barnet Enfield And Haringey Mental Health NHS Trust & Anor v Mr K & Ors* [2023] EWCOP 35 (John McKendrick KC, sitting as a Tier 3 Judge)

*Medical treatment – best interests*

### *Summary*

*This case concerned* the health and welfare of a 60 year old man, Mr K, and in particular the relief necessary to protect him from his resistance to the treatment of his chronic bilateral venous leg ulcers. He was subject to a standard authorisation in a care home following five years spent in a mental health facility in which he was not detained but which he refused to leave. He suffered from persistent delusions and paranoia and refused to engage with professionals. He had a long-standing heart condition which made any treatment against his will extremely difficult to carry out. Previous orders made by the Vice President of the Court of Protection, Theis J, had authorised his successful conveyance from hospital to a care home with provision for physical and chemical restraint – neither of which was in fact required. He had longstanding leg ulcers which he had previously treated himself. He refused to allow staff or other medical professionals to assist him or assess them.

In light of the evolving medical evidence (from both treating and independent clinicians), and evolving care plans, produced at considerable speed – and by clinicians during the course of the junior doctors' strike in England – John McKendrick KC summarised the dilemma faced by Mr K at the point the court had to decide, at speed, what to do:

> *62 […]. On the one hand, he needs an urgent assessment of, and treatment for, his chronic bilateral venous leg ulcers. Without this, the evidence suggests, an infection may become sufficiently serious that amputation of both legs below the knee will be indicated. He remains resistant to professional assessment of his ulcers at B Home. He remains resistant to being returned to hospital for investigations and treatment. As far back as 26 June 2023 serious concerns were raised in respect of the urgent necessity of treatment of the ulcers. A member of staff noted they could see bone appear in the wound. After a short period of time in Mr Ks' room, the manager of B Home rushed out to vomit, over-powered by the smell of the wounds. Urgent safeguarding concerns were raised at round table meeting in June 2023.*
>
> *63. Mr R, the Manager at B Home has provided an alarming level of detail of concern. He states that in his opinion Mr K's wounds are severely infected and malodorous. He says "the ankle bone is visible and seriously infects skin is hanging down his leg". He thinks the wounds have not been dressed since 17*

> *July 2023. He states that Mr K screams in pain, mainly at night. Notwithstanding this, Mr K refused assistance from B Home staff and from tissue viability nurses and will "never allow anybody to touch his leg and will retaliate with force if someone tries ". Paramedics have been called in May and June but Mr K refused to engage.*
>
> *64. On the other hand, as a result of his documented cardiac problems, the evidence from the cardiologists and experts in anaesthesia suggests, for now at least, that the use of chemical and physical restraint poses significant risks to Mr K if conveyed to hospital against his will. Further, should he remain resistant to treatment when in hospital and therefore require longer term sedation, the risks of prolonged chemical sedation are significant.*
>
> *65. Even if he were to be conveyed to hospital and underwent the necessary investigations set out above in the vascular evidence, there is a reasonable likelihood that any procedure which involves a general anaesthetic would be contrary to his best interests because of the risks it poses to his cardiac ill-health and in any event may not be an option and clinicians may not provide it.*
>
> *66. This is the stark background that confronts the court. Mr K is in a parlous state.*

Proceeding in stages to seek to resolve the dilemma, the first question was as to Mr K's capacity. John McKendrick KC noted at paragraph 57 that:

> *Section 48 of the 2005 Act has most recently been considered in the cases of: (i) Local Authority v LD [2023] EWHC 1258 (Fam) (Mostyn J) and (ii) DP v London Borough of Hillingdon [2020] EWCOP 45 (Hayden J). I take from these authorities that the language of section 48 needs no gloss and that the court need not be satisfied, on the evidence available to it, that the person lacks capacity on the balance of probabilities, but rather a lower test is applied. Belief is different from proof. Section 48 requires: 'reason to believe that P lacks capacity.' Section 2 requires: 'whether a person lacks capacity within the meaning of this Act must be decided on the balance of probabilities'. That being said in a case of this nature, where medical treatment is being considered which the patient does not consent to, the court must be satisfied there is evidence to provide a proper basis to reasonably believe the patient lacks capacity in respect of the medical decision.*

On the basis of the material before him, in a situation where no party sought to persuade him that Mr K had capacity in respect of the treatment of his ulcers, John McKendrick KC was "*entirely satisfied*" (paragraph 68) that there was reason to believe that Mr K lacked the material capacity. He made a declaration to this effect under s.48. Upon receipt of the draft judgment, Counsel for the Official Solicitor questioned whether he should make such declarations in light of the decision of Hayden J in *DP v LB Hillingdon* in which the former Vice-President had questioned (in the context of s.21A proceedings) whether there was such a power, as opposed to simply making a judicial 'finding'. John McKendrick KC amplified his reasoning accordingly, from the starting point that it was desirable that the Court retains the power to make interim declarations in respect of capacity (paragraph 102):

> A *determination that there is reason to believe P lacks capacity in relation to the matter, is an important steps which establishes the court has jurisdiction to make best interests orders in respect of*

> *P, if additionally the section 48 (c) test of 'without delay' is met. The declaration should be precisely worded to make clear the matters in respect of which the court has jurisdiction. A finding is a less precise basis upon which to exercise the court's jurisdiction.*
>
> *103. Therefore I add to the [relevant paragraph] that I am making a section 48 order and an interim declaration pursuant to section 47 of the 2005 Act and COP Rule 10.10. (1) (b).*
>
> *104. I have not heard argument on this narrow matter, as there is a pressing need to hand down judgment and approve the orders to permit the assessment at B Home to take place tomorrow, so if I am wrong in respect of this analysis, I also apply the learning of paragraph 40 of DP v London Borough of Hillingdon and make a finding in the same terms as the interim declaration. Through either route, as there can be no further delay, the best interests orders above are made for Mr K, who needs the Court's protection.*

As regards best interests, and whilst the last paragraph above gives a spoiler, John McKendrick outlined how there were (at least) four options: await further evidence; provide for an order to permit urgent investigation, assessment and interim treatment at B Home; convey him to hospital; and persuade Mr K to attend hospital. The first option was not viable. The third was, at this stage, too risky, but it was finely balanced, given that:

> *73.* […] *on the evidence of the vascular surgeons, that some form of inpatient investigations will be needed, for scans etc to assess the damage to Mr K's venous and arterial system and to assess whether or not his wounds are capable of healing. Option three is not currently in his best interests, but I anticipate that the evidence which emerges from the assessment to take place this week (see below) and the evidence from the two experts instructed by the Official Solicitor, will result in the court confronting the acutely difficult dilemma of balancing the risks to Mr K's physical and psychological health of non-admission to hospital and therefore limited treatment at B Home for his chronic bilateral venous leg ulcers, against the cardiac risks of chemical and physical restraint in, or being conveyed, to hospital. This will be a difficult balancing act and will require clear, expert evidence to assist the court to undertake the balancing exercise in Mr K's best interests.*

The fourth option was potentially viable, given that there was a different hospital under the management of a different Trust Mr K had previously spoken very highly of. This was an option that had to be explored at speed, but if it was not going to be possible, John McKendrick KC found himself in a position where he had to endorse option 3, for assessment and treatment to take place at the care home, including with the use of chemical and physical restraint as a last resort, prior to a further hearing to consider the next steps.

## Comment

The dilemma faced by all concerned was acute, and could not be avoided – although, as so often, it is difficult not to want to ask as to all the points along the way at which other options might have presented themselves for Mr K and those concerned with his welfare. John McKendrick KC's careful examination of the position that now prevailed, and – in particular – his concern to ensure that each step on the restriction ladder would be as carefully tested as time would allow, is a very useful 'worked example' of how to proceed in thinking through such dilemmas.

Of wider interest, at least to procedural enthusiasts, is the judge's crisp analysis of the vexed issue of s.48. His summary of the threshold and of the ability of the court to make interim declarations would, we would suggest, draws a line under what had become an unnecessarily complicated debate. And his observation that 'belief is different to proof' is clearly of relevance also in relation to those applying s.5 MCA outside the court room setting, who are held to the standard of a 'reasonable belief' in the person's lack of capacity to consent to the relevant act(s) of care and treatment.

## Legal aid – some good news

Reflecting commitments made in the response to the Legal Aid Means Test Review, the Criminal and Civil Legal Aid (Amendment) Regulations 2023 (SI 2023/745) have been laid before Parliament. The SI amends the civil and criminal legal aid means tests to remove the means test for:

- Individuals under the age of 18 applying for criminal advice and assistance;
- Individuals under the age of 18 applying for all civil legal representation (including Exceptional Case Funding representation) and family help (higher);[8]
- Legal representation for parents of, or those with parental responsibility for, a child (aged under 18) facing the withdrawal or withholding of life-sustaining treatment; and
- Legal help relating to inquests where, if the individual were to make an application for Exceptional Case Funding (ECF) representation, due to a breach of Human Rights, or, where the Director of Legal Aid Casework thinks there is a significant wider public interest in legal aid being provided, it would be reasonably likely to succeed.

The SI will also make amendments so that determinations of legal help for inquests can be dated to an earlier date than the determination itself, so that legal aid providers can continue to claim for legal help carried out prior to the date of determination.

The changes made by this SI, except for the legal help assessment for inquests, came into force on 3 August 2023. The changes for legal help for inquests came into on 4 September 2023.

## Short note: good practice in life-sustaining treatment cases

*Alder Hey Childrens NHS Foundation Trust v D & Ors* [2023] EWHC 2000 (Fam) and [2023] EWHC 1997 (Fam)[9] concerned a 14 year old boy who had been in hospital for over a year, and was suffering from a range of medical conditions which meant that he required artificial ventilation and would not be able to be discharged home.

We mention the case here to identify one point of relevance to medical treatment cases involving adults, and one important point of difference.

D's mother supported the withdrawal of active treatment, but his father did not. D's was conscious, and experienced significant pain but was also seen to respond with pleasure. He was not asked for his views because of the distress it would cause him and the difficulty in eliciting a meaningful response. In the first hearing, the court refused to grant the declarations sought by

[8] See further in this regard also the updated guidance from the Lord Chancellor at section 2.7, which also addresses the situation where the child turns 18.

[9] Katie was involved in the case, but has not contributed to this note. Despite the neutral citation number being higher, the decision reported as [2023] EWHC 2000 (Fam) came before the decision reported as [2023] EWHC 1997 (Fam)

the Trust such that active treatment would cease, notwithstanding that those declarations were supported by both the child's mother and his Guardian. Instead, the court directed further expert evidence to be obtained from a neurologist, and a paediatric intensivist – there having been no independent second opinion previously obtained in the latter discipline. Morgan J identified (*Alder Hey Childrens NHS Foundation Trust v D & Ors* [2023] EWHC 2000 (Fam) at paragraph 110) that such a practice was 'routine' in cases involving children and – we would suggest – involving adults.

The two experts duly reported and concluded that there was no realistic prospect of the child's situation improving. He could live for years in ITU in a minimally conscious state, but could equally succumb to an infection or other complication and die much sooner. The court concluded that continued treatment was not in his best interests, because the burdens of his condition and the treatment required to keep him alive outweighed the ability he had to derive comfort and pleasure from the company of his family.

We note that the independent neurologist applied the 2013 Royal College of Physicians Guidance to determine that C was in a minimally conscious state (*Alder Hey Childrens NHS Foundation Trust v D & Ors* [2023] EWHC 1997 (Fam)). We have no reason to question the conclusions reached, but it is perhaps important to note both that the 2013 guidance has been superseded by a 2020 iteration, and that the 2020 guidance expressly states that it is to apply to those aged 16 and above (see page 14). Caution must therefore be exercised before applying it to those under 16.

# THE WIDER CONTEXT

## The CQC and restrictive practices

*The CQC published on 3 August a new cross-sector policy position statement on restrictive practice, as follows:*

> *In all services CQC expects care to be person-centred. We expect providers to promote positive cultures which support recovery, engender trust between patients and staff, and protect the safety and wellbeing of all patients and people using services. They must listen to and seek to understand people, including how people communicate their needs, emotions, or distress. This understanding must be used to support adjustments that remove the need to consider the use of any restrictive practice. The focus needs to shift to one which respects all patients' rights, provides skilled, trauma-informed therapy, follows the principle of least restriction, and promotes recovery.*
>
> *We recognise that the use of restrictive practices may be appropriate in limited, legally justified, and ethically sound circumstances in line with people's human rights. An example may be where there is no other option but to restrain a person to avoid harm to themselves or others. Restrictive practice must never be used to cause pain, suffering, humiliation or as a punishment. Regardless of which registered service any restrictive practice occurs in, CQC expects that the board or equivalent will analyse incidents and work to reduce them.*
>
> *Wherever restraint, seclusion or segregation is perceived to be the only safe option, providers must consider whether services were provided which met the needs of the individual and are preventative in their approach to stop situations reaching crisis point. This must include considerations of any failures in people's care, learning or gaps in listening to and understanding people, and the required proactive system wide joined up working. We expect providers to respond to any restrictive practice by organising timely therapeutic interventions for the person/s subjected to the restrictive practice, to address any trauma caused to them, and to support their future wellbeing.*
>
> *We will take appropriate enforcement action wherever care falls below the fundamental standards people have a right to expect.*
>
> *We will hold registered persons to account where we have evidence that they have failed to comply with regulations 12 (safe care and treatment) or 13 (safeguarding service user from abuse and improper treatment) in this context, and this has resulted in avoidable physical or psychological harm to people, or people being exposed to significant risk of it.*

## Social Work England consults on best interests assessor training standards

Social Work England is consulting on the standards that it will use to approve and monitor BIA courses. SWE has had responsibility for BIA courses since it came into being in December 2019, but had previously not taken steps in relation to BIA courses because it – along with everyone else – was under the impression that the BIA role was shortly to cease to be relevant. The consultation ends on 26 October 2023. You can respond by answering an online feedback survey or by email (with 'BIA consultation' as the subject line).

## "Proportional assessments," remote assessments, the Care Act and the MCA

Chief social worker for adults Lyn Romeo and principal social workers have issued (8 August 2023) guidance on carrying out proportionate assessments under the Care Act 2014. As it says in the introduction:

> *This guide, written in partnership with principal social workers, offers a series of suggestions and case studies to help practitioners, their local authorities and trusts consider the positive lessons learned and opportunities from the pandemic to adjust practice in a person-centred way. It will also help professionals think carefully about how they respond in line with the Care Act 2014 in proportionality and work alongside people (and their carers) who are in need of care and support. This is a supplementary guide to the Care Act 2014 and Care and support statutory ('CASS') guidance.*

The guidance will no doubt provoke important discussions about the meaning of proportionality. However, for present purposes, we focus on the guidance note's discussion of capacity. Having set out a range of ways in which assessments can be carried out flexibly under the Care Act, including discussion of remote / virtual assessments, it has a section on mental capacity and deprivation of liberty, as follows:

> *The same flexibility is not allowed for in the application of other legislation. For example, mental capacity assessments will always need to be completed in person, and the principles of the Mental Capacity Act 2005 must underpin assessments where there is a proper reason to doubt that the person has the capacity to make the decision in question. Most deprivation of liberty safeguards assessments should be face to face in order to, for example, meet any communication needs of the person.*
>
> *An important principle of the Mental Capacity Act 2005 is that it must be assumed that the person has capacity unless it is established that they lack capacity. Assuming capacity, however, should not be used as a reason for not assessing capacity in relation to a decision. There should always be an assessment where there are doubts about a person's capacity to make a decision.*

It is from our perspective very helpful that this section emphasises the need to consider capacity where there is proper reason to do so – as the courts have reminded us:

> *The presumption of capacity is important; it ensures proper respect for personal autonomy by requiring any decision as to a lack of capacity to be based on evidence. Yet the section 1(2) presumption like any other, has logical limits. When there is good reason for cause for concern, where there is legitimate doubt as to capacity* [to make the relevant decision]*, the presumption cannot be used to avoid taking responsibility for assessing and determining capacity. To do that would be to fail to respect personal autonomy in a different way.*

It is, however, somewhat unfortunate that the second sentence in the section from the guidance set out above is wrong when it asserts that "mental capacity assessments will always need to be completed in person." This is undoubtedly the case in relation to assessment for admission under the MHA 1983 (whether it is also the same in relation to renewals of detention under the MHA 1983 is a question currently before the courts). That this is not the case in relation to assessments under the MCA was confirmed by the then Vice-President of Court of Protection in *BP v Surrey County Council & Anor* [2020] EWCOP 17:

> *37. [*citing from a guidance document he had issued]*: Can capacity assessments be undertaken by video when it is established that P is happy to do so and can be "seen" alone?*
>
> *Suggested solution: In principle, yes. The assessor will need to make clear exactly what the basis of the assessment is (i.e. video access, review of records, interviews with others, etc.) Whether such evidence is sufficient will then be determined on a case by case basis. It is noted that GPs are rapidly gaining expertise in conducting consultations by video and may readily adopt similar practices for assessments. Careful consideration will need to be given to P being adequately supported, for example by being accompanied by a "trusted person." These considerations could and should be addressed when the video arrangements are settled. It should always be borne in mind that the arrangements made should be those which, having regard to the circumstances, are most likely to assist P in achieving capacity.'*
>
> 38. Accordingly, though I recognise the challenges, I consider that the outstanding assessment by Dr Babalola can be undertaken via Skype or facetime with BP being properly prepared and supported by staff and, to the extent that it is possible, by his family too.

As we noted in our guidance note on assessing and recording capacity:

> Remote assessment undoubtedly poses particular challenges, and requires considerable creativity if it has to be undertaken. It should never be undertaken simply for administrative convenience.
>
> Some of those challenges, and ways in which it is proving possible to overcome those challenges, are discussed in this *webinar* led by Alex for the National Mental Capacity Forum. However, the following key points are crucial:

- None of the fundamentals set out above, or below, are altered by the need to conduct assessments remotely. However, preparation – including identification of the decision in question and the information relevant to the decision – becomes all the more important. Indeed, some DoLS assessors have identified that this process means that they are ultimately more confident that the assessment that they have reached is robust than might have been the case when they carried out such assessments previously;

- The requirement is always on the assessor to explain why, on the balance of probabilities, they have reached the conclusion that they have as to the person's capacity. Where assessments are taking place remotely, it may well be that the evidence that they take into account includes a considerable amount of 'triangulation' of the evidence that they have gained by way of the (remote) assessment of P themselves. In a limited number of cases, this surrounding evidence may have to do all the work because it is simply not possible to interact even in a limited way with P remotely;

- In some cases, assessors have identified that, in fact, providing P with technology and enabling a remote assessment constitutes a practicable step to supporting them to make their own decision – for instance, an autistic person who is more comfortable talking by video than face to face.

## 'Warehousing' and the limits of appropriate

## treatment under the MHA 1983 – important new Upper Tribunal case

*SF v Avon and Wiltshire Mental Health Partnership* [2023] UKUT 205 (AAC) (Upper Tribunal (UTJ Church))

*Mental Health Act – treatment for mental disorder*

The issue facing the Upper Tribunal in this case was crisply delineated by UTJ Church thus:

> *1. This appeal is about RB, a woman with a primary diagnosis of autism spectrum disorder and a secondary diagnosis of complex post-traumatic stress disorder. RB was at the relevant time detained in hospital for treatment under section 3 of the Mental Health Act 1983 (the "MHA").*
>
> *2. An application was made to the First-tier Tribunal to review her section and it was the tribunal's job to hear evidence and argument and to decide whether the criteria set out in section 72(1)(b) MHA were satisfied. If they were not, it had to discharge her section.*
>
> *3. The circumstances of this case are very distressing. By all accounts, RB was very unwell and unhappy. The witnesses from the clinical team accepted that RB needed psychosocial support, but this was not available in her current setting on an acute psychiatric ward at Fountain Way. They accepted that being on such a ward was "not beneficial" to RB's mental health. However, the witnesses from the clinical team didn't support RB's discharge because they held justifiable worries that, were her section to be discharged, RB might harm (or even kill) herself, or harm others.*

The First Tier Tribunal had identified that:

> *16. All the professional witnesses who gave evidence agreed that an acute psychiatric ward was not beneficial to [RB's] mental health. This, however, was not the test we are required to apply. We fully accepted that the treatment provided to [RB] was not tailored to her diagnosis, and the essential psychosocial work was not available on this acute ward. We did, however, conclude that medical treatment for the purpose of preventing a worsening of the symptoms or manifestations of her disorder, is available, appropriate and necessary. In reaching this decision we reminded ourselves of the guidance provided in DL-H v Partnerships in Care & SoSJ [2014] AACR 16 and DL-H v Devon Partnership NHS Trust v SoSJ [sic] [2010] UKUT 102 (AAC). We decided that [RB's] refusal to engage with most of the professionals and the limited therapies available on this ward did not negate the availability nor appropriateness of that treatment. […] The treatment available today was OT and art therapy. Intensive 1:1 observation sought to protect [RB] against significant acts of deliberate self-harm which might otherwise prove fatal. [RB's] physical health was closely monitored because she restricted her diet. As recently as the last week she has been referred to the general ward following concerns regarding her deteriorating physical health. When appropriate, sedative medication had been administered with [sic] in the last week or so to protect [RB's] own safety but also protect nursing staff from her outbursts. […] In relation to Ms Wall's closing submissions, we decided that the current treatment did offer a therapeutic benefit to [RB] in the short term. The outcome was that [RB] had been prevented from harming herself (perhaps even fatally) and others around her were kept safe.* [emphasis added]

UTJ Church noted that the underlined finding was a "striking" one (paragraph 26). He further

noted that:

> *31. Each of the First-tier Tribunal's findings as to the purpose of the interventions provided relates solely to concerns for RB's physical health or for her physical safety and the physical safety of those attempting to care for her. The First-tier Tribunal acknowledged this in paragraph [16] of its decision with reasons.*
>
> *32. The First-tier Tribunal didn't need to be satisfied that the treatment available would "serve to treat the overarching autism long-term", but it did need to be satisfied that the treatment available at least had the purpose to "alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations" (section 145(4) MHA).*

Critically, in relation to restraint, UTJ Church accepted that:

> *36. Restraint, whether physical, mechanical or chemical, can form a legitimate part of a patient's treatment plan, but that doesn't necessarily mean that it amounts to "medical treatment" in the MHA sense. To do so it must have the purpose of (at a minimum) preventing a worsening of relevant symptom or manifestation (in this case RB's urge to harm herself or others). In the case of a neurodiverse patient such as RB such an outcome does not seem likely. Indeed, such an intervention is likely to exacerbate a neurodiverse patient's frustration and need for control and to increase their anxiety.*

This led him to make the following important observations:

> *38. If the requirement for appropriate medical treatment could be satisfied simply by confining someone with mental disorder in a way that prevents them from engaging in risky behaviour arising from a symptom or manifestation of their mental disorder, this would mean that all manner of interventions would amount to treatment in and of themselves, such as confinement in a soft room, sedation, and mechanical restraint, and nothing else would be required.*
>
> *39. If such 'treatment' satisfied section 72(1)(iia) then there is no reason why it shouldn't continue to do so for as long as the symptoms or manifestations persist. If such 'treatment' stands no real prospect of achieving any therapeutic purpose beyond preventing physical harm, then this could result in indefinite detention (subject to periodic review under sections 66, 68(2) and 68(6) MHA)).*

UTJ Church was satisfied Parliament could not have intended that the kind of "stasis" described should be permitted (paragraph 41):

> *If it was intended that detention for the sole purpose of ensuring physical safety were to be permitted then there was no need for section 72(1) MHA to make any reference to medical treatment at all. Rather, it could have said that the tribunal shall direct the discharge of a patient liable to be detained otherwise than under section 2 if it is not satisfied:*
>
> > *a. that he is then suffering from mental disorder or from mental disorder of a nature or degree which makes it appropriate for him to be liable to be detained, and*
> >
> > *b. that it is necessary for the health or safety of the patient or for the protection of other persons that he should be detained, and*
> >
> > *c. (in the case of an application by virtue of paragraph (g) of section 66(1) MHA, that the patient, if*

> *released, would be likely to act in a manner dangerous to other persons or to himself.*
>
> *42. The fact that section 3 is headed "Admission for treatment", and the fact that the purpose of treatment runs through all but the last of the criteria in section 72(1), indicates that to interpret the provisions as permitting detention where the only treatment available is provided for the purpose of maintaining physical safety, without treating the mental disorder itself, would be to frustrate parliament's statutory purpose.*

Nor did UTJ Church consider that OT, art therapy and discharge planning satisfied the necessary s.72 criteria. In relation to the latter, and in an observation with wider resonance, he noted "[w]*hile the First-tier Tribunal reached the conclusion that discharge planning was "part of the treatment" it is by no means clear what was actually being done by way of preparing for RB's discharge. If discharge planning had reached stasis then it is difficult to see how it can be said to have been 'available'*."

Drawing the threads together, therefore, UTJ Church identified that:

> *50. 'Appropriate medical treatment' can only mean treatment that is appropriate to the relevant patient's particular needs. While it is accepted that to satisfy the requirement in section 72(1)(b)(iia) the treatment available need not be the best or the most comprehensive treatment that could be provided, but it cannot be the case that treatment that is wholly inadequate for a patient's needs can satisfy that test.*
>
> *51. This case is unusual in that the First-tier Tribunal reached a clear finding of what treatment RB required (psychosocial support) and an equally clear finding that such treatment was not available at the hospital in which she was detained. Importantly, the First-tier Tribunal characterised that treatment as 'essential'. 'Essential' does not mean 'ideal', or 'desirable' or 'the most appropriate'. It means that nothing else will do. If treatment that was 'essential' was not available, it must follow that the treatment that was available was not, by itself, 'appropriate'.*

UTJ Church made clear that he considered that his interpretation of "appropriate medical treatment" was compatible with the decision of in *Rooman v Belgium* [2019] ECHR 105, in which the Grand Chamber of the European Court of Human Rights had recalibrated the approach to be taken in the context of mental health detention, and that, in consequence,

> *54.* […] *the First-Tier Tribunal erred in law in deciding that 'appropriate medical treatment' was available to RB at Fountain Way because its decision was based on two misunderstandings:*
>
> *a. that interventions which had the purpose merely of containing risk of physical harm, were capable of amounting to 'medical treatment'; and*
>
> *b. that medical treatment may be 'appropriate' even where it is "not tailored to [the patient's] diagnosis", and where treatment that is "essential" is not available.*

UTJ Church did not rule on the second ground of appeal, in relation to the FTT's refusal to adjourn the application, although he noted that "[g]*iven its obvious discomfort about the unsatisfactory nature of the situation, it is perhaps surprising that it didn't take the opportunity to agree to the adjournment application to explore whether the risks to RB's safety could be managed more appropriately in the community with appropriate*

*aftercare. Had it not reached the firm findings that it did (about what was 'essential' treatment and what was available in hospital) such a decision would have been open to it. Indeed, it would have been entitled to adjourn of its own motion to seek such information*" (paragraph 56).

### Comment

Although based on specific facts, the observations of UTJ Church about appropriate treatment (informed as they were by the approach taken by the ECtHR in *Rooman*) are both of wider application and considerable significance, in particular – but not exclusively – in the context of neurodiverse patients. SF's circumstances bear strong resemblances to many who are 'stuck' in hospital, and the decision should (at a minimum) make it much more difficult to assert that they meet the criteria for detention under the MHA 1983. Difficult questions may arise at that point as to whether (if they lack capacity to consent to their residence care arrangements) they could be deprived of their liberty under the DoLS framework, or whether the *Rooman* tightening of the approach would also make it equally inappropriate to rely upon DoLS in such circumstances, but the decision of UTJ Church is to be welcomed for its very clear and crisp delineation of the fact that many conventional assumptions about the breadth of the definition of mental disorder are simply wrong.

The irony of this decision being handed down at the point when *The Times* reports that the process to amend the Mental Health Act may be about to come to a grinding halt will not be lost on many.

## Section 117 MHA, after-care, and ordinary residence: the Supreme Court gives clarity

*R (on the application of Worcestershire County Council) v Secretary of State for Health and Social Care* [2023] UKSC 31 (Supreme Court (Reed, Hamblen, Leggatt, Burrows and Richards SCJJ))

*Other proceedings – judicial review*

### Summary

The Supreme Court has clarified one aspect of the perennially thorny question of responsibility for funding aftercare under s.117 MHA 1983. In *R (on the application of Worcestershire County Council) v Secretary of State for Health and Social Care)* [2023] UKSC 31, the court was concerned with the situation where, after being discharged from hospital the person in question, JG, moved from the area of one local authority (Worcestershire) where she was ordinarily resident to the area of a second local authority (Swindon), where (in accordance with s.117) she was provided with after-care services by Worcestershire. She was then compulsorily detained in hospital for a second time. At that point, the question became which local authority was responsible after she was discharged from hospital: Worcestershire or Swindon?

At first instance, Linden J held that Swindon was responsible; the Court of Appeal reached the opposite conclusion. Swindon appealed; the Secretary of State cross-appealed seeking to uphold the decision on a ground rejected by both courts below.

Worcestershire's primary case was that its duty to provide after-care services for JG under s.117 ended upon the second discharge. Its alternative case was that the duty ended at the start of the second detention. If either argument is correct, it followed that Swindon, and not Worcestershire, had a duty to provide after-care services for JG after the second discharge on the premise that, as the courts below held, JG was ordinarily resident in the area of Swindon immediately before her second detention. The Secretary of State disputed that premise. He submitted that

applying the reasoning of the Supreme Court's decision in *R (Cornwall County Council) v Secretary of State for Health* [2015] UKSC 46, Worcestershire's placement of JG in a care home in Swindon did not change where she was ordinarily resident, which as a matter of law continued to be in Worcestershire. In applying s.117(3), the Secretary of State argued, the area in England in which JG was ordinarily resident immediately before the second detention was therefore Worcestershire.

Lords Hamblen and Leggatt (with whom Lords Reed, Burrows and Richards agreed) first analysed Worcestershire's arguments on the premise that JG was ordinarily resident in Swindon immediately prior to the second detention. As they identified, the conundrum was that, prima facie, both local authorities owed her obligations upon the second discharge, but that:

> *30. It has, however, been common ground throughout these proceedings that Parliament cannot have contemplated that two parallel duties, owed by two different local authorities, to provide after-care services for the same individual should exist at the same time. This would be a recipe for disputes between local authorities and risk logistical chaos. No party to this litigation, and no judge, has suggested that section 117 should be interpreted as having this result. The question that arises, therefore, is how (if at all) section 117 can properly be interpreted in a way that avoids such an unacceptable outcome and identifies only one of the two local authorities which are prima facie responsible as having a duty to provide after-care services for JG under section 117(2) following the second discharge.*

Three potential ways through the conundrum were put forward. The Supreme Court were not attracted by Worcestershire's first suggestion (which had been the view taken by Linden J), namely that its duty to provide after-care services ended on the second discharge. This would mean reading into the statute that the duty terminated where a duty was owed by another authority. The problem was that this required wording to be read into s.117(2) in circumstances where Worcestershire was unable "*to provide any justification in terms of the statutory language and purpose for reading section 117(2) as if it included these additional words*" (paragraph 33).

The Supreme Court were equally underwhelmed by the Secretary of State's argument: as it was the converse of Worcestershire's case, it was open to exactly the same objection in reverse. The Secretary of State's argument (accepted by the Court of Appeal) was that the duty imposed by s.117(2) continued until an express decision was taken that the person was no longer in need of after-care services; as only one duty could exist at any one time, that meant no new duty owed by another local authority could arise. However, Lords Hamblen and Leggatt identified, the Secretary of State and the Court of Appeal failed to explain why, on the second discharge, Swindon did not owe a duty under s.117(2): "[a]*pplying section 117(2) and (3)(a) in accordance with their terms, upon an individual leaving hospital after ceasing to be detained a duty is imposed on the local authority for the area in which the individual was ordinarily resident immediately before that period of detention. There is nothing in section 117 which says that such a duty will not arise if there is a pre-existing duty resting on another local authority*" (paragraph 36).

The problem, therefore, was that each approach "*rests on nothing more than assertion that its preferred duty trumps the other without identifying any basis in the language and purpose of the statute for reaching this conclusion*" (paragraph

40).

Nor were the practical considerations prayed in aid by both parties of much assistance, especially in circumstances where there was no evidence to allow them to be tested.

The answer, the Supreme Court found, lay in Worcestershire's alternative case, namely that the duty to provide after-care services ended if the individual is compulsorily detained in hospital for treatment.

> 44. […] That individual is no longer a person who has ceased to be detained and has left hospital but rather a person who is detained and is in hospital. The criteria set out in section 117(1) are therefore not met. When that period of detention ends and the individual leaves hospital, a new duty under section 117(2) will arise. On this interpretation, therefore, there is never any possibility of concurrent or competing duties. So there is no need to try to explain why one duty should oust or prevail over another.

Lords Hamblen and Leggatt noted that this approach was grounded in the language and purpose of s.117:

> 45. […] *It is implicit in the wording of section 117(1), and in the very concept of "after-care", that the section does not apply to persons who are (currently) detained under section 3 for the purpose of receiving medical treatment in hospital, but only to persons who have ceased to be and therefore are not now so detained (although they previously were)…*
>
> *46. Furthermore, as specified in section 117(6)(b), to constitute "after-care services", the services must have the purpose of "reducing the risk of a deterioration of the person's mental condition (and, accordingly, reducing the risk of the person requiring admission to a hospital again for treatment for mental disorder)". That purpose is only capable of being fulfilled if the person concerned is not currently detained in a hospital for treatment for mental disorder. It makes no sense to speak of reducing the risk of the person requiring readmission to a hospital for treatment after the person has been readmitted.*

The Secretary of State argued that it was inconsistent with the language of section 117(2) to assert that the duty to provide after-care services will cease at a time when no decision has been taken by the relevant bodies that the services are no longer needed. However,

> *49. As a matter of linguistic analysis, the answer to this argument, in our view, is that the duty under section 117(2) is to provide after-care services "for any person to whom this section applies". The duty will therefore cease not only if and when a decision is taken that the person concerned is no longer in need of after-care services but, alternatively, if the person receiving the services ceases to be a person to whom section 117 applies. As Mr Sharland KC pointed out, that would be the case if, for example, the person concerned were to die or was deported or imprisoned. Although there is nothing in section 117(2) which says that the duty will cease in that event, there would then be no person to whom section 117 could apply. That is also true if the person concerned ceases to fall within the class of persons specified in section 117(1). For the reasons given, interpreted in the context of section 117 as a whole and its purpose, the class of persons specified in section 117(1) does not include persons who are currently detained in a hospital under section 3 for treatment. Upon such detention an individual therefore ceases to be a "person to whom this section applies".*

> *50. Looking at the matter more broadly, where a person who has been receiving after-care services is admitted to a hospital for treatment under section 3 (or one of the other provisions mentioned in section 117(1)), it is inherent in the person's situation and the nature and purpose of after-care services that she has no need for, and is incapable of being provided with, after-care services. It is therefore unnecessary for the relevant authorities to take any decision that they are satisfied that the person concerned is no longer in need of such services. Such a decision is only necessary, and it is only necessary for section 117(2) to require such a decision, if the situation of the person concerned is one in which a present need for such services could possibly exist.*

The Secretary of State disputed the proposition that a person who is compulsorily detained in a hospital for treatment cannot be in need of after-care services. The Secretary of State's Counsel submitted that during a short period of such detention the need for after-care services would not necessarily cease, as steps might be required to plan ahead and prepare for care to be provided in the community for the person upon her anticipated discharge. However, the Supreme Court considered it was wrong "*to characterise such planning or preparation as the provision of after-care services. Planning or preparing to provide a service is not the same as providing the service. The fact that the local authority has a power, but not a duty, to engage in such planning and preparation before a person is discharged* […] *does not show that a duty to provide after-care services does or may exist before the person's discharge. On the contrary, it is inconsistent with that suggestion.*"

Importantly, Lords Hamblen and Leggatt were at pains to make clear that their analysis applied only to those detained under s.3 (or one of the other provisions mentioned in s.117(1) for treatment for mental disorder, rather admission to hospital or detention alone. As they identified:

> *53.* […] *under section 117(6) after-care services are directed at reducing the risk of admission to hospital for "treatment" and to admission to hospital "again" for such treatment. This is clearly referring to further treatment under section 3 of the 1983 Act (or the other provisions referred to in section 117(1)). Where after-care services have not avoided that risk eventuating and there has been readmission for such treatment, there is no room for the continued provision of services which are aimed at reducing that specific risk. The same does not apply in relation to other admissions to hospital. It is wrong to suppose, therefore, that a voluntary admission to hospital or admission for assessment could lead to permanent loss of the right to receive after-care services.*

On the facts of the case, therefore, duty to provide after-care services for JG ended upon her second detention. Upon the second discharge a new duty to provide such services arose. Which local authority owed that duty was determined by s.117(3) and depended on where JG was ordinarily resident immediately before the second detention – i.e. Swindon.

Lords Hamblen and Leggatt then turned to the Secretary of State's cross-appeal, challenging the premise that JG had been ordinarily resident in Swindon immediately prior to her second detention. The Secretary of State's position was that

> *in determining where a person is ordinarily resident for the purposes of section 117(3), a person remains ordinarily resident in the area of a local authority which is providing her with*

> *accommodation in performing its statutory duty under section 117 even if the accommodation is situated, and the individual is therefore living, in the area of another local authority. So, as immediately before the second detention JG was living in accommodation provided by Worcestershire, she remained ordinarily resident in Worcestershire for the purposes of section 117(3).*

Lords Hamblen and Leggatt started with broad observations, drawing on the 'classic' statement of what is meant by the term "ordinarily resident" made by Lord Scarman in *R v Barnet London Borough Council, Ex p Shah* [1983] 2 AC 309, and noting that:

> *57. We think it clear in principle and from the examples given by Lord Scarman that the circumstances in which a person will not be regarded as ordinarily resident in a place because the person's presence there is involuntary are narrow and are limited to situations where the person is forcibly detained. Along with kidnapping and imprisonment, compulsory detention under the 1983 Act would fall into this category. On the other hand, the fact that someone has no other accommodation (or suitable accommodation) available to her in which to live does not prevent it from being said that she is ordinarily resident where she is living. The occupation of that accommodation is still adopted voluntarily in the requisite sense and the absence of any practical alternative only tends to confirm that her situation has the necessary degree of settled purpose to amount to ordinary residence. This situation may arise where, for example, a person dependent on a local authority for accommodation is only offered accommodation by the local authority in one particular place, as happened here on the first discharge.*

> *58. The test articulated in Shah requires adaptation where the person concerned is someone such as JG who lacks the mental capacity to decide where to live for herself. It seems to us that in principle in such a case the mental aspects of the test must be supplied by considering the state of mind of whoever has the power to make relevant decisions on behalf of the person concerned. Under the Mental Capacity Act 2005 that power will lie with any person who has a lasting power of attorney or with a deputy appointed by the Court of Protection or with the court itself.*

Applying this approach:

> *58.* […] *JG's residence in the area of Swindon was adopted voluntarily in the relevant sense, as it was the result of a choice made on her behalf to live in the accommodation that Worcestershire provided for her following the first discharge. Manifestly, her residence in that place was also adopted for settled purposes as part of the regular order of her life for the time being. Thus, if the term "ordinarily resident" is given its usual meaning, it is clear that immediately before the second detention JG was ordinarily resident in the area of Swindon. Indeed in these proceedings the Secretary of State has not sought to argue otherwise.*

However, the Secretary of State argued that the words 'ordinary resident' had a special meaning for purposes of s.117 MHA 1983, being subject to the 'rule' that if the accommodation in which the person concerned is living is provided by a local authority for the purpose of performing its statutory duty under section 117, then residence in that place should be disregarded in determining where the person is "ordinarily resident" for the purpose of section 117(3).

As Lords Hamblen and Leggatt identified at

paragraph 59: "[t]*here is no such rule to be found in the language of the 1983 Act (or any other legislative provision). But the Secretary of State submits that it follows from what the Supreme Court decided in Cornwall*." As they identified at paragraph 68: "[t]*he precise legal basis of the majority decision in Cornwall is a matter of some controversy*."

They rejected, however, the Secretary of State's case that *Cornwall* decided that:

> *"ordinary residence" for the purpose of care statutes such as the NAA 1948, the CA 1989, the 2014 Act and the 1983 Act depends on fiscal and administrative considerations and that under all of those statutes responsibility remains with the local authority which arranges accommodation for the person concerned for the purpose of fulfilling its statutory duties. Although the 1983 Act contains no deeming provision, section 117 achieves substantially the same result as, once a local authority is fixed with responsibility for providing care, a move out of that local authority's area will not generally affect that responsibility (as when JG moved to Swindon).*

Rather:

> *70. In agreement with the courts below, we would reject this attempt to extend the Cornwall decision beyond the specific context of the statutes under consideration in that case and their "parallel statutory context" (per Lord Carnwath at para 58). Both those statutes contained provisions which shared the same "underlying purpose" (para 54) and the particular problem which arose was what was to happen on the transition of care responsibility from one statutory regime to the other when PH turned 18. The 1983 Act does not contain a deeming provision or other similar provision; nor does it sit in a "parallel statutory context" to those statutes. As the judge observed [2021] EWHC 682 (Admin), at para 87, "it serves a different category of person, with different needs, to those who are served by the care and support legislation."*
>
> *71. We do not accept that section 117(3) of the 1983 Act is functionally equivalent to the deeming or disregarding provisions in the other statutes. Unlike those provisions, section 117(3) does not manifest any intention that the term "ordinarily resident" should be given anything other than its usual meaning. Section 117(3) does not state or imply that providing residential accommodation for an individual in the area of another local authority will not, or is not to be taken to, change the individual's place of ordinary residence. All it does is to specify the time at which the person's ordinary residence is to be determined for the purpose of allocating responsibility to provide and pay for their care. This carries no implication that, at the point in time at which the person's ordinary residence is required to be determined for the purpose of section 117, any special rule or test of ordinary residence different from the normal test should be applied.*

As Lords Hamblen and Leggatt noted, the independence of s.117 from other care legislation was borne out by the decision of the Court of Appeal in *R (Hertfordshire County Council) v Hammersmith and Fulham London Borough Council* [2011] EWCA Civ 77, which served as "*clear Court of Appeal authority that section 117(3), before it was amended by the 2014 Act, fixed responsibility for after-care services on the local authority where the person concerned was resident immediately prior to detention, even if his residence came about because he was living in accommodation provided or paid for by another local authority. Section 117(3) did not contain a deeming provision equivalent to section 24(5) of*

*the NAA 1948, nor did that provision apply to the free-standing regime under section 117.*" Nor did anything said in *Cornwall* cast doubt on the correctness of the decision.

The Secretary of State was therefore driven to argue that everything changed when in 2014 Parliament amended the wording of section 117(3). However, as Lords Hamblen and Leggatt made clear at paragraph 79 "[l]*ike the courts below, we would unhesitatingly reject that argument*," and identified that:

> *We think it clear that the amendments subsequently made to section 117(3) did no more than (i) replace the concept of residence with that of ordinary residence and (ii) make clear on the face of the legislation that the time at which ordinary residence is to be determined for the purpose of section 117(3) is the point immediately before the person is detained (reflecting how the original wording had anyway been interpreted: see para 76 above). The amended wording cannot properly be interpreted as going further and as applying the same rules which govern where a person is ordinarily resident for the purpose of the 2014 Act to the determination of ordinary residence under section 117(3).*

Their Lordships also found unconvincing the Secretary of State's attempt to explain away s.39(4) Care Act 2014, which provides that an adult being provided with accommodation under s.117 MHA 1983 is to be treated for the purposes of this Part as ordinarily resident in the area of the local authority in England or the local authority in Wales on which the duty to provide the adult with services under that section is imposed. The Secretary of State argued that s.39(4) was, in fact, otiose (i.e. unnecessary) because the effect of *Cornwall* was already to have implemented a deeming regime. However, Lords Hamblen and Leggatt were not persuaded:

> *86.* […] *It was clearly essential to the conclusion reached in Cornwall that the two relevant statutory regimes each contained a deeming (or disregarding) provision intended to achieve exactly the same effect. Far from being otiose, their existence was therefore critical. The significance of section 39(4) is in confirming that, unlike the rules in the adult social care legislation and the CA 1989, the ordinary residence rules in the 2014 Act and section 117 of the 1983 Act are not congruent with each other, so that a specific provision is needed to align them where they interact.*

## Comment

Perhaps heeding the plea for the need for clarity by Mind in its written intervention, Lords Hamblen and Leggatt were at pains both to set out a very clear answer to the conundrum before them, and to explain precisely how they reached that answer. Whilst clear, the decision will no doubt require a considerable number of situations to be revisited where local authorities in the position of Worcestershire become aware that people they are providing s.117 aftercare to have been re-detained out of area.

It is also important to note that, whilst detention under s.3 (or another of the provisions identified within s.117(1)) extinguishes a pre-existing s.117 duty, and Lords Leggatt and Hamblen were clear s.117 and s.3 cannot co-exist whilst a patient is in hospital, it is possible for s.3 and s.117 to exist whilst a patient is liable to be detained under s.3 but not in hospital. Lord Leggatt, whilst in the Court of Appeal, had "readily accept[ed]" in *R(CXF) v Central Bedfordshire Council NHS North Norfolk Clinical Commissioning Group* [2018] EWCA Civ 2852, that there will be cases in which a patient granted leave of absence from hospital under s.17 MHA 1983 does 'cease to be detained' and 'leave hospital' within the meaning of s.117(1), so as to be

eligible for s.117 aftercare. *CXF* was (unsurprisingly) referred to in approving terms by Lords Leggatt and Hamblen in their judgment in the current case, so clearly remains good law.

The Supreme Court held that there are no deeming provisions in the MHA. So where a person from local authority 'A' is placed out of area in local authority 'B' and detained under a qualifying section of the MHA, it is 'B' that will be responsible for their after-care. Note that this is different to the rules under the Care Act 2014 (for social care) and the deprivation of liberty safeguards (for identifying the supervisory body). Whilst the decision has significant implications for after-care responsibilities, it will not affect the position under the Care Act (where there are deeming provisions) or responsibility for DoLS.

However, one aspect of the decision that will be helpful for determining ordinary residence under the Care Act 2014 and DoLS is paragraph 58. When applying the *Shah* test, rather than ignoring the 'voluntarily' adopted limb where the person lacks capacity (which has hitherto been done), the Supreme Court says the "*the mental aspects of the test must be supplied by considering the state of mind of whoever has the power to make relevant decisions on behalf of the person concerned*" and refers to LPAs, deputies or the Court of Protection. In the absence of such people, the "state of mind" with "the power" will be the best interests decision-maker. So it will be the best interests decision that reflects the place of abode being adopted voluntarily.

A recording of a webinar about the implications of the *Worcesteshire* decision held on 5 September will be available on the 39 Essex Chambers website shortly.

## The limits of autonomy – what happens where healthcare professionals consider the choice too risky?

*R (JJ) v Spectrum Community Healthcare CIC* [2023] EWCA Civ 885 (Court of Appeal (Lord Burnett of Maldon, LCJ; King and Lewis LJJ))

*Other proceedings – civil*

### Summary

This decisions raises starkly the limits of autonomy in healthcare decision-making.

As a result of a rare genetic condition, X-linked hypophosphatemia, JJ was quadriplegic and without teeth. While his cognitive and communication skills were unimpaired, his physical capacity was limited to pushing a button with one finger. Since 2016 he had been bed-bound and wholly dependent on care staff for all his personal care and for feeding. He was nursed in a supine position. He was serving a lengthy determinate sentence of imprisonment. He was cared for in the Healthcare Wing at HMP Liverpool by the staff of Spectrum Community Healthcare CIC ('Spectrum'), a community interest company which provided NHS-funded healthcare services to prisoners.

As a result of JJ's condition, eating food posed a risk of death or serious injury by choking or aspiration. Some foods poses a more significant risk than others. Until 2021, JJ ate a mixed diet of soft and non-soft foods. Meals would be sent to his cell and he would decide whether he was capable of eating them. He would regularly supplement his diet with snacks brought from the prison canteen, including non-soft foods such as boiled sweets. However, his care team became increasingly concerned at his risk of choking, and following a SALT assessment, began denying him any foods which did not fall within a so-called Level 6 diet of soft and bite-sized food. JJ, who wanted to be able to eat boiled sweets, biscuits and crisps (referred to in the judgment cumulatively as "boiled sweets"), responded by refusing all food in protest, and

challenging Spectrum's decision by way of judicial review. JJ had also made an advance decision to refuse treatment, confirming that food refusal was to apply even when his life is at risk and that he did not wish to be ventilated or to have cardiopulmonary antibiotics (CPR).

In October 2022, HHJ Sephton KC ('the Judge') dismissed JJ's claim. JJ appealed to the Court of Appeal, which handed down judgment on 25 July 2023.

In a witness statement cited at paragraph 85 of the judgment, JJ described:

> *how he has little or no quality of life. He is completely bed-bound, lying on his back for 24 hours a day, and is unable to do anything for himself other than call for help or control a television. He concludes his statement by saying that he has lost almost everything in his life and 'being able to eat what I want represents my last shred of humanity and dignity. I want to be able to cling on to it for as long as I can'.*

King LJ, with whom the Lord Chief Justice, Lord Burnett, and Lewis LJ agreed, crisply delineated the issue in the opening section of the judgment thus:

> *2. The issue before the court is whether a medical professional is acting lawfully in restricting the foods which are to be offered to a patient because, in their medical opinion, to do so would expose the patient to a high risk of choking and aspiration which might lead to his death.*
>
> *3. Put the other way around, is a patient entitled to demand medical treatment which is not clinically indicated and therefore not offered to him by the doctor?*

Having set out the background, and before turning to the grounds of appeal, King LJ made clear three contextual matters at paragraph 38:

> *(i) This appeal is an appeal from a decision about medical treatment or care made at first instance. It is not about prison or prisoner's rights (see Prison Rules 1999/728 rule 24(1) Food: 'no prisoner shall be allowed, except as authorised by a health care professional to have any food other than that ordinarily provided.') As with all prisoners, therefore, JJ only has such choice of foods as are provided by the prison authorities.*
>
> *(ii) The provision of food is treatment or care for the purposes of medical treatment decisions. Where, as here, the patient is unable to feed themselves, all food such as boiled sweets are part of treatment or care: Airedale NHS Trust v Bland [1993] AC 789 at p 858G.*
>
> *(iii) This appeal raises no new points of law. The law in relation to both the common law and Article 8 of the European Convention on Human Rights ('ECHR') is well established and the arguments put forward on behalf of JJ relate to the proper interpretation of that law. I therefore refer only to those authorities that in my view address what I regard as the well-established legal position in relation to a patient's autonomy in respect of their choice of medical treatment.*

There were two grounds of appeal, dealt with in turn below:

*Autonomy*

JJ argued that the Judge's conclusion that the applicant's autonomy could lawfully be overridden by Spectrum was not supported by the evidence and was contrary to established authority on the scope and extent of autonomy as a fundamental principle of common law.

King LJ rejected the first limb of this ground, holding (at paragraph 53) that

> *In my judgement, the judge's decision that JJ's 'autonomy could lawfully be overridden' by Spectrum was 'supported by the evidence' both in relation to the risk of harm to JJ and in relation to the risk of prosecution or regulatory action to the staff of Spectrum in the event that they fed JJ boiled sweets. Regardless of any prosecution or regulatory action, the death of JJ would inevitably lead to a coroner's investigation and inquest which in itself would be both stressful and distressing for the carers involved.*

En route to this conclusion, she noted at paragraph 45 that:

> *Guidance in relation to issues around eating is provided by the Royal College of Speech and Language Therapists 'Eating and drinking with acknowledged risks' and by the Royal College of Physicians 'Supporting people who have eating and drinking difficulties'. This latter guidance was referred to by the Intervener*[10] *who, helpfully, drew the attention of the Court to the guidance found at 'Box 2' in relation to 'Risk Feeding' decisions. I note from reading this guidance that 'in any 'risk feeding' decision, there needs to be a calibration between being risk averse, and placing carers in an impossible position in the name of patient autonomy'. This is a statement which is particularly apposite in the present case.*

Turning then to what King LJ identified as the main issue in the case, namely whether Spectrum were entitled to override JJ's capacitous decision, she noted at paragraph 55 that:

> *Ms Weereratne's core submission was that this is a case about choice and that the court could not and should not have overridden JJ's choice as to what food he eats in circumstances where he is of full capacity and understands and accepts the risk he faces of choking to death if he eats boiled sweets.*

In support of this proposition, JJ's team relied upon cases such as *Ms B*, relating to the refusal of treatment. King LJ, however, considered that such cases were, in fact, of no assistance, and dealt with "*a wholly different situation from that of JJ which is concerned with the provision of treatment and not the withdrawal of treatment*" (paragraph 67). Rather:

> *68. The common law authorities so far considered therefore establish (i) that a patient with capacity can choose between various treatment options, which choices have to be respected by the clinicians even if the treatment chosen is not the one that was recommended by the treating team and (ii) a patient with capacity can refuse medical treatment. That then leaves the question as to whether, as advocated by Ms Weereratne, there is a common law right of autonomy which allows a patient to demand, and obliges a clinician to provide, medical treatment that is not offered to that patient by their doctors.*
>
> *69. In my judgement, the answer is an unequivocal 'No'* […]

That 'no' had been provided by the Court of Appeal in Burke, which JJ's Counsel submitted:

> *70.* […] *had no application to JJ's situation as Spectrum had said that they would feed the boiled sweets to JJ if ordered to do so. Further, she said that*

[10] The Royal College of Physicians, on whose behalf Alex acted.

> *she would rely on the Montgomery principle to override the clinical judgment of the clinician on the basis that, as JJ is prepared to take the risk of choking and dying, the provision of boiled sweets is lawful given that Spectrum would be complying with JJ's properly informed food choices.*

This did not convince King LJ:

> *72. A party to proceedings confirming that they will comply with a court order or the terms of a declaration does not, in my view, serve to convert Spectrum's position from that of a refusal to give JJ boiled sweets because it is unsafe to do so and is therefore 'off the table' as a treatment option which can be chosen by JJ, to being one of merely 'ill advised' and an option capable of being chosen by JJ in line with the Montgomery principles. Neither, contrary to Ms Weereratne's submission does the fact that Spectrum have taken the precaution of identifying staff who would be willing to carry out a court order to give JJ boiled sweets in the event that a declaration were made, serve to create an option which JJ can choose.*

Therefore, and following *Burke* in circumstances where "*as here, Spectrum has concluded, in the light of the SALT assessments and the evidence of Dr Thomas* [the associate medical director of Spectrum], *that the treatment sought by JJ is not clinically indicated, then they are not legally obliged to provide it and the judge was right to find that to be the case*" (paragraph 73). Importantly, further, on the way to this conclusion King LJ noted (at paragraph 62) that the decision of the Supreme Court in McCulloch & Others v Forth Valley Health Board [2023] UKSC 26 – handed down between the hearing and the delivery of judgment in *JJ* "*confirm*[ed] *that the determination of what are reasonable treatments to offer is a matter of professional skill and judgment on the part of the doctor offering those treatments*."

*Article 8 ECHR*

JJ also appealed on the basis that the Judge erred in concluding that Spectrum's interference with his Article 8 ECHR rights was in accordance with the law and proportionate, and hence justified under Article 8(2) ECHR.

As King LJ identified, it was common ground that JJ's Article 8 right to respect for private life was engaged and that Spectrum's refusal to provide him with boiled sweets was an interference with that right. That therefore left consideration as to whether the conduct of Spectrum was in 'accordance with the law', was for a permitted reason under Article 8 and whether it satisfied the test of proportionality.

JJ's first argument was that the common law authorities (including *Burke*) did not satisfy the requirement that the law be clear, foreseeable and adequately accessible. Only legislation or formal governmental policy would satisfy the test, he argued.

King LJ dismissed this argument crisply, noting that it was "*well established*" that the common law sufficed for the purposes of the 'accordance with the law' requirement of Article 8(2), and (at paragraph 79):

> *In my judgement, the analysis of Lord Philips at para.[50] in Burke clearly contains "sufficient precision to enable the citizen to regulate his conduct", even if it is not absolutely prescriptive in all situations. In any event, the provisions of the CQC regulations provide regulations dealing with the situation in which care and treatment are provided.*

It was also submitted on JJ's behalf that the Judge erred in his approach to proportionality by failing to consider less intrusive measures, in

particular by moving JJ from a supine position and (ii) that the interference was not necessary to protect the professional autonomy of the clinicians in circumstances where Spectrum had indicated that it would feed JJ if the court declared it was lawful to do so.

In relation to the first of these limbs, King LJ noted that the issue of JJ being fed in a less supine position was not before the Judge and that not only did the Judge not have any evidence in relation to the issue, but that JJ had declined to have the physiotherapy assessment on offer which was specifically aimed at discovering if he could be nursed in a more elevated position. King LJ rejected the second limb for essentially the same reasons as she dismissed the argument as developed in relation to the first ground of appeal, and made clear that she considered that the Judge "*had conducted an exemplary and concise proportionality analysis*" (paragraph 83).

*Concluding observations*

King LJ made clear that:

> *86. One can fully understand the dire situation in which JJ finds himself and a view that says that if JJ understands and is happy to take the risk of choking for the modest pleasure of eating a boiled sweet, then that is a matter for him. It may be that in certain different medical circumstances the balance would come down in JJ's favour but not, in my view, in this case. JJ cannot feed himself. He cannot obtain boiled sweets from the prison shop, unwrap them and put them in his own mouth. The provision of boiled sweets in circumstances where JJ cannot even put a sweet into his mouth is different; it is treatment or care carrying with it the considerable risk that on any given day, giving JJ that boiled sweet may cause him to choke to death and in circumstances where JJs advance decision would prevent all but the most basic life-saving intervention on the part of the person who had given him the boiled sweet.*
>
> *87. In my judgement the judge was right having considered the well-established authorities, to conclude that it was lawful for Spectrum to refuse to provide JJ with boiled sweets in those circumstances, and that had they done so and JJ had choked to death or suffered serious harm as a consequence of aspiration, they were at a more than fanciful risk of prosecution under regulation 12 CQC or in the criminal courts for gross negligence manslaughter.*

### Comment

In some ways, it is surprising that the issue raised in JJ's case has not been the subject of appellate level consideration before, as – whilst JJ's case is particularly stark – it is a situation which is not in fact that uncommon. Despite the sustained efforts of his legal team to frame it as a pure question of choice, the Court of Appeal were very clear that it was not as simple as that, because it was a choice which had consequences for others. Viewed through that prism, it flowed essentially inexorably that if those upon whom the consequences were to be visited could not properly countenance them that the appeal would fail (although it should be noted that it remains possible that JJ will seek permission to appeal from the Supreme Court).

More broadly, the judgment is important for implicitly endorsing the guidance of both the Royal College of Physicians and the Royal College of Speech and Language Therapists as to how to navigate the dilemmas that arise. But, equally broadly, and in line with that guidance, it is important to be clear that the judgment is **not** saying that risk can simply be deployed as a

'trump card' in the context of an expressed wish by a person to be fed in a particular way. As King LJ made clear, even in JJ's situation, there might be circumstances in which the balance would come down in his favour – and in any other situation, a decision that a person is not be fed in the way that they wish must be based upon very clear evidence.

## Short note: Deciding what alternative treatments are reasonable: a task for the doctor or the patient?

In a decision handed down with considerable speed (the hearing being on 10-11 May 2023, and judgment being delivered on 12 July 2023), the Supreme Court has made clear in *McCulloch and others v Forth Valley Health Board* [2023] UKSC 26 that the "professional practice test" (i.e. whether the doctor has acted in accordance with a practice accepted as proper by a responsible body of medical opinion) applies to the assessment of whether an alternative treatment is reasonable and requires to be discussed with the patient.

As Lords Hamblen and Burrows (with whom the other three Supreme Court Justices agreed) set out at the start of the judgment, in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11:

> *this court decided that the professional practice test did not apply to a doctor's advisory role "in discussing with the patient any recommended treatment and possible alternatives, and the risks of injury which may be involved" (para 82). The performance of this advisory role is not a matter of purely professional judgment because respect must be shown for the right of patients to decide on the risks to their health which they are willing to run. "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" (para 87). The courts are therefore imposing a standard of reasonable care in respect of a doctor's advisory role that may go beyond what would be considered proper by a responsible body of medical opinion.*

Before the Supreme Court, the appellants (the widow and other family members of Mr McCulloch challenged a decision of the Scottish courts that the professional practice test applied to determining whether an alternative treatment was reasonable. They accepted that whether the doctor should know of the existence of an alternative treatment was governed by the professional practice test. However, they submitted (as summarised at paragraph 4) that:

> *whether the alternative treatments so identified are reasonable depends on the circumstances, objectives and values of the individual patient and cannot be judged simply by the view of the doctor offering the treatment even though that view is supported by a responsible body of medical opinion.*

Lords Burrows and Hamblen had little hesitation in rejecting the appeal and – somewhat unusually, but helpfully – noted that:

> *57. A hypothetical example may help to explain, in more detail, how we regard the law as working. A doctor will first seek to provide a diagnosis (which may initially be a provisional diagnosis) having, for example, examined the patient, conducted tests, and having had discussions with the patient. Let us then say that, in respect of that diagnosis, there are ten possible treatment options and that there is a responsible body of medical opinion that would regard each of the ten as possible treatment options. Let us then say that the doctor,*

> *exercising his or her clinical judgment, and supported by a responsible body of medical opinion, decides that only four of them are reasonable. The doctor is not negligent by failing to inform the patient about the other six even though they are possible alternative treatments. The narrowing down from possible alternative treatments to reasonable alternative treatments is an exercise of clinical judgment to which the professional practice test should be applied. The duty of reasonable care would then require the doctor to inform the patient not only of the treatment option that the doctor is recommending but also of the other three reasonable alternative treatment options (plus no treatment if that is a reasonable alternative option) indicating their respective advantages and disadvantages and the material risks involved in such treatment options.*
>
> *58. It is important to stress that it is not being suggested that the doctor can simply inform the patient about the treatment option or options that the doctor himself or herself prefers. Rather the doctor's duty of care, in line with Montgomery, is to inform the patient of all reasonable treatment options applying the professional practice test.*

Lords Burrows and Hamblen gave a number of reasons for reaching their conclusion, namely (1) consistency with *Montgomery*; (2) consistency with *Duce* (a Court of Appeal decision applying *Montgomery*); (3) consistency with medical professional expertise and guidance; (4) avoiding an unfortunate conflict in the doctor's role (which would arise if they were required to inform a patient about an option they properly considered to be unreasonable); (5) avoiding bombarding the patient with information; and (6) avoiding uncertainty. In respect of the latter, the Justices expressed their concerns of acceding to the appellants' approach would be "*would be defensive medicine with the doctor advising on all possible alternative treatment options, however numerous or clinically inappropriate they may be*."

### Comment

Whilst perhaps not entirely surprising as a decision, following both the decision of the Scottish courts and a decision of the Court of Appeal in June 2023 which appears to have been determined without awareness that this case was being heard (see here at paragraph 66), the judgment is both very clear and emphatic.

There will no doubt be a range of views expressed about this judgment, in which the word autonomy will doubtless feature heavily. One way of reading the judgment is to see it as the Supreme Court recognising that autonomy within the medical context is not simply a question of information-giving by medical professionals, but represents a joint exercise between the medical professional as the expert (one hopes) in the medicine, and the patient (or, if they lack capacity, those able to contribute on their behalf) as the expert in themselves.

## Short note: forced marriages and non-recognition

In *Re SA (Declaration of Non-Recognition of Marriage)* [2023] EWCA Civ 1003, the Court of Appeal has firmly quashed another of Mostyn J's gadfly attempts to challenge conventional wisdom,[11] reasserting that, as previously held in *Westminster City Council v C and Others* [2009] Fam 11, the Family Law Act 1986 does not prevent the court from making a declaration of

[11] In obiter observations in *NB v MI (Capacity to Contract Marriage)* [2021] 2 FLR 786.

non-recognition of forced marriage, including, importantly, where the marriage is deemed to be forced because one party lacks the relevant capacity. On the facts of the case, and dismissing the appeal against the making of the order, Moylan LJ held at paragraph 100 that:

> *It is clear that, when making his decision, the judge took all the relevant factors into account, including the fact that SA wanted the marriage to continue. On the facts of this case, the judge was clearly entitled to decide that the circumstances of the marriage were sufficiently offensive to justify making the declaration. It was a forced marriage in respect of a person who has a significant learning disability and is in the extremely low range of ability in all areas of cognitive and adaptive functioning; who lacked capacity to consent to marry or to engage in sexual relations; and who is suggestible and has no ability to resist how she was being steered by others. Indeed, in my view, he was right to make a declaration.*

## Litigation friends – their duties and discharge: putting right a serious misstep

*Major v Kirishana* [2023] EWHC 1593 (KB) (King's Bench (Cotter J))

*Other proceedings – civil*

### Summary

This is a distinctly troubling case, in that it involved – at one stage – a person being effectively forced to continue acting as litigation friend in circumstances where she had made clear that she had developed mental health issues, could not cope with the stress of the litigation, could not properly discharge the role of litigation friend and no longer consented to the role. The underlying proceedings related to a claim for breach of contract in relation to (primarily) the payment of various loans brought against a Mr Major by a Ms Kirishana, with whom he had previously been in a relationship. Mr Major had mental health issues, the detail of which are not relevant for present purposes,12 and, whilst he sought initially to act for himself in person, it became very clear that he lacked capacity to conduct them. Efforts were made by Mr Major's parents to find a way in which to protect his interests in the face of robust efforts by HHJ Luba KC to progress the case. As Cotter J noted:

> *20. Shortly before a further hearing on 8th March 2021 Ms Cowell* [a long-term friend of Mr Major's] *was approached by Mr Major's parents and pro-bono counsel and asked if she would be Mr Major's litigation friend. She was initially hesitant but eventually agreed and filled in (and filed) a certificate of suitability (dated 7th March 2021). She stated that she had known Mr Major for ten years and was extremely concerned about the effect the proceedings were having on him. She stated that in her opinion they were an extension of harassment which he had already suffered. The form required Ms Cowell to confirm that she consented to act as a litigation friend and that*
>
> > *"I am able to conduct proceedings on behalf of (Mr Major) competently and fairly…"*

[12] In passing, it is striking – and at one level troubling – how much detail is set out in the judgment relating to those issues, their consequence, and their management. Although perhaps necessary for determination of the application, one might query whether – given that Mr Major did not bring the proceedings, and lacked capacity to conduct them – consideration might not have been given to anonymising him in the same way as would have been done had the case been proceeding before the Court of Protection.

> *21. On 8th March 2021 His Honour Judge Luba QC declared that Mr Major lacked capacity and ordered that Ms Cowell be appointed as his litigation friend.*
>
> *22. Given some references in subsequent statements/skeleton arguments on behalf of the Respondent it is important to understand its implications of the finding that Mr Major lacked the capacity to litigate. Capacity must be considered as at any given time/stage in within the litigation on all the available evidence. It is a binary issue. Capacity can be lost and gained, but if a person lacks capacity the proceedings should not continue. If they do so any step take may be of no effect. Whilst this may be frustrating for an opposing party and prevent the progress of the litigation that is of no weight at all in the assessment of capacity. Also the extent to which there is a person willing to act as a litigation friend is irrelevant when considering the question of capacity*
> .
>
> *23. I pause to observe that if Ms Cowell had not agreed to be the litigation friend then the litigation would have ground to a halt until a litigation friend was in place. It seems clear that (as is usually the case in my experience) the Official Solicitor would have been reluctant to act unless some arrangement as to her fees was in place. The Respondent may have been asked to give an indemnity (the likely response has not been indicated to me). So Ms Cowell's appointment was no doubt welcomed by the Respondent.*

Not helped by variously "mistaken," "unnecessarily aggressive" and "inappropriate" emails from the solicitor acting for Ms Kirishana, Ms Cowell's mental ill health started to suffer, to the point where she found herself unable to continue to act for Mr Major. At a hearing changed at the last minute from in-person to remote, at which Ms Cowell acted for herself and at which, as Cotter J observed, she should have been treated as vulnerable, HHJ Luba KC did not challenge the veracity or accuracy of her account, refused to discharge her, and ordered her to pay Ms Kirishana's costs of the application.

Mr Major himself attempted to appeal the decision before Ms Cowell did. He also tried to seek an urgent non-molestation application against Ms Kirishana. At the appeal hearing, her Counsel described the step as follows:

> *On 10 June 2021, Mr Major despite* ***purporting to lack capacity*** *or funds or capacity) instructed solicitors to make an urgent non-molestation application in the Horsham Family Court against the Respondent. That was dismissed.* (emphasis in original)

As Cotter J somewhat tartly noted:

> *75. This comment again illuminates the Respondent's attitude to capacity and meshes with the earlier comments about Mr Major "messing about" with capacity. As I have already set out at any given stage a person either has capacity or they do not. It is a matter for the court to assess. Once that assessment is made it remains valid until varied or set aside. It is also not surprising that the person who lacks capacity may take an unmeritorious or unwise decision. That is the very reason why they need a litigation friend.*

Ultimately, and – perhaps rather surprisingly given the outstanding appeal against the decision not to remove Ms Cowell as litigation

friend[13] – the the claim proceeded to trial, at which point Ms Cowell did not have an advocate, although Counsel previously acting directly for her pro bono made an application to adjourn the trial). Mr Major did not give evidence, and HHJ Raeside KC gave judgment in favour of Ms Kirishani. Defending the appeal against the order declining to remove Ms Cowell, Counsel for Ms Kirishani sought to:

> *84.* […] *pray in aid a number of matters that happened at the trial in relation to the merits of the decision taken by His Honour Judge Luba QC and of the action as a whole.*
>
> *85. In my view there needs to be a very significant degree of caution exercised before embarking upon consideration of whether any such subsequent matters can impact upon the issue which is considered within this judgment i.e. whether the Judge erred in law at an earlier hearing.*
>
> *86. Mr Major did not give evidence, lost and was subject to an order for indemnity costs (of itself a concerning matter). In my judgment the court should be very slow to enter into evaluation of the performance of a litigation friend in such circumstances. In a witness statement of 14th December 2022 Ms Cowell referred to her impaired ability to assimilate the content of the bundle, that she missed significant discrepancies in the evidence and was too anxious to focus properly.*
>
> *87. As for the merits of the action it is not as simple as considering the judgment on the issues in evidence before the court at the trial. Consideration would have to be given to what arguments could/should have been run but were not (including as to how the court should approach Mr Major), what evidence could/should have been called (and what offers could/should have been made). It is also important to recognise that the litigation remains live and issues of privilege and conflict of interest arise.*
>
> *88. As a result I have not considered what happened at the trial in any detail.*

In determining the central question, namely whether HHJ Luba KC erred in not discharging Ms Cowell, Cotter J set out at paragraphs 101-110 a helpful overview of the framework governing litigation friends in civil proceedings, noting that:

> *110* […] *the duties of a litigation friend can be onerous. Also a Defendant's litigation friend does not have an immunity against a personal costs order. This of relevance if a litigation friend is required to act against their wishes a fortiori when the person doubts their ability to conduct the litigation competently.*

Turning then to the question of discharge of a litigation friend and, again, setting out a review of the framework, Cotter J made clear that he agreed with the conclusion of Foskett J in *Bradbury v Paterson* [2014] EWHC 3992 that:

> *115.* […] *that there is no necessity that a substitute litigation friend be identified before an order can be made under CPR 21.7. As for the observation that a litigation friend who is being required to act on an unwilling basis will have an interest adverse to the protected party (because his/her primary interest will be in bringing the litigation, and with it their*

[13] The reason appears to have been administrative complexities, including the lack of any transcript or even note of the judgment of HHJ Luba KC.

> *unwanted involvement, to an end as speedily as possible, regardless of whether this is in the interests of the protected party), this has very considerable, if not overwhelming force where the litigation friend is not a lawyer, and so has no professional obligations to the protected party or the Court. As I have set out the litigation friend is charged with the conduct of the litigation, aspects of which are particularly demanding for a litigant in person (and if not progressed competently the litigation friend is potentially exposed to a personal costs order) and a litigation friend for a defendant is not entitled to expenses (contrary to Mr Karia's submissions).*

Cotter J then set out how this framework applied (or should have applied) to the position before HHJ Luba KC:

> *129. The starting point when considering whether the appointment of a litigation friend (legally qualified or not) should be terminated is whether the conditions in CPR 21.4 (3) continue to be satisfied and whether the litigation friend continues to consent to act. These are not merely factors which may be taken into account in the balance with no more weight than any other considerations. The Court should guard against any weakening of these mandatory requirements which may deprive a protected party of what the rules deem as necessary protection. If the conditions are no longer satisfied, or the Litigation Friend no longer consents to act it, it will require exceptional circumstances for the appointment to continue. Here there was no finding that the application, made by a litigation friend who was acting as a litigant in person, was anything other than bona fides. She no longer consented to act and doubted her ability "to comply with my duties to act in the Defendant's best interests and have concerns about my ability to make effective decisions on behalf of the Defendant." Having raised no issue with Ms Cowell about her mental health and its impacts the Judge should have considered whether there were any exceptional circumstances which could mean that it was proper to order her to remain in the role. In the absence of such circumstances the application should have succeeded.*
>
> *130. Although not expressly set out within CPR 21.4(3) consent is a fundamental requirement for a litigation friend's appointment. It is very difficult to envisage circumstances where a person who makes an application to be appointed does not consent to the appointment at the time the application is made. The Court will ordinarily require consent to be specifically addressed through form N235 although this is no longer expressly required by a Practice Direction. It will only be in very rare circumstances that the Court will appoint a person without first considering this issue (or being able to arrive at a view that consent is likely as in Kumar v Hellard).*
>
> *131. Consent is a requirement not just a matter of basic principles of justice and fairness but also for the reasons particularly emphasised in Bradbury. For the avoidance of doubt I agree with Foskett J's statement in Bradbury that*
>
> > *'I do not think that there is any warrant for the conclusion that the consent of any person to act as a litigation friend is irrevocable, certainly under the regime provided for by the CPR.'*
>
> *132. Whilst the withdrawal of consent will not axiomatically lead to the termination of an appointment (as also noted in Bradbury), it must be a key factor both in its own right (because the court faces forcing someone to do*

*something which they no longer wish to do) and also due to the risk that the presence of an unwilling, non-consenting litigation friend poses to the fairness of the proceedings and to the safeguarding of the protected party's interests. I think it likely that these factors gave rise to Pepperall J's "first blush" concern about the order in issue.*

*133. Mr Karia's submission that consent is "not a true factor" for a litigation friend is misconceived. The argument "at a slightly lower level" that the requirement of consent exists only at the time of appointment is also wrong. The need for consent continues throughout the appointment. As was pointed out in **Bradbury** in the absence of consent a conflict of interest arises.*

*134. In the present case the withdrawal of consent was understandable and justifiable and His Honour Judge Luba KC raised no issue with Ms Cowell's evidence as to the onset of her mental health issues and the likely impact of continuing her role as a litigation friend. It appears that the Judge quite properly ignored the comments about her "claiming" to suffer anxiety and to her "changing whims". These comments should not have been made.*

*135. Mr Burkett's unnecessarily aggressive conduct of the litigation unsurprisingly, and considerably, heightened Ms Cowell's anxiety and this was not her fault.*

*136. Given that Ms Cowell no longer consented and doubted her ability to comply with her duties it required exceptional circumstances to justify forcing her to continue. However the application had additional merit given the consequential risk to Ms Cowell's health of making her continue, the lack of continuous legal representation, the complexity of the matter (the trial bundle being around 2500 pages with Mr Major's lack of capacity likely to impact on the extent of the defence evidence), and the need to consider settlement/conduct generally.*

*137. The loss of a trial date alone cannot ordinarily outweigh the fact that there is no longer consent or that the requirements for appointment as a litigation friend are no longer met. The reason for this is obvious. The trial may well not be a fair one if the protected party has his/her interests in the hands of a person who cannot competently and/or and fairly conduct the proceedings and/or no longer wishes to do so ( in which case a conflict of interest arises as the litigation friend's interest lies in the speedy conclusion of proceedings). There is also the risk of consequential litigation brought on behalf of the protected party in respect of any perceived failings of the Litigation friend to act with appropriate care.*

Taking all of these matters together, Cotter J fully recognised:

*138. […] that this decision was an exercise of discretion. However it is a well established principle that an appellate court can, and should, interfere with that exercise if it has gone seriously wrong. In my Judgment the Judge failed to properly direct himself as to the correct approach to the issue before him and fell into serious error. As a result the decision was plainly wrong and/or outwith the discretion allowed by the CPR upon an application by a litigation friend to be discharged.*

*139. The circumstances of Ms Cowell plainly and overwhelmingly were such that they should have led to her being discharged. She no longer consented to act and there was a real risk (due to her significant mental health difficulties and related personal situation) of her not*

*being capable of performing her duties properly and/or of her having an interest adverse to that of Mr Major in that she would want the litigation to be over and could not face interaction with Mr Burkett (including with regard to settlement).*

*140. Whilst a discretion exists on an application to terminate it is trammelled. As I have set out once the conditions in CPR 21.4 and/or consent are no longer present it would take exceptional circumstances for a decision to continue the appointment to be justified. As Foskett J observed in Bradbury the Court has*

> *'little room to manoeuvre when presented with such an application'*

*141. In the present case the loss of a trial date (which had only be obtained as a result of Ms Cowell agreeing to act) and the fact that no substitute had been identified could not constitute sufficiently exceptional circumstances to displace the usual result of a lack of consent and/or inability to satisfy the conditions at CPR 21.4(3).*

*142. Ground one is successful, the decision was wrong and the order that Ms Cowell continue as litigation friend should not have been made.*

Cotter J dealt more briefly with grounds two and three. In respect of the second, he agreed that HHJ Luba KC fell into error by taking into account and attaching weight to his view that there was "*relatively little left to do before the trial*" given that "*all that remains to be done for trial in the instant case is agreement of the bundle and attendance at the trial, and suitable instruction of an advocate for Mr Major*". Cotter J considered that HHJ Luba KC had been encouraged into this error by the Respondent's submissions:

*144. .[…] As Ms Cowell correctly stated she had "to make decisions about his trial", in respect of which she did "not feel confident to do that at all."*

*145. The conduct of litigation is an onerous responsibility and cannot be sensibly divided into set procedural steps without consideration of the ancillary duties such as the continuing need to review prospects of success, evidential issues and to also to consider settlement. Here Ms Cowell was faced with the difficulty of Mr Major lacking capacity yet being the sole potential witness of fact in his own defence.*

*146. Care is also necessary when equating assistance from a pro-bono advocate at hearings with a solicitor having conduct of the action. The Judge's finding was only that it was likely that there would be "assistance" specifically at trial. He failed to properly take into account the conduct required of Ms Cowell involved far more than simply preparing for the trial date. In particular the Judge overlooked that Ms Cowell should be considering settlement. Had he addressed his mind to it he would have had to recognise Ms Cowell's understandable reluctance to engage with Mr Burkett given her health could impair that process.*

Ground three – which also succeeded for essentially the reasons identified in relation to ground two – was that HHJ Luba KC wrongly applied, in effect, a pre-requisite that a substitute litigation friend be appointed. As it was not necessary to do so, Cotter J declined to address ground four, namely that "[the] *Judge was wrong in law in that ordering Ms Cowell to continue as a litigation friend meant that he was ordering forced labour in breach of Article 4 of the European Convention on Human Rights*." He did note, however, that "[i]*t is a not a straightforward issue and has some substance. Conduct of litigation*

*can be very onerous, time consuming and a litigation friend acting for a defendant is not entitled to expenses*" (paragraph 150).

Cotter J, finally, identified that it would be of assistance if the Civil Procedure Rules Committee to consider clarification of the issue of consent in respect of an application under CPR21.6 given that the Practice Direction accompanying Part 21 is no longer in force (and there may be doubt as to the Court's ability to require form N235 be signed).

### Comment

The summary set out above is lengthy, but this is both because the nuances of the saga are, themselves, important, and because of the careful and detailed way in which Cotter J analysed the law, the obligations upon litigation friends, and the obligations upon the court when a litigation friend considers that they can no longer continue, all of which are observations of wider application to just the case before him.

Perhaps the only surprising thing about his conclusions as to the application of the provisions of the CPR was his view that an appointment could be required to continue in exceptional circumstances. Unless, by "exceptional circumstances," Cotter J had in mind a situation where there was proper reason to consider that the litigation friend was in effect making up excuses to stop acting (which might have been what he was contemplating), I would suggest that, if a litigation friend stops consenting, then that has to be end of the matter, no matter the difficulties to which this puts the other party / parties and the court. This is so even if the litigation friend is the Official Solicitor as the decision in *Bradbury v Paterson* makes clear – and even though the Official Solicitor is described as the litigation friend of last resort, a description which *Bradbury v Paterson* makes clear has to be taken with a distinct pinch of (funding) salt.[14]

## Capacity to conduct proceedings: the family context

Two recent cases in the Family Division have once more considered the vexed question of litigation capacity and its broader implications.

At the end of July, Lieven J handed down judgment in *BF v LE* [2023] EWHC 2009, an attempted appeal, ultimately, of a decision made some four years previously, in which the importance of considering the issue of mental capacity at a specific point in time was reiterated.

The wife, BF, had been a victim of domestic abuse and made significant allegations during financial remedy proceedings as to the coercive and controlling behaviour of her husband, LE. These so-called "conduct" issues were, however, placed outside the financial remedy proceedings following an order made in April 2019, preventing either party from relying on them for the purposes of financial remedy resolution.

The instant appeal was brought by the wife in March 2022, challenging the decision of a district judge, DJ Solomon, in September 2020 not to set aside a further decision of a district judge, DJ Parry in September and October 2019 following which an order was made by consent dealing with the division of the former matrimonial home and when it should be sold. It appears – though is not entirely clear in the judgment – that permission to appeal the original decision on the grounds of material non-disclosure was refused

[14] Note, we are not criticising the Official Solicitor or her office here, but rather a system which asserts that there is a litigation friend of last resort, who would have been able to pick up the pieces in a case such as Mr Major's, but which does not in fact provide sufficient funding to enable this to happen.

in January 2020.

The appellant wife sought to argue that the October 2019 consent order and the financial remedy order contained therein should be set aside on the basis of "mistake" or "a subsequent event" (paragraph 39). It was submitted that DJ Solomon ought to have set aside the original 2019 decision on the basis that the appellant wife "lacked mental capacity" (sic) (paragraph 69) at the hearing of September 2019. Further, it was submitted that it was incumbent on the court to consider of its own volition whether a party was vulnerable and special measures ought to be put in place (paragraph 35).

Unpicking the proceedings, Lieven J found, first, that the original grant of permission to challenge the DJ Solomon decision was made on the erroneous basis that it was a challenge to a decision of September 2021, rather than 2020. Ultimately the appeal was refused – permission having been granted on the basis of a compelling reason to hear it rather than a real prospect of success (paragraph 60) - on the basis of the very significant delay in bringing it (16 months out of the time) and the appellant's inability to satisfy the *Denton v White* test in terms of justifying the said delay (paragraph 63).

As to the failure to make adequate arrangements at trial in light of the wife's vulnerability, Lieven J further observed that "*there is no consequence that a lack of participatory directions, even if they might have been appropriate under the relevant Rule and Practice Direction, will lead to a decision being quashed*" (paragraph 41).

On the capacity point, Lieven J held at paragraph 70 that:

> *A hearing that proceeded in circumstances where one party lacked mental capacity would be an error of law and would therefore fall under the right of appeal rather than the power to set aside in FPR9A. I do not consider this was an issue which could properly be described as a "mistake", nor was it something the W only became aware of later. I would therefore dismiss the appeal on this Ground as well*

She noted that the capacity report on which the appellant sought to rely referred only to a purported "lack of capacity" subsequent to the hearing. She noted:

> *72. It cannot simply be assumed that the W did not have capacity at the earlier hearing on the basis of* [the appellant's expert] *Dr Shaapveld's later opinion. Capacity is decision specific and there is a presumption in favour of a person having capacity, see s.1(2) MCA. Dr Shaapveld was focusing not simply on the one specific date, but also on whether the W had capacity to sign the agreement. That is not the same question as whether she had capacity during the earlier hearing and when she was giving evidence.*
>
> *73. It is highly relevant to the issue of capacity at the earlier hearing that DJ Parry, who was an extremely experienced DJ, did not appear to have any concerns about whether the W had capacity. Although the consideration of whether participatory directions are required in cases where domestic abuse is alleged has developed considerably in the time since DJ Parry's hearing, any experienced DJ would have been well aware of the need to consider whether a litigant, and particularly a litigant in person, might not have capacity.*
>
> *74. Further, I agree with DJ Solomon that the fact that the W was continuing to work as a solicitor throughout the period is relevant to whether she had mental capacity. Dr Proudman refers to the evidence that the W was suffering from a mental disorder, or at least the*

> *traits thereof, and that she was under a great deal of stress. But there is a significant difference between having a mental disorder and not having capacity to conduct litigation. Very many people with mental disorders still have mental capacity, as is apparent from the fact that many of those detained under the Mental Health Act 1986 continue to have capacity to instruct lawyers.*
>
> *75. Finally, the MCA creates a presumption in favour of capacity. I do not consider there was any error in DJ Solomon in not considering there was any evidence to find that presumption had been rebutted before DJ Parry.*

In the second week of the characteristically busy vacation period, Mostyn J handed down judgment in Baker v Baker [2023] EWFC 136, a financial remedies claim between a couple in their mid seventies with significant (albeit disputed) assets, divorcing after 37 years of marriage.

The husband was considered, in a report by clinical neuropsychologist, Dr Marcus Rogers, remarked upon by Mostyn J as being of "*exceptionally high quality*", to be "*very clearly incapacitous in respect to all his responsibilities, suggesting that at best he should now be viewed as being at risk of having only "fluctuating to capacity"*". Notwithstanding that Mr Baker's cognitive abilities and general health were in a more stable state at the time of the hearing, Mostyn J held at paragraph 4 that:

> *The finding of fluctuating capacity meant that when looking at the matter "longitudinally" the husband could not be said to have capacity to conduct these proceedings, as that requires continuous capacity over a prolonged period. Whether he had the capacity to give oral evidence would depend on his state at the time. In the event, it was not suggested that he lacked capacity to give oral evidence before me, and he did so. However, when assessing his evidence I must keep in mind the findings of Dr Rogers.*

The husband's clear vulnerabilities notwithstanding, Mostyn J characteristically pulled few punches in describing the *"abysmal quality of the husband's written and oral evidence which was a combination of bluster, avoidance and dishonesty* (paragraph 13).

Nonetheless, on the question of whether the husband had squirrelled away large sums of so-called *"pixie money"* in order to reduce the couple's combined assets to £11m as opposed the wife's estimation of over £30 million, the Mostyn J ultimately preferred the evidence of the husband.

Mostyn J observed that "[i]*n terms of demeanour the wife was by far the better witness. She answered questions directly and unemotionally. Her body language was not aggressive or avoidant. In contrast, the husband, in terms of demeanour, was an exceptionally poor witness. He was rude, argumentative, avoidant of direct questioning, truculent, and capped his testimony with a highly offensive and inflammatory remark*" (paragraph 15).

Nonetheless, Mostyn J noted:

> *18.* [...] *If the court is not on its guard, the influence of demeanour may insinuate itself into a trial judge's subconscious and contribute to the formation of an adverse perception of the witness as an unworthy person who does not deserve to succeed in the litigation. The formation of such a perception would be a form of bias. It is for this reason that I constantly remind myself when, in terms of demeanour, a witness is giving oral evidence very poorly, to put thoughts of annoyance and irritation out of my mind.*

Finding that past references to the husband holding sums of $100 million to be *"delusional braggadocio,"* (paragraph 7), Mostyn J held ultimately that the wife was better off than the husband such that while capital payments previously agreed should be discharged by the husband, and a maintenance award previously made by the court pending suit, complied with, no further maintenance payments were ordered by the husband to the wife and she was unsuccessful in her pursuit of a lump sum of over £9 million.

Despite her being the unsuccessful party, Mostyn J held that it would not be just for the wife to have to pay any of the husband's costs. He noted the wife's conduct during proceedings to have been reasonable, while the husband's was "abysmal". Accordingly, he held it would be "*a travesty of justice if he were not required to pay a substantial sum as a penalty for his delinquent behaviour, notwithstanding that I have approached this case on a net-of-costs basis*" (paragraph 113). He accordingly ordered him to pay £200,000 towards his wife's costs.

Permission to appeal has been extended to 15 September 2023: this may be a case of watch this space.

As paragraph 148 of the judgment notes, this was the final judgment of Mostyn J's judicial career. We wish him well, noting that although Parkinson's has brought down the curtain early on his judicial career it has, to mix a metaphor, opened the door to a broadcasting career in the shape of the Movers and Shakers podcast that he records with others with the condition, such as Jeremy Paxman.

## Short note: competence to conduct proceedings

In *C (Child: Ability to Instruct Solicitor)* [2023] EWCA Civ 889, the Court of Appeal conducted an important stock take of the position relating to the ability of children to instruct their own solicitor in care proceedings, to show that:

> *58.* [...] *whether the answer falls to be given by the child's solicitor or by the court, the question will be: Does this child have the ability to instruct a solicitor in the particular circumstances of the case, having regard to their understanding? The assessment will be based on a broad consideration of all relevant factors and any opinions from solicitors and experts. The guidance in Re W bears repeating:*
>
> > *"Understanding can be affected by all sorts of things, including the age of the child, his or her intelligence, his or her emotional and/or psychological and/or psychiatric and/or physical state, language ability, influence etc. The child will obviously need to comprehend enough of what the case is about (without being expected to display too sophisticated an understanding) and must have the capacity to give his or her own coherent instructions, without being more than usually inconsistent."*
>
> *The assessment will be case-specific. It will not be driven by welfare factors, or by a theoretical comparison between protection and autonomy, but by a practical assessment of the child's understanding in the particular context of the case. There are no presumptions and care will be taken not to over-value any particular feature. The consequence of a sound assessment will be that the child's rights and interests are respected and preserved.*

The court also considered the position of judges

meeting children, and the current status of the *Guidelines for Judges Meeting Children who are Subject to Family Proceedings*, issued by the Family Justice Council and Sir Nicholas Wall P in April 2010. Peter Jackson LJ considered that it did still remain a workable framework, and made the important points that

> *70. The right approach is for the judge to give close consideration to the Guidance with its numbered guidelines when planning and taking part in a meeting with a child. This will increase the likelihood of the meeting being as valuable as it can be for the child, whilst taking care to ensure that it is not allowed to develop into an evidence-gathering exercise. That risk may increase if the meeting becomes as long as it was in Re KP and in the present case; by keeping the meeting to an appropriate length, its purpose will be clearer to everyone. Where the judge does consider that something of evidential significance has arisen in the meeting, the parties should be made aware, as occurred in B v P.*
>
> *71. […], the Guidance affirms that the primary purpose of the meeting is to benefit the child but it realistically acknowledges that it may also benefit the judge and other family members. I take that to mean no more than that a meeting with a child can provide an additional perspective for the judge, as I said in Re A (Children) (Contact: Ultra-Orthodox Judaism: Transgender Parent) [2017] EWFC 4, [2017] 4 WLR 201 at [137]. The meeting does not change the evidence, but it may illuminate certain aspects of it. There is nothing wrong with that, and provided that the judge observes the limits surrounding the meeting and the parties have a clear account of what has occurred, problems are unlikely to arise in the great majority of cases.*

## Short note: deprivation of liberty and the need for precision

The case of *Re EF (A Child)* [2023] EWHC 1574 (Fam) concerned a 16 year old girl, who was under a care order and had been subject to a secure accommodation order (s.25 Children Act 1989). The local authority applied to invoke the inherent jurisdiction of the High Court to authorise a move to a 'therapeutic residential home' to which EF did not consent. Initially the authorisation was given, relying on Article 5(1)(d) (educational supervision) and (e) (unsound mind) of the European Convention on Human Rights. The placement broke down and EF moved to a holiday let with a 3:1 support package. EF moved to the current placement and a renewal of the DoL authorisation was sought.

David Lock KC (sitting as a Deputy High Court judge) queried why a further secure accommodation order had not been sought rather than use of the inherent jurisdiction and the local authority conceded that the threshold for such an order were met. The care provider was CQC-registered but the placement was not registered with OFSTED, although the application had been submitted.

David Lock KC considered the exhaustive list of justifications to deprive liberty in Article 5 ECHR, noting in passing "*that it may seem somewhat strange that depriving a child of his or her liberty to protect the child from coming to harm is not one of the grounds under article 5, but we have to work within the wording of the ECHR.*" He found no evidence that EF was of "unsound mind" so Article 5(1)(e) was not relevant. In relation to Article 5(1)(d), he noted the wide scope given to the concept of "educational supervision" in *Re T* [2022] AC 723 at paragraphs 88-88 but held:

> 24. […] *Whilst I accept that "educational provision" is to be interpreted widely in article 5, in my judgment it is not the*

*same as child protection. In this context, child protection is about protecting a child such as EF from coming to harm. "Education" in this context can include a proper protective element but must also, and possibly primarily, be focused on supporting, teaching, coaching and possibly persuading a child to understand the world around herself better and thus to support him or her to develop the skills she needs to protect herself from harm. A child may be protected in the short term from harm by series of restrictions which constrain his or her actions. However, in order to come within article 5 there needs to be a sufficient educational element to the care provision which is aimed at ensuring that the child is being educated to protect himself or herself from harm in the future. If that essential educational input is not present, in my judgment a package of restrictions which are aimed at preventing the child from coming to immediate harm may fall outside article 5(1)(d).*

*25. In this case there is evidence that the restrictions on EF's freedoms, including her ability to have money or use a phone, are considered by social workers to be necessary and appropriate to prevent her coming to harm. However, there is no evidence about any formal or informal education presently being provided to EF or any evidence about the educational strategies that staff are undertaking to help her to understand the world around her better and thus develop her own skills to protect herself from harm going forward. There is mention in the social work of the various attempts that have been made to date to provide formal education to EF but this is not the main focus or purpose of the care package. Whilst I accept that "education" is to be interpreted widely, there is no indication in the evidence that care staff consider that providing education in the broadest sense is part of their role, have been trained to deliver that education or are monitored by the Council on whether they are providing any educational input to her.*

There was no education plan for formal education to be provided to EF and it was not clear on the evidence what steps were being taken by care staff to educate EF with the aim of teaching her the skills she needed to keep herself safe as an adult or that care staff understood that this was an essential role that they have to undertake.

The judge considered *Re T* [2022] AC 723 which related to the use of the inherent jurisdiction to authorise a DOL in a placement which is either not in a registered children's home or is in a children's home that has not been approved for secure accommodation. He held:

*33. I thus consider that there are two factors that any local authority has to address in making a DOLS application. First, it must show that there are "imperative considerations of necessity" which justify the use of the DOLS on the facts of the particular case. That means showing both why the restrictions are necessary and why the local authority has not discharged its duties to the child by arranging secure accommodation. Secondly, the local authority must demonstrate that the President's Guidance is being followed or, if it is not being followed, to explain why that is the case.*

Given that the criteria for a secure accommodation order were conceded, the local authority had to justify why it had not been used (paragraph 40). In the meantime, given there was no alternative accommodation available, and the present restrictions were necessary and in EF's best interests, the judge authorised the deprivation of liberty until the next hearing in 2 weeks. At that hearing the local authority would

need to explain:

> *a. Why the Council consider there are imperative considerations of necessity which justify EF to be deprived of her liberty in unregulated accommodation as opposed to being placed in a regulated secure children's home;*
>
> *b. What steps are being taken to provide EF with educational provision at the Property as opposed to just ensuring that she is safe from harm and what instructions and training have been provided to care staff around educating EF. There will need to be a proper educational plan for EF;*
>
> *c. How, if this placement is to continue, the Council propose to scale back the restrictions on EF so that she can gradually develop the skills needed to keep herself safe when she becomes an adult in less than 2 years time; and*
>
> *d. What the Council propose for EF in the event that the court is not prepared to make a DOLS order.*

### Comment

The legal justification under Article 5 ECHR for depriving those under 18 of their liberty has not received the intellectual rigour in the case law that it deserves, and this judgment is the beginning of an important discussion. Article 5 does not permit the State to detain someone simply because it is in their "best interests". The grounds are exhaustive and the *Cheshire West* interpretation of a deprivation of liberty challenges public bodies to justify the arrangements within them. On the facts, the lack of evidence regarding educational supervision was probably the key problem in this case.

The decision also calls into question what the basis for was authorising the albeit short-term 2-week continuing deprivation of liberty. Perhaps it could be said that the inherent jurisdiction was deployed as an emergency pending the further enquiries and evidence that was ordered.

## Deprivation of liberty for under 18s

The government has published some concise guidance on placing children in circumstances amounting to a deprivation of liberty. The key points are:

1. A DoL order is required to make the arrangements lawful and the order 'allows these restrictions as a maximum – it does not mean that, as a provider, you must apply all the restrictions at all times (for example, if the need for the restrictions has reduced and this has been agreed with the child's social worker).'
2. The DoL order 'only makes the restrictions/deprivation of liberty lawful – it does not mean that the provider does not need to register with Ofsted or CIW if operating a children's home or care home service.' And the court may refuse to authorise if the placement provider will not apply to register as it is an offence to operate or manage these unregistered.

It should be read in conjunction with the Guidance issued by the President of the Family Division on 12 November 2019 in relation to placing a child in an unregistered children's home and with the addendum dated 1 December 2020 to the Guidance.

# NORTHERN IRELAND

## Short note: suicide risk, the ECHR balancing exercise and the inherent jurisdiction – a Northern Irish perspective

*A Health and Social Care Trust v JU* [2023] NIFam 12 provides an interesting take on the extent of positive obligations under Article 2 ECHR owed

in the context of mental ill-health. Importantly, and by contrast with the majority of the cases in which this issue been examined, the question was asked in real time, rather than after the event.

The case arose in relation to a woman in her early seventies, who lived in a private residential nursing home in a rural setting. She was married but estranged from her husband. She had two children and had contact with them on an occasional basis. She suffered from long-standing mental health problems and has diagnoses (which she contested) of persistent delusional disorder, emotionally unstable personality traits and recurrent depressive disorder. She had had number of hospital admissions, including under the compulsory provisions of the Mental Health (Northern Ireland) Order 1986 ('MHO'). She was now subject to a guardianship order under the MHO.

The Health and Social Trust responsible for her made an application under the inherent jurisdiction for orders – including authority to deprive JU of her liberty, because it considered that it might require powers to ensure her safe management should her condition deteriorate. The application was made under the inherent jurisdiction because it was agreed that JU currently had capacity (precisely as to what was not set out in the judgment), such that the deprivation of liberty provisions under the Mental Capacity Act (Northern Ireland) could not currently apply to her.

Helpfully, especially for those not familiar with the legislative landscape in Northern Ireland, McFarland J summarised JU's situation and the framework relating to it thus (all references to 'Art' being to Articles in the MHO):

> 29. […] *She is subject to a guardianship order because it has been determined that she is suffering from a mental illness or severe mental handicap of a nature and degree which warrants her reception into guardianship. It has also been determined as being necessary in the interests of her welfare (Art. 12(2)).*
>
> *30. Under the terms of the guardianship order JU is required to reside at the nursing home. Should she absent herself from the nursing home without the leave of her guardian, a police officer, a social worker or any other person duly authorised by the guardian, or the Trust has the power, without warrant, to detain JU and to return her to the nursing home (Art. 29(2)).*
>
> *31. JU does not at present satisfy the detention provisions for either an assessment order or a hospital order (see Art. 4 and Art. 12) which require evidence of a substantial likelihood of serious physical harm either to her or to another person. The diagnostic test for an assessment order is that she is suffering from a mental disorder of a nature or degree which warrants her detention in a hospital for assessment. The diagnostic test for a hospital order is that the patient is suffering from a mental illness or severe mental impairment of a nature or degree which warrants her detention in hospital for medical treatment.*
>
> *32. Should JU's condition deteriorate, and it is considered that she does satisfy the conditions for the making of an assessment order, on the making of an application, the Trust has the power to take and convey JU to a hospital (Art. 8(1)) and to detain her in the hospital (Art. 8(2)(a)). If she was already an in-patient at a hospital, any application gives the Trust the power to detain her (Art. 7A).*
>
> *33. The DOL provisions in the MCA can not apply to her because she is capacitous, however should JU lose her*

> *capacity, power is vested in the Trust to take emergency steps to apply DOL provisions (section 65).*

The Trust's case was that, should JU's condition deteriorate, it was powerless to act to secure her well-being and to fulfil its Article 2 ECHR positive obligations towards her. As McFarland J identified at paragraph 35, this gave rise to the following questions:

> *a) Does the Trust owe an operational Article 2 ECHR duty of care to JU?;*
> *(b) If so, is that duty currently engaged?;*
> *(c) If not currently engaged, in the event of deterioration in JU's mental health and the duty becomes engaged, are the existing statutory powers sufficient for the Trust to take lawful steps to fulfil its duty?;*
> *(d) If the existing statutory powers are insufficient, is the inherent jurisdiction of the court available to permit the deprivation of the liberty of JU?;*
> *(e) If they are available, should the court exercise its discretion and grant the Trust, and others, the powers the Trust seeks, and on what terms?*
> *In relation to the first of these, McFarland J identified at paragraph 36 that it exposed what he considered to be a fundamental, if not fatal, flaw in the Trust's argument:*
> *Its case is that the operational Article 2 ECHR duty applies and as it cannot lawfully exercise control over JU, it needs extra-statutory powers from the court. The case-law however suggests that the state's operational Article 2 ECHR duty only arises to citizens over whom the state exercises control.*

The case-law referred by McFarland J included the Supreme Court decisions in *Rabone v Pennine Care* [2012] UKSC 2 (upon which the Trust placed reliance) and *Maguire* [2023] UKSC 20 (which McFarland J identified as more relevant to the interface between Article 2 and medical negligence), and, in particular, *Oliveira v Portugal* [2019] 69 EHRR 8. He also referred to the English Court of Appeal decision in *Morahan* [2021] EWHC 1603.

Contrary to the position advanced by the Trust, McFarland J found (at paragraph 51) that it – and the guardian exercising powers under the guardianship order – did exercise control over JU, such that it owed an operational duty towards her. However, it is perhaps more accurate to say that he found that they owed an 'in principle' duty towards her, because in the next section he considered whether the operational duty was, in fact, currently engaged, requiring him to look at factors set out in the *Oliveira* case:

> *52 […] There is clearly a history of mental health problems. At times these problems have presented as being grave, but currently they are under control. There have been previous attempts at self-harm including drug over-doses and a significant incident of attempted suicide in 2017. There is no evidence of any current suicidal thoughts or threats. Occasionally JU presents in a heightened state of distress but there is no evidence to suggest that this cannot be managed within the nursing home and by its staff. The only significant factor is the suicide attempt [in 2017], however because of the vintage of that event, the fact that it has not been repeated, the successful response by JU to medical intervention to date, and her current presentation within the setting of the nursing home where she now resides, the level of the duty has to be regarded as being at a relatively modest level. To use the popular phase, there are no current 'red flags' in this case.*
>
> *53. In the circumstances the evidence suggests that the operational Article 2 ECHR duty is not currently engaged.*

> *54. JU's mood and condition may fluctuate from time to time, as will often be the case with people with mental health problems, but there is nothing to suggest any particular problem at this moment. All the evidence suggests that the staff within the nursing home are well able to identify and cope with any heightened displays of anxiety by JU and, again, there is nothing to suggest that the nursing home staff are not able to cope with any peaks and troughs in JU's presentation based on the history of her period of residence in the nursing home.*

Turning, then to the question of whether the Trust had adequate powers to fulfil its Article 2 operational duty if JU's condition deteriorated, McFarland J noted (at paragraph 57) "*the problem of leaving of such decision making powers as to the diagnosis of a deterioration in JU's mental condition to non-medically qualified staff and then vesting the exercise of powers of DOL in the hands of non-state actors, ie the nursing home staff.*" More fundamentally, McFarland J did not consider that the powers of "significant and constant" monitoring of JU sought by the Trust were required because, whilst nursing home staff could not under the provisions of the guardianship order stop her leaving, "*once she stepped over the threshold of the premises and did so without leave, she would be subject to detention and return*" (paragraph 61). He also considered that, given the asserted opinion of the psychiatrist upon whose evidence the Trust relied as to "*the substantial likelihood of harm, and the already confirmed diagnoses of her mental health conditions, it is difficult to come to a conclusion that she could not be subject at the very least to an assessment order, if not a hospital order, even at this time and without any deterioration*" (paragraph 63). Finally, McFarland J noted that "[t]*he DOL provisions in the MCA would also be available in any emergency (see sections 24 and 65). Section 65 (5) would allow a person without expertise (ie a nursing home employee) to act in an emergency based on their reasonable belief that it was necessary to deprive JU of her liberty without delay, on the basis that she lacked capacity and to prevent harm to JU*" (paragraph 64).

In light of his conclusions, it was not strictly necessary for McFarland J to determine whether the inherent jurisdiction of the (Northern Ireland) High Court was available and, if it were to be, whether it should be exercised. Starting with the first question, he reminded himself it was necessary to show that there was a gap in any legislative scheme before the court can invoke its inherent jurisdiction. Whilst the failure to commence the MCA (NI) 2016 in full meant that certain legislative provisions were not available, McFarland J considered that it was "*difficult to actually itemise any gaps in the legislation when it comes to imposing DOL on capacitous adults*"(paragraph 71), continuing – after a review of the Strasbourg case-law that:

> 74. With the necessity for the strict interpretation of Article 5(1)(e) ECHR and the narrow interpretation of "person of unsound mind", I would conclude that the legislative provisions in the MHO and the MCA are adequate and do not have any gaps that need to be filled by the inherent power. There are powers to detain, assess and treat within the MHO. The provisions are compliant with Article 5(1)(e). The MHO powers allow for an immediate response in the event of a sudden deterioration. Similarly, although a capacitous person cannot be subject to a DOL, should they lose their capacity, then there are powers available under the MCA to put in place appropriate DOL orders. Both the MHO and the MCA provide for permissible steps to be taken in an emergency.

And, having reviewed the line of English cases concerning the use of the inherent jurisdiction in relation to capacitous adults, he summarised them thus:

> *83. The theme emerging from this recent line of authority is not a new one but reflects a caution which the courts have always held against any form of interference in the liberty of a citizen. If the citizen lacks capacity either because of their age or their medical condition, then the court will act, as required, to protect their well-being. If, however, they do not lack capacity, it is not the role of the court to interfere with the liberty of a citizen, albeit for the best of motives. The deprivation of the liberty of a capacitous adult is a matter for the legislature subject to the compatibility provisions of the Human Rights Act 1998.*

McFarland J, it appears, would have followed this line of thinking, making clear in his conclusion at paragraph 89 that, even if there were gaps in the legislation allowing the court to exercise its inherent jurisdiction, the "court could not restrict the liberty of JU so long as she retained her capacity."

Before he reached his conclusion, however, McFarland J had made the following observations about Article 8, noting that:

> *85. This case does raise important issues, not least for JU but also the guardian and for the Trust, but the starting point must be that JU does not lack capacity. The concern in this case is that JU may, at some time in the future, take steps to end her life. The law in this country recognises that people who have capacity can exercise that capacity by making decisions to end their own life. They can do so by refusing medical treatment or they can do so by taking active steps to bring about their death. This has been recognised by the ECtHR in Haas v Switzerland [2011] ECHR 2422 in the following terms:*
>
> > *"An individual's right to decide by what means and at what point his or her life will end, provided he or she is capable of freely reaching a decision on this question and acting in consequence, is one of the aspects of the right to respect for private life within the meaning of Article 8 of the Convention."*
>
> *86. In Hiller the ECtHR made specific reference to The Council of Europe's Recommendation (Rec (2004) 10) concerning the human rights and dignity of persons with mental disorder, Principle 9.1 of the UN General Assembly's resolution (17 December 1991) – "Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others", and the UN's convention on the rights of persons with disabilities (13 December 2006).*
>
> *87. The ECtHR at [54] and [55] concluded that there had been no disregard by Austria of its Article 2 ECHR obligations because it was necessary to scale back any DOL without delay when the patient's medication started to work, and he was compliant with the hospital rules because the advantages of an open hospitalisation clearly outweighed the disadvantages of a closed option. Ultimately it was decided that had the patient's liberty been restricted more than it had been, then this would have raised issues not only under Articles 3 (prohibition of torture and inhuman treatment), Article 5 and Article*

*8 ECHR.*

In light of this authority, McFarland J noted:

> *88. There is a strong argument to suggest that granting these powers to the Trust when JU is not only capacitous, but also receiving and taking appropriate medication, and is both settled and compliant within the nursing home and capable of carrying on her life with appropriate social interaction with staff, fellow residents and the wider community, would be hard to justify under Article 8 ECHR as a proportionate response.*

### Comment

The judgment was delivered in the Northern Ireland context, such that its specific conclusions need to be read against that context. For instance, the emergency provisions of the MCA (NI) that McFarland J relied upon to find that there was no legislative gap do not have any equivalent in the MCA (E&W), and are not likely to for the foreseeable future given that the amendments proposed to s.4B in the Mental Capacity (Amendment) Act 2019 are not being brought into force.

But the observations about the ECHR are ones that might be thought to have a wider resonance. In relation to Article 2, it is not quite correct to say, as McFarland J did, that operational obligations under Article 2 arise only in relation to those over whom the State exercises control. The obligation under Article 2 to 'take appropriate steps to safeguard the lives of those within its jurisdiction' arises in a range of different circumstances, helpfully summarised at paragraphs 11 to 67 of the guide to Article 2 produced by the staff of the ECtHR. It is, however, undoubtedly true that, in the context of self-harm and suicide risk, the question of the control being exercised by the State is particularly significant – even, as then identified by McFarland J – reference may then have to be made to both Articles 5 and 8 in terms of seeking to determine the correct course of action.

Above all, perhaps, it is of importance that it is infinitely better that these difficult questions are tackled, where necessary by way of court application, whilst there are still steps that might be taken, rather than applying the 'retrospectoscope' after a person has died to identify all the possible points at which something different might have been done.

## IRELAND[15]

It has been an immensely interesting full legal term since the commencement of the Assisted Decision-Making (Capacity) Act 2015 ('ADMCA'). The Circuit Courts around the island are getting to grips with their new jurisdiction, with the list in Dublin forging ahead under the careful stewardship of Judge John O'Connor. The High Court is balancing its list between reviewing detention orders, discharging wards from wardship, exercising its inherent jurisdiction in respect of new detention orders, and continuing to hear applications for wardship under the transitional provisions. In that time, there have been three judgments touching upon and concerning capacity, the ADMCA, and wardship. In this edition, Emma Slattery considers *In the Matter of KK* and a *Governor of a Prison v XY*, whilst Henry Minogue considers *In the Matter of CF*.

### Detention Orders in Ireland post-enactment of the ADMCA

*In the Matter of KK* [2023] IEHC 306, the Irish High Court considered the appropriate basis on which

[15] Prepared by our Irish correspondents, Emma Slattery BL and Henry Minogue BL.

to make a detention order in respect of an existing ward of court, who did not have a detention order in place at the time of commencement of the ADMCA. Given the particular facts, the case may be of limited application. However, the process of statutory interpretation warrants consideration. The case concerned KK, a young woman who is a Ward of Court, who had been admitted to wardship prior to the commencement of the ADMCA. The Child and Family Agency ('CFA') sought detention orders to ensure KK's return if she absconded or failed to come back from leave.

The CFA and the Health Service Executive ('HSE') argued that a detention order could be made under a transitional provision in s.56(2) of the ADMCA which provides that '*pending a declaration under* section 55*(1), the jurisdiction of the wardship court as set out in sections 9 and 22(2) of the Courts (Supplemental Provisions) Act 1961 shall continue to apply*', whilst the General Solicitor disagreed and submitted that new detention orders could only be made based on the inherent jurisdiction of the High Court.

Ultimately, the court concluded that the power to make new detention orders under the s.9 of the Courts (Supplemental Provisions) Act 1961 had not survived the commencement of the ADMCA despite section 56(2). The court's reasoning was based on the changes introduced by Part 10 of the ADMCA, which requires the review of the detention of wards who were detained on the date of commencement of the ADMCA '*as soon as possible*'. The difficulty posed by Part 10 was that any new detention order would not benefit from the review process. The court found that the changes indicated a legislative intent to alter the regime for detaining wards, that s.9 did not explicitly provide for the making of detention orders, and that the transitional provision retained the jurisdiction without specifying its nature. The court determined that the inherent jurisdiction of the High Court to make orders regarding persons lacking capacity, including detention orders, could protect the personal rights of incapacitated individuals.

In summary, the court concluded that the power to make new detention orders pursuant to s.9 no longer applied to existing wards, in respect of whom a detention order was not already in place, after the commencement of the ADMCA, despite s.56(2). However, detention orders could still be made under the inherent jurisdiction of the High Court to protect the personal rights of those who lack capacity.

*Emma Slattery*

### Irish High Court considers Advance Healthcare Directive

Part 8 of the ADMCA provides for the creation of Advance Healthcare Directives ('AHD'). An AHD is an advance expression made by a person who has capacity of his or her will and preferences concerning treatment decisions that may arise in respect of him or her if he or she subsequently lacks capacity.

The first consideration of an AHD made under the ADMCA was in the case of a *Governor of a Prison -v- XY* [2023] IEHC 361. This case addressed the issue of what actions the prison authorities should take when a mentally capable prisoner decided to stop eating and drinking, knowing that it would inevitably result in his or her death. The prisoner had been assessed to have full capacity and the Governor of the prison sought orders to respect the prisoner's wishes. The Governor sought orders confirming the validity of the AHD and confirming that the prisoner's wishes as set out in the AHD should be respected and should thus remain operative in the event that the prisoner was to lose capacity or to become unconscious or otherwise

incapable of making a decision whether to accept food, fluids, and medical intervention.

The Advance Healthcare Directive (AHD) signed by the prisoner addressed the prisoner's on-going food and fluid refusal whilst in prison. It emphasised that the directive applied to life-sustaining treatment even if the prisoner's life is at risk. The AHD expressed the prisoner's wishes to not receive any medical intervention, including CPR, IV fluids, or any medication. Additionally, it stated that if the prisoner were actively dying, he or she preferred that it be in a clinical setting, such as a hospital or hospice. The document was signed by the prisoner and its execution witnessed by two prison officials.

The Court determined that the Advance Healthcare Directive (AHD) made by the prisoner was valid. The AHD complied with the formal requirements set forth in Part 8 of the 2015 Act. It was a written document that included the prisoner's name, date of birth, and contact details. The AHD was signed by the prisoner and witnessed by two individuals.

The case does raise an interesting issue regarding the delineation between basic care and artificial nutrition or artificial hydration. The ADMCA states that an AHD does not apply to the administration of basic care to the directive-maker. Basic care includes, but is not limited to, provisions such as warmth, shelter, oral nutrition, oral hydration, and hygiene measures. However, it does not encompass artificial nutrition or artificial hydration.

The AHD at issue in *XY* did not purport to provide for the issue of basic care. It is limited to the prisoner's intention not to receive any medical intervention and to die in a clinical setting in the context of his or her refusal of food and hydration in prison. The question arose as to whether the prison would be required to provide oral nutrition or hydration against the wishes of the prison. The court found that no such obligation exists. The Court held at paragraph 103 that:

> *The prisoner made it very clear that he or she did not wish to take food or fluids. The provision of food or fluids against the prisoner's clearly expressed decision and wishes would be fundamentally inconsistent with the entire objective of Part 8 of the 2015 Act as set out in ss. 83(1) and (2)."*

The Court found that force-feeding or forcibly providing hydration to an individual would likely fall under the category of "artificial nutrition" or "artificial hydration".

Ultimately, the court declared that the prisoner's AHD was valid, but not yet applicable as the prisoner continued to have capacity. However, the Court confirmed that the Governor was entitled to give effect to the AHD if the prisoner were to lose capacity.

*Emma Slattery*

### Balancing best interests under the wardship jurisdiction

*In the Matter of C.F* [2023] IEHC 321 concerned a 75-year-old man with dementia who had limb-threatening ischaemia and severe peripheral vascular disease in his right leg. Despite a successful initial surgery, his post-operative course has been complicated by his refusal to follow medical advice, leading to a series of infections and risks. All of the medical professionals agreed that Mr. F lacked the capacity to give or to refuse consent to medical treatment, including amputation. The issue before the court was whether Mr. F's leg ought to be amputated. The court noted that "*…a strict medical approach to Mr. F's treatment and care would require amputation of his right leg. While the amputation of the leg would solve the medical crisis, this would likely lead to a significant*

*disturbance to his mental wellbeing, which would amount to a further crisis that would impact on him for the rest of his life*".

From a procedural perspective, the case provides some helpful guidance as to when the wardship jurisdiction can continue to apply despite the fact that the person had not been admitted to wardship prior to the commencement of the ADMCA. The court found that the wardship jurisdiction had been invoked prior to the commencement of the ADMCA because an inquiry order was made prior to commencement.

In considering whether Mr. F's leg ought to be amputated, in addition to considering the long-standing principles enumerated by Ms. Justice Denham *In Re A Ward,* President Barniville set out some additional 'fundamental principles' at pars. 160 – 170, as follows:

1. *An adult person with full capacity must provide consent if medical treatment is to be provided, subject to some very rare exceptions;*
2. *The fact that a person has lost capacity does not mean that he or she has lost the benefit of the personal rights guaranteed under the Constitution;*
3. *There is a strong presumption in favour of maintaining life and of taking all necessary steps to do so;*
4. *Apart from the constitutional right to life, several other constitutional rights are engaged in a case such as this, such as the constitutional rights to privacy, bodily integrity, autonomy, equality, and dignity in life and in death;*
5. *The clearly and consistently expressed wishes of the ward must be given considerable weight, notwithstanding his or her lack of capacity; and*
6. *The views of the ward's family are also important and should thus be accorded considerable weight.*

After having comprehensively considered Mr. F's personal circumstances and thoroughly analysed the applicable jurisprudence, [16] the court decided that it would not be in Mr. F's best interests that his right leg be amputated. Instead, it was determined that Mr. F ought to be discharged home with extensive palliative care and other arrangements, when clinically appropriate to do so.

*Henry Minogue*

## FURTHER AFIELD

### The EU, the CRPD, older adults and the international protection of adults

As noted in the July Report, on 31 May 2023, the European Commission set out two proposals to seek to secure better cross-border cooperation in relation to adults who are not in a position to protect their own interests. The UN Special Rapporteur on the Rights of Persons with Disabilities (Gerard Quinn) and the Independent Expert on the Enjoyment of all Human Rights by Older Persons (Claudia Mahler) published a joint submission on 2 August 2023 to the European Commission setting out a number of ways in the proposals required to be reconsidered in light of the obligations imposed by the CRPD, together with the modern understanding of the rights of older persons.[17]

[16] *See* paras 147 to 182 of Judgment. See also *In Re A Ward of Court (withholding medical treatment) (No. 2)* [1996] 2 I.R. 79 ("In Re A Ward"), *In Re C. (A Ward of Court)* [2021] IEHC 318, *In Re J.J.* [2021] IESC 1, *Health Service Executive v. Ms. A.* [2021] IEHC 836.

[17] Full disclosure, Alex having assisted the Rapporteur and Expert with previous work in this area, assisted again with this submission.

## News from Australia

An important development in Australia merits note, in the form of the Research Report published in July 2023[18] on *Restrictive practices: A pathway to elimination*, as part of the Australian Royal Commission into Violence, Abuse and Neglect of People with Disability. The report's analysis of the 'ecological' system of violence, coercion and control, in particular, is both compelling and of wider application. We note here, for instance, the five core workplace concerns that appear to work both separately and together to drive use of restrictive practices:

> *a. Experience levels of staff. Research suggests that staff who have worked in their role for a long period of time are more likely to use restrictive practices against people with disability than staff who are less experienced in the role. Studies suggest that more experienced staff are often resistant to change, even after receiving contemporary training. This resistance to change can occur because staff express a preference to do things in the same way that they always have; staff hold beliefs that the old way of doing things is the best; and/or because of four other complex, workplace dynamics outlined separately below.*
>
> *b. Institutional cultures of blame and risk management. One of the workplace dynamics that appears to inform and shape staff views about restrictive practices is an institutional culture of blame and risk management. Studies suggest a blaming culture within institutions and organisations can increase staff preoccupation with risk. This focus on risk can then contribute to persistent stigmatising beliefs about people with disability as inherently risky and/or dangerous. In many organisational settings, this persistent stigmatising belief typically centres around perceived 'behaviours of concern'.*
>
> *c. Occupational health and safety concerns of staff. Australian research has identified a growing number of organisations which justify increased use of restrictive practices by reference to occupational health and safety concerns of staff. These concerns both emerge from, and play out within, a context where there are uneven power dynamics between those who 'work' and those who 'reside' in these formally administered settings. These uneven power dynamics set the scene for the occupational health and safety concerns of staff to be prioritised over the rights of people with disability in these settings.*
>
> *d. Staff perceptions about their 'duty of care' obligations. A duty of care is a legal obligation to avoid doing things that could foreseeably cause harm to another person. Research suggests staff may work with vague or incorrect proximations of duty of care obligations. Restrictive practices may therefore be used as a mechanism by staff to avoid perceived situations of harm where staff believe they could be held legally liable if they do not take action.*
>
> *e. Under-resourced services and supports for people with disability. Research suggests there is an association between the resourcing of the workplace, staff perceptions of safety, and staff attitudes towards and use of restrictive practices for the purposes of maintaining a 'safe' environment. In practice this can mean that some staff may use restrictive*

[18] The authors being Dr Claire Spivakovsky (The University of Melbourne); Associate Professor Linda Steele University of Technology Sydney); and Associate Professor Dinesh Wadiwel (The University of Sydney)

> *practices as one of the primary tools via which they can negotiate the broader structural and economic issue associated with an under-resourced and understaffed disability sector*

And that:

Notably, restrictive practices are also often shrouded by institutional cultures of silence. These cultures see the actions of staff that occur in the workplace – including decisions to use restrictive practices as a matter of convenience or control – not being discussed with the person with disability nor anyone else external to the organisation.

# SCOTLAND

## 1. Scotland in violation of Article 3 ECHR?

Article 3 of the European Convention on Human Rights is succinct, and best quoted rather than described. It reads: "No-one shall be subjected to torture or to inhuman or degrading treatment or punishment". Unhelpfully for some purposes, it is headed "Prohibition of torture", which can obscure, or at least divert attention from, the four potential combinations of "inhuman or degrading" and "treatment or punishment". A further complicating factor is that the report of the relevant Council of Europe Committee to the United Kingdom in June 2021 appears to report solely in relation to England, excluding the other nations of the United Kingdom. The full title of the report is "Report to the United Kingdom Government on the periodic visit to the United Kingdom carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment from 8 to 21 June 2021." This leaves the uncomfortable possibility that inhuman or degrading treatment or punishment, contrary to Article 3, could be occurring "under the radar" in Scotland, in violation of Article 3.

That such is not only a theoretical possibility, lurking in some murky area, has been brought starkly to our attention by press reports of a decision of Mr Justice Paul McDermott in the High Court of Ireland on 29th June 2023. A man identified as "RS" was described as suffering from "a medley of mental health conditions". He was accused of threatening a man with a firearm (contrary to section 16A of the Firearms Act 1968) and assaulting the man by stamping on his head and hitting him with a brick, to the severe injury of that man and to the danger of his life. Scotland's Crown Office sought to extradite RS from Ireland. The court heard that RS would, if extradited, be remanded to prison in Scotland where he would be confined for 22 hours a day with less than three square metres of personal space. Mr Justice McDermott held that RS would in such circumstances have found prison "much more severe" than persons not suffering from his mental health conditions. He refused the extradition request on the basis that if sent to Scotland RS would face "a real and substantial risk of inhuman or degrading treatment".

*Adrian D Ward*

## 2. His Majesty's Advocate v Tigh-Na-Muirn Ltd [2023] HCJAC 30

This case involved an appeal by the Crown against the level of a fine imposed on a care home for breach of its statutory health and safety obligations. It is another very sad reminder of the potential serious consequences of isolation affecting people living in residential care during the pandemic. It involved the tragic death of a 90 year old man, David Fyfe, who had underlying health conditions, including Alzheimer's disease, and who was living in a privately owned residential home that was owned and run by the respondent, Tigh-Na-Muirn Ltd (TNM).

Mr Fyfe had contracted Covid-19 in May 2020 and was therefore isolated in his room at the home to prevent the spread of infection. The home's covid resilience plan, made by THM managers, was updated regularly (in accordance with HSE, Public Health Scotland, Health Protection Scotland, Care Inspectorate, Social Work and Angus Council advice) and was based on the availability of supplies at any given time. However, despite employing health and safety consultants, TNM did not consult them about the resilience plan. Moreover, TNM staff found that the advice was changing daily and official information sometimes confusing or conflicting. Because there were pandemic associated supply issues relating to clinical wipes the resilience plan was altered to include Sterigerm (ammonia)

cleaning sanitiser. The resilience plan stated that that isolated rooms would have their own cleaning kits to be kept in each room and not removed. Unfortunately, Mr Fyfe ingested some of the cleaning sanitiser and as a result he developed acute severe airway inflammation and pneumonia from which he died. This was found to be the primary cause of his death.

A local authority investigation found that 'control of substances hazardous to health risk' assessments had been carried out by TNM but these had not covered risk to residents from chemicals. This was because chemicals were not usually left in such a way that residents were exposed to them.

TNM accepted its responsibility and pled guilty to a breach of sections 3(1) and 33(1)(a) of the Health and Safety at Work etc Act 1974. The sheriff court found this to be a serious breach of obligation, and that although the breach was not deliberate and one of omission there was an aggravating factor in that Mr Fyfe was a vulnerable individual owing to his Alzheimer's disease and TNM being responsible for his care. However, the sheriff considered TNM's culpability to be low. This was because:

> '• *The management team did not have any cause to imagine that Mr Fyfe might deliberately or accidentally ingest the cleaning agent;*
>
> • *Genuine efforts were being made in extremely challenges* [sic] *circumstances to respond to and react to a rapidly changing situation and to keep residents and staff safe, although they were inadequate on this occasion; and*
>
> • *The incident was an isolated one.*'

The sheriff was therefore of the opinion that a fine at the lower end of the range of possible sentences was appropriate. She accordingly set the fine at £30,000 reduced to £20,000 because TNM had entered a guilty plea.

The Crown appealed to the High Court of Justiciary against this sentence. Finding in favour of the Crown, the Court sympathised with TNM regarding the very difficult position care homes were in during the pandemic. However, on the facts, it found that, contrary to the sheriff's view, the risk of harm not an isolated incident (as claimed by TNM) but a continuing breach and that TNM's culpability therefore was not low. For this reason, the Court increased the fine to £90,000 reduced to £60,000 because of TNM's guilty plea.

A full reading of the case for its facts and the High Court of Justiciary's reasoning is strongly recommended. It reminds us of the stark realities facing people living in care homes and those responsible for their care during the pandemic, and of the lessons to be learned. Interestingly, however, the Court did not mention or consider Article 2 ECHR (the right to life). This was perhaps because it was considering sentencing relating to statutory offences, but it nevertheless seems unusual given the circumstances and seriousness of this case.

## 3. AB Report

On 3rd August 2023 the Mental Welfare Commission issued its report on its "Investigation into the care and treatment of AB", available at: Investigation into the care and treatment of AB | Mental Welfare Commission for Scotland (mwcscot.org.uk). We do not seek here to summarise this most significant and important 53-page report, but rather to draw attention to its issue and to recommend that it be read, though we do pick out a few points. We do however seek to outline briefly the circumstances and some particular points, with comments. One cannot better the overview

provided by Suzanne McGuinness, the Commission's Executive Director (Social Work) in the introduction to the report at the above link:

> *"This is a very distressing case, where a vulnerable person was isolated from their family by another individual over many years, to their personal detriment. It resulted in increased poor health and an early death. Despite opportunities, no effective intervention which would have changed AB's circumstances was made.*
>
> *"Our recommendations for change cover social work and health care, but they also address the issue of legal authority and power of attorney, recognising that someone who may lack capacity for decision making about their health or welfare needs may be under the undue influence of another person.*
>
> *"It is vital that this report is shared, read and discussed in detail by social work, mental health and general health services across Scotland, and by legal services. We believe there are lessons to be learned across the country and we hope this in-depth report will help raise awareness of the importance of identifying where undue influence may exist and the legislative frameworks which can be used to avoid similar situations in future."*

One would only add the explanation that the person referred to as "another individual" above is identified as CD in the report. AB granted a power of attorney in favour of CD. A solicitor prepared the power of attorney, and certified it on the basis of the solicitor's personal knowledge of AB, without reference to having consulted anyone. That solicitor had represented AB at an appeal against short-term detention five months before preparing the power of attorney document, at which hearing the solicitor would have heard the concerns of a consultant psychiatrist about AB's impaired capacity arising from AB's mild to moderate learning disability, and also concerns about CD's influence on AB. The Commission is clear that the solicitor ought to have sought a medical report on AB's capacity to grant the power of attorney.

In sections 9 and 10 of the report, the Commission makes six recommendations to "NHS A and local authority A". One national recommendation, and ten "learning points", including learning points relating to undue pressure and coercive control; and a learning point specifically in relation to solicitors acting in the granting of powers of attorney, in the following terms:

> *"Solicitors when consulting with clients seeking to grant power of attorney must fully consider their client's capacity to do so, if there is any undue influence or vulnerability and the attorney's ability to fully comprehend their role. The Commission addressed this issue in a report published in 2012 Mr and Mrs D. In response the Law Society of Scotland introduced guidance for solicitors which remains current. The guidance for Rule B1:5 of the Law Society of Scotland Rules notes that whilst the solicitor must satisfy themselves that a client has capacity, "if there is any doubt as to a client's capacity to instruct in a particular case (for example a client may have a profound learning disability), input should be sought from an appropriate professional."*

Further issues arose because the same solicitor wrote to social work, and made complaints to the Health and Social Care Partnership, in each case referring in the headings to those letters to both AB and CD, without making clear for which of them the solicitor was acting. The question "Who is my client?" featured prominently in a series of seminars that I gave for the Law Society of Scotland around the country in the 1990s, and

– shortly after passing of the Adults with Incapacity (Scotland) Act 2000 – in paragraphs 2-11 to 2-17 of my book "Adult Incapacity" (W Green/Sweet & Maxwell Ltd, 2003). That question does not appear to have been addressed, nor answered, by the solicitor. It would appear that the solicitor ought to have been aware of potential conflict of interest. If acting for CD, the solicitor should have made clear whether that was CD as an individual, or CD in the role of AB's attorney. The Commission stresses the importance of relevant staff following guidance (including the Commission's own good practice guide "Common concerns with power of attorney") to refer promptly to the Public Guardian any concerns about the granting of a power of attorney.

A further issue that is evident from the report is that relevant staff repeatedly "backed off" in the face of difficulties which they ought to have addressed, and in one respect failed to take steps which it was their Council's duty to take. On my reading of the Commission's report, it seems to me that the conditions in section 57(2) of the 2000 Act for a local authority application for guardianship were met. If so, the local authority had no option about that. There is a clear statutory obligation to apply: "they [the local authority] shall apply under this section for an order". One of the difficulties said to have been encountered by the local authority in proceeding with a guardianship application appears to have been difficulty over access for medical practitioners to prepare the required reports. It is not clear why powers under the Adult Support and Protection (Scotland) Act 2007 were not utilised to overcome that difficulty.

One apparent training need, not listed in the report's recommendations or learning points, is the need for non-legal staff to understand when they should access specialist legal advice, available in-house in most if not all local authorities.

*Adrian D Ward*

## 4. Had attorneys complied with s1 principles?

On 16th May 2023 Lord Sandison, in the Court of Session, decided [[2023] CSOH 30] a challenge brought "in substance" by the three children of a Mrs Elizabeth Kaye with reference to a Deed of Variation of the Will of Mrs Kaye's late husband Peter Kaye. On 22nd June 2010 Mrs Kaye had granted a continuing and welfare power of attorney in favour of Mr Kaye and a Mr Johnstone, with a Ms Foster as substitute. On 6th May 2017 Mr Kaye made a Will which appointed Mr Johnstone and Ms Foster as his executors, and in which he bequeathed the residue of his estate to Mrs Kaye if she survived him, whom failing to a charity named "The Scar Foundation". Mr Kaye died on 22nd May 2017 leaving estate in excess of £2.5 million.

The Deed of Variation of Mr Kaye's Will was entered between Mr Johnstone and Ms Foster on the one hand as Mrs Kaye's attorneys, and on the other as Mr Kaye's executors, on 26th March 2019. It provided that instead of Mrs Kaye receiving the monetary residue of Mr Kaye's estate, it should go to Blind Veterans UK. The monetary residue amounted to approximately £2.45 million. Before entering the Deed of Variation, Mr Johnstone and Ms Foster had obtained Counsel's Opinion that they had power to carry out the variation and that it was appropriate for them to do so. For further details of all of this, see Lord Sandison's judgment. For procedural reasons explained in that judgment, Mr Johnstone brought this action as – by then – sole surviving executor nominate of Mrs Kaye, though truly as a means of having determined by the court the objections of the children, who – as described by Lord Sandison – "conceive[d] themselves to be grossly disadvantaged by the

terms of the Deed". Mr Johnstone brought the action in his own name as executor nominate of Mrs Kaye against himself as former continuing and welfare attorney for Mrs Kaye, and himself as executor nominate of Mr Kaye, and Blind Veterans UK.

Lord Sandison held that entering the Deed of Variation was within the powers of Mrs Kaye's attorneys, and that they were not in breach of their fiduciary duties. On the question of "benefit" under section 1(2) of the Adults with Incapacity (Scotland) Act 2000, Lord Sandison held that Mrs Kaye's attorneys had complied with that requirement. He narrated that:

> *"It was common ground at the debate that the benefit referred to in the subsection need not be financial, and that a benefit in the sense of having one's apparent wishes while capax fulfilled might well suffice."*

He likewise held with reference to section 1(3) of the 2000 Act that the actions of the attorneys complied with the requirement that it should be the least restrictive option in relation to the freedom of the adult, consistent with its purpose. Section 1(2) is qualified: "the person responsible for authorising or effecting the intervention is satisfied …". Section 1(3) is not. Lord Sandison pointed out that the requirement of s1(3) "is an objective matter for the court and not the attorneys to determine". For reasons explained in his judgment, Lord Sandison held that the pursuers' assertion that the Deed of Variation was contrary to the requirements of section 1(3) failed.

In relation to section 1(4), Lord Sandison upheld the criticism that there should have been consultation in terms of that section by the attorneys before they decided to execute the Deed of Variation. He refers to Mrs Kaye's "eight nearest relatives" (an impossibility – see item 6 of this Report), but he nevertheless directly identifies the "real issue" here as being:

> *"whether the presumed antipathy of those relatives to the proposed Deed of Variation (given that it would, subject to the incidence of inheritance tax, deprive them of a share of £2.4 million) and the supposed conflict of interest to which that situation is said to have given rise, makes it reasonable for Mrs Kaye's attorneys not to have sought their views"*

He held that it did not. He pointed out that:

> *"Section 1(4) plainly contemplates that the views of the relatives may be of some moment in coming to the decisions to be made, and some cogent factor (such as clear estrangement or alienation from the adult, or incapacity or relevant vulnerability on the part of the relative) would require to be present to make obtaining those views unreasonable. The extent to which any views expressed may be thought to be coloured by self-interest is something that the attorneys are entitled to take into account in coming to what are their own decisions as to whether to proceed with the proposed intervention or some variant thereof; presumed self-interest in the views is not in itself an adequate reason for not seeking them."*

Nevertheless, he concluded that in the circumstances of this case, and for reasons explained in paragraphs [41] – [43] of his judgment, while there had been a failure to comply with section 1(4), that did not warrant reducing the Deed of Variation because:

> *"the equities of the situation point firmly in favour of permitting matters to remain where they stand, rather than unravelling a position that cannot be remade on account of a clear but*

> *practically inconsequential failure to comply with one of the general principles of the 2000 Act."*

Possible criticisms of the decision are that Lord Sandison narrated that "Mrs Kaye was diagnosed with dementia in 2016" but not whether there was any evidence before him as to whether she lacked relevant capacity, or the ability to express (if need be with assistance) her wishes and feelings in the matter, at the time when the attorneys decided to execute the Deed of Variation. It would in addition have been helpful to have known what was the trigger for bringing the relevant powers under the power of attorney into force, and whether the trigger provisions had been fulfilled.

*Adrian D Ward*

## 5. Mother representing adult?

A decision (*KT v Principal Reporter* [2022] CSOH 80, 2023 SLT 747) by Lord Brailsford in the Court of Session on 28th October 2022, reported in Scots Law Times on 4th August 2023, seems remarkable, all the more so that it follows previous authority.

The decision of a Children's Hearing had the effect of severing all contact between two siblings, KT (aged 16 and thus an adult) and DJT (a child). The mother of KT and DJT appealed unsuccessfully to Hamilton Sheriff Court against the outcome of the Children's Hearing. KT then sought leave to bring a judicial review against decisions of sheriffs at Hamilton. Lord Brailsford refused that application.

KT's application founded on decisions of the sheriffs in Hamilton that the mother's appeal should not be intimated to KT, and that the decision at Hamilton to sever contact between KT and KT's sister DJT was made without KT's participation. It should be noted that the mother had no authority (by way of power of attorney, guardianship or intervention order, or otherwise) to represent KT in any proceedings. Scots law has no provisions for automatic representation of an adult by someone related to the adult, such as does exist – for example – in Austria, Czech Republic, Norway, Spain and Switzerland. Lord Brailsford nevertheless held:

> *"that KT's mother, also the mother of DJT the subject of the appeal, had rights to participate in the appeal to the sheriff and was therefore able to address the wider interests of her family, including the question of inter sibling contact between KT and DJT. Second it was not disputed that KT's mother's grounds of appeal did discuss the merits of sibling contact. Moreover the mother's grounds of appeal did contain material relative to KT and contact with her sibling."*

Lord Brailsford relied on *DM v Locality Reporter*, 2019 SC 196 that compliance with Article 8 of the European Convention on Human Rights "does not necessarily require personal attendance by a sibling at the hearing", and that failure to intimate to KT was within the discretion of the Children's Hearing under the Children's Hearings (Scotland) Act 2011, and under the relevant rules of court (in Part VIII of the Act of Sederunt (Child Care and Maintenance) Rules 1997).

However, the fact that something was technically competent does not mean that it was proper or lawful. The sibling excluded from personal attendance in the DM case was a child, aged 12 at the time. KT was an adult. His mother had no authority to represent his position. Article 6 of the European Convention reads (edited):

> *"1. In the determination of his civil rights … everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal*

*established by law."*

In Scotland, that is an absolute right from which neither legislation by the Scottish Parliament, nor rules of court, nor a judge in any court, may derogate. It can hardly be argued that all rights of contact between KT and his young sister DJT did not address KT's civil rights. The simple fact is that the ultimate determination of the matter by the court in Hamilton proceeded without intimation to him, and without his participation either personally or through anyone with authority to represent him.

(Lord Brailsford is chair of the Scottish Covid-19 Inquiry, which was formally opened on 28th August 2023.)

*Adrian D Ward*

## 6. "Nearest relative" in the 2000 Act

An application by Renfrewshire Council to have its chief social work officer appointed welfare guardian to the adult "HS" was unopposed and successful, but nevertheless resulted in an appeal to the Sheriff Appeal Court because of a dispute involving HS's three children about who, if anyone, should be nearest relative. The decision of the Appeal Court was delivered by Sheriff Principal S F Murphy KC on 2nd June 2023 [SAC/2023/PAI-AW77-21]. The identity of the other members of the court is not disclosed, and at time of writing is not available on the scotcourts website. "Headline points" likely to be of general interest include these:

a. The Appeal Court held that only one person could be nearest relative in terms of the Adults with Incapacity (Scotland) Act 2000 ("the 2000 Act"). Two or more persons cannot jointly hold that role. That issue did not feature to any major extent in this particular case. Sheriff Principal Murphy narrated that: "There was some discussion before the sheriff, less so in the appeal" on this point. He nevertheless confirmed the Appeal Court's agreement with the conclusion of the sheriff at first instance that, for reasons at paragraph [29], "the plain language of the Act indicated that it was a position to be held by one individual only". This clarification is likely to be helpful in the future. It was arrived at for the reasons given in paragraph [29], and would appear to be unobjectionable.

b. This case shares a theme also with item 4 in this Report of general interest regarding provisions of the 2000 Act relating to consultees specified in section 1(4)(b), (c) and (d) of the 2000 Act. In relation to any intervention under the Act, being an intervention such as is described in section 1(1), account must be taken of the views of each of them "in so far as it is reasonable and practicable to do so". The present case considered provisions regarding the nearest relative [section 1(4)(b)] and "any person whom the sheriff has directed to be consulted" [section 1(4)(c)(ii)] (item 4), but did not address the equally relevant provisions concerning other persons appearing to have an interest [section 1(4)(d)].

c. This case also shares with item 5 troubling issues about whether assumptions may be made in any proceedings about the views of an adult without involvement of that adult, or of someone explicitly empowered to represent the adult.

d. The Appeal Court clarified the ways in which an application with regard to the nearest relative may be made under section 4 of the 2000 Act. Section 4(1) authorises the Court of Session or the sheriff to grant certain orders with regard to the nearest relative. If the adult to whom the application relates, or

any person claiming a relevant interest, so applies (and only if such a person so applies), the court may make an order that specified matters should not be disclosed or intimated to the nearest relative [section 4(1)(a)]; that the functions of the nearest relative shall (during the continuance in force of the order) be exercised by a person other than the person defined as "nearest relative" in section 254 of the Mental Health (Care and Treatment) (Scotland) Act 2003 ("the 2003 Act"), and instead by the person who would otherwise be the nearest relative in terms of that definition, if in the opinion of the court that other person is a proper person to act as the nearest relative, and is willing so to act [section 4(1)(b)]; or that no person shall, during the continuance in force of the order, exercise the functions of the nearest relative. These provisions apply only to exercise of the functions of the nearest relative under the 2000 Act, thus not affecting exercise of functions under the 2003 Act. Upon application by such a person, the court may subsequently vary an order granted under these provisions [section 4(3)]. Upon an application under section 4(1), the court may make the order applied for or may instead make one of the other orders permitted by section 4(1). In the present case the court considered whether making an application under section 4 always required a Summary Application in terms of section 2(2) of the 2000 Act. The court held that application could also be made by motion in existing proceedings (the application in the present case having been made by motion in the course of the guardianship proceedings). The court referred to Rules 2.30 and 2.31 of the Summary Application Rules providing that (except where the sheriff otherwise directs) any motion relating to a Summary Application should be made and regulated in accordance with Chapter 15 of the Ordinary Cause Rules (Rule 2.30), and that the sheriff should make such order as the sheriff thinks fit for the progress of the Summary Application insofar as it is not inconsistent with section 50 of the Sheriff Courts (Scotland) Act 1907 (Rule 2.31). The court thus held that the sheriff has very wide powers to consider any motion relating to a Summary Application, and to make such order as the sheriff thinks fit for the progress of the application. That is what the sheriff had done in the present case (see below). It was correctly done.

Beyond these points of clarification, this case is more startlingly notable for what was not done by the Appeal Court (or, apparently, the court at first instance), or not insisted upon, than what it did do. But first, a brief identification of parties and narration of the facts and issues in this particular case is appropriate.

As to the parties, HS was described as an adult aged 95, suffering from dementia, and resident in a care home. Surprisingly, it is not narrated in the decision, though presumably established in evidence before the court, that HS lacked capacity relevant to the matters before the court. The applicant for the guardianship order was Renfrewshire Council ("the Council"). The adult had three children, all daughters: JM the eldest, and the nearest relative of HS in terms of the definition imported into the 2000 Act from the 2003 Act; LM, described in the decision as the first interested party and appellant; and KG, described as second interested party and respondent. Potentially confusingly, the decision refers in paragraph [2] to "the interested party", without distinction, but it is clear that this must have been a reference to LM, the first interested party. The Council, LM as first interested party and appellant, and KG as second interested party and respondent, were all represented before the

court. HS and JM neither appeared nor were represented.

Issues arose among the three daughters over who should exercise the functions of the nearest relative (the court, inaccurately, referred to "nomination of one of them as HS's 'nearest relative'"). LM moved the court either to nominate her to be nearest relative jointly with JM, or else to be appointed as a consultee in terms of section 1(4)(c) of the 2000 Act. KG made a counter motion that no-one be appointed to exercise the role of nearest relative. The sheriff, having considered that there was a history of conflict among the sisters with regard to HS's welfare to an extent which had sometimes compromised her day-to-day care, refused both motions, and (again in the words of the Appeal Court) "declined to appoint anyone as the nearest relative" or as consultee, meaning, one must presume, that the sheriff applied the option of ordering that during the continuation of that order no person should exercise the functions of the nearest relative.

The Appeal Court summarised LM's grounds of appeal as being (i) the sheriff erred in law by allowing KG's oral motion "to remove JM as nearest relative without intimating the motion to JM, which was iniquitous"; (ii) the sheriff erred in law "in removing the nearest relative by failing to consider the benefit to the adult and failing to apply proper weight to the protective benefit to the adult"; and (iii) the sheriff erred in law "by failing to appoint the appellant either as nearest relative or consultee, for the protection of the adult's rights".

The arguments before the Appeal Court are narrated in paragraphs [3] to [11], confused by grouping "argued for the respondent" and "argued for the second interested party" under separate headings when KG was both second interested party and respondent. Regarding (i), the challenge to the procedure by oral motion was dealt with as above, but it is difficult to see how the argument concerning failure to intimate that motion to JM was competently dismissed. That concern also applies to (ii).

It is relevant to read in full the Appeal Court's narration of the sheriff's reasoning, and of the Appeal Court's own reasoning and conclusions, but for the purposes of the concerns expressed below one might focus upon paragraph [28] of the Appeal Court's decision, which is in the following terms:

> *"The sheriff has set out his reasoning in the note attached to his interlocutor. He was provided with reports from two medical practitioners and a mental health officer ("MHO") in connection with the guardianship application. All three reported that disagreements between the adult's daughters had contributed to her decline and that they had been obstructive in her care at times. The MHO had concluded that she was unable to support the appointment of any of the siblings as their mother's guardian on the basis that their ongoing conflict 'would continue to impact on the care and support of the Adult' (Sheriff's note, paragraphs 27 – 30). The sheriff further traced the history of the dispute and its detrimental effect upon the care of the adult as noted by the social workers who had been involved in the case {Sheriff's note, paragraphs 32-35). He concluded that this information was relevant to his decision in respect of the issue of nearest relative as well as to the issue of guardianship {Sheriff's report, paragraph [36]). He was correct to do so as the information was clearly relevant to both. At paragraph [37] of his report he noted three recent instances in which the issues among the siblings had led to disputes over everyday decisions over arrangements within their mother's care home. The sheriff concluded, at paragraph [38]:*

> *'This sorry state of affairs has left me to conclude that to have any of the sisters in the role of nearest relative presents risks to the wellbeing of the Adult'.*

> *"In the light of the difficulties reported by the medical and care professionals that conclusion is a reasonable one. The sheriff can only make an order where he is satisfied that it will benefit the adult. He could not be so satisfied in relation to the specification of any of the adult's daughters as the nearest relative on account of the material which had been placed before him and to avoid any further difficulties of the kind identified it was reasonable for him to conclude that an order under section 4(1)(c) that no person should exercise the functions of the nearest relative was appropriate in this case as it would benefit the adult by ending the prospect of further disruption."*

In addition, the Appeal Court held that JM "was aware that her younger sister LM was seeking to take over the role of nearest relative from her" by reference to the email quoted later. The inferences that the Appeal Court drew from that email are also as described below.

All of the foregoing is predicated upon a proper understanding of the role of nearest relative, and the roles of consultees generally, under the 2000 Act. The views of the nearest relative must be taken into account in relation to any intervention under the Act "in so far as it is reasonable and practicable to do so". The same applies to all the other consultees under section 1(4)(b), (c) and (d). Beyond such consultation, the role of the nearest relative includes the following. An application for authority to intromit under Part 3 must give particulars of the nearest relative, to whom the application must be intimated by the Public Guardian [s27(1)(b)]. Managers of establishments must intimate to the nearest relative their intention to have a resident medically examined with a view to managing that resident's affairs under Part 4 [s37(3)]. In relation to procedure under Part 4, the nearest relative is entitled to require production of relevant records [s41(f)]. The nearest relative may consent to research for the purposes of s51(3)(f) and (3A) (in the case of s51(3)(f) where there is no guardian or welfare attorney with relevant powers). The Public Guardian must intimate to the nearest relative an application for discharge of a financial guardian, and the nearest relative is entitled to object and to be heard [s72(2)]. Likewise, applications to the Public Guardian, Mental Welfare Commission or local authority for recall of a guardian's powers, or the intention of one of those authorities at its own instance to recall such powers, must be intimated to the nearest relative, who is entitled to object and to be heard [s73(5)]. An application to the Public Guardian for consent to dispose of accommodation must be intimated by the Public Guardian to the nearest relative [Sch. 2, para 6(2)]. Insofar as relating to HS's property and financial affairs, all of these functions could be relevant. Some, but only some, would not be relevant in matters concerning her personal welfare insofar as within the powers of the welfare guardian appointed, for so long as that appointment endured. It is reasonable to see the nearest relative as a conduit by which information may be given to an adult's family and representations may be made. If an adult has no nearest relative, the benefit of all of these provisions would be lost. Nowhere do either the sheriff at first instance or the Appeal Court appear to have determined that there was no potential benefit to the adult in having a nearest relative, in relation to these provisions. Nowhere is it narrated that either court sought to ascertain whether, faced with the prospect of no-one having these roles for the benefit of their mother and themselves, they might have been motivated to resolve the squabbles among themselves.

That is a course to my knowledge taken by some sheriffs, expert in this essentially inquisitorial jurisdiction, where it seemed necessary to clarify the possible results of parties continuing their squabbles.

As regards the obligation to consult in terms of section 1(4)(b), (c) and (d), the nearest relative's status is precisely the same as other consultees. They include, under section 1(4)(d), any person appearing "to have an interest in the welfare of the adult or in the proposed intervention". The distinction between persons claiming an interest and persons having an interest is relevant. The term "person having an interest" is not defined in the 2000 Act, nor in regulations made under the Act. For the reasons given in paragraph 14-59 of "Adult Incapacity" (Ward, W Green, 2003), it could mean "any relative" (on the basis of old authority there cited), or a person "close to an adult", and which might be "a close relation of the adult, or the person who has lived with, or cared for or about them, over a significant period" (again, see sources quoted in paragraph 14-59). In any event, in the present case HS's three children clearly were and are, in terms of section 1(4)(d), all persons having an interest, and known to those responsible for "authorising or effecting" any interventions in relation to HS as having an interest. In practical terms, in relation to all consultation obligations under section 1(4), whether any one of them, or none of them, should have the functions of nearest relative is irrelevant. There is no provision in the Act explicitly allowing close relatives to be deprived of that function. It is arguable that this could be done in relation to a particular, specified person who would otherwise require to be consulted, in specified matters, by an order under section 3(3) of the 2000 Act, but that would have to comply with the section 1 principles, and was not something that was sought in the present case.

Paragraph [28] of the Appeal Court's judgment is quoted in full above. It fails to relate to the status of the daughters as consultees in terms of s1(4)(d), or how the difficulties might be ameliorated if any one of them, or more of them, should in addition have the status of consultee under s1(4)(b) or s1(4)(c). In particular, it is difficult to see how any of the orders sought by any of the parties, or the order made by the sheriff, could have had any impact upon the reported difficulties: certainly, that is not answered by the judgment of the Appeal Court. A direction to those required to consult under s3(3), setting out thresholds for when it would not be reasonable to consult at all, could perhaps have achieved what the proceedings as conducted were destined not to.

Paragraph [28] of the Appeal Court decision appears to conflate the functions of a nearest relative, and of consultees generally, with the quite different functions of a guardian, to which they bear no similarity, and to fail to consider the distinctive roles of a nearest relative only, and the roles of all consultees.

What is certainly essential is that if conflicting views exist among members of an adult's family, the person effecting or authorising a proposed intervention needs to know about them. Misunderstanding of the role of the nearest relative however extends further.

The Appeal Court asserts in paragraph [1] that the function of nearest relative "had previously been exercised by the adult's eldest daughter, JM". It is not identified what functions were previously so exercised, or whether any of them were previously exercised at all. It also appears that JM, and possibly the other daughters of HS, had no understanding of what were the functions of a nearest relative. Much was made of an email dated 12th August 2021 from JM to LM, in the following terms:

> *"To whom it may concern,*

> *"I believe that my mother (named above) would have wanted me, her eldest daughter, to look after her affairs. I justify this by pointing out that she entrusted me with her finances by adding my name to her bank account to act on her behalf.*
>
> *"Unfortunately due to my ill health I am not in a position to look after my mother as well as I would like to and believe that my mother would want my sister [LM] to take care of her affairs as she is her second daughter and next in line as next of kin."*

What is clear from this is that JM evidently thought that the role involved looking after her mother, looking after her affairs, and being entrusted with her finances. None of these are relevant to the role of nearest relative. JM appears to have had no understanding that the role of nearest relative was limited to that of consultee, together with the specific additional roles explained above. She had no concept of those roles, and there is no evidence that she considered whether or not she was a suitable person to continue to have those roles. Surprisingly, that misunderstanding appears to be amplified, rather than identified, in the sentence with which the Appeal Court followed narration of the email:

> *"This message clearly indicates that JM was aware that LM was seeking to be placed in charge of their mother's affairs and that she supported that application because she felt that she herself was not capable of doing so on account of her own ill health."*

This also covers the Appeal Court's conclusion on the criticism that no indication was given to JM that she might be removed, and that to do so without intimating to her was iniquitous. Given that JM evidently had no understanding of what the role was, it is difficult to understand how the Appeal Court could assert that JM *"was aware that the question of the nearest relative was a live consideration before the court and she did not enter process when she had the opportunity to do so."*

These concerns extend all the more strongly to the proposition that HS should be deprived of the benefit of having any nearest relative at all.

In these matters it is difficult to see how either the sheriff at first instance or the Appeal Court can be said to have complied adequately with the section 1 principles, or with Articles 6 or 8 of the European Convention, in this essentially inquisitorial rather than adversarial jurisdiction, all of these being binding upon the court regardless of submissions made to the court, and any omissions in evidence placed before the court. In terms of section 1(6) an "adult" means any person who has attained the age of 16 years, and section 1(1) requires compliance with the section 1 principles in relation to any intervention in the affairs of an adult under or in pursuance of the 2000 Act. Article 6 of the Convention requires procedural fairness in relation to, *inter alia*, a determination of JM's civil rights, and Article 8 prohibits any interference by a public authority in exercise of any person's right to respect for private and family life "except such as is in accordance with the law" or for other exceptions not relevant here. "In accordance with the law" includes compliance with the section 1 principles. For further understanding of the position, see my article "Two 'adults' in one incapacity case?: thoughts for Scotland from an English deprivation of liberty decision" (2013 SLT (News) 239-242). It is not open to any court randomly to dispense with intimation "to an adult". The Parliament provided a specific mechanism for doing so, therefore a court should not bypass that mechanism. The mechanism is provided in section 11. It was not

utilised in this case.

Even more startling than the failure to ensure that section 1 and Articles 6 and 8 were adequately complied with in relation to JM, is the failure to have done so in relation to HS, undoubtedly “the adult” at the centre of these proceedings. Having regard to the huge amount of work done in recent years on the obligation of states under Article 12.3 of the UN Convention on the Rights of Persons with Disabilities, coupled with the clearly stated intention of the Scottish Parliament to incorporate the provisions of that provision into Scots law (and the presumption meantime in favour of interpretation in accordance with international obligations), it must be virtually inconceivable that HS should never have had at least any past wishes and feelings relevant to these proceedings. In terms of section 4(1)(a), the obligation to ascertain and take account of these is absolute. It is not qualified “in so far as it is reasonable and practicable to do so”, in contrast to the other provisions of section 1(4). Regardless of the past, there appears to be nothing narrated in the Appeal Court decision to indicate that HS would not, even then, supported if necessary by the absolute obligation under section 1(4) to ascertain her wishes and feelings “by any means of communication”, to have any views in the matter, which ought to be placed before the court. There is no narration that either the sheriff at first instance or the court complied with the obligation under section 3(4) to consider whether it was necessary to appoint a safeguarder.

We understand that an application by JM seeking leave to appeal further to the Court of Session was made but refused.

*Adrian D Ward*

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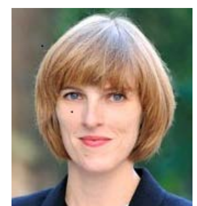

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# Conferences

Members of the Court of Protection team regularly present at seminars and webinars arranged both by Chambers and by others.

Alex is leading a masterclass on approaching complex capacity assessment with Dr Gareth Owen in London on 1 November 2023 as part of the Maudsley Learning programme of events. For more details, and to book (with an early bird price available until 31 July 2023), see here.

Alex is also doing a regular series of 'shedinars,' including capacity fundamentals and 'in conversation with' those who can bring light to bear upon capacity in practice. They can be found on his website.

### Advertising conferences and training events

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

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

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