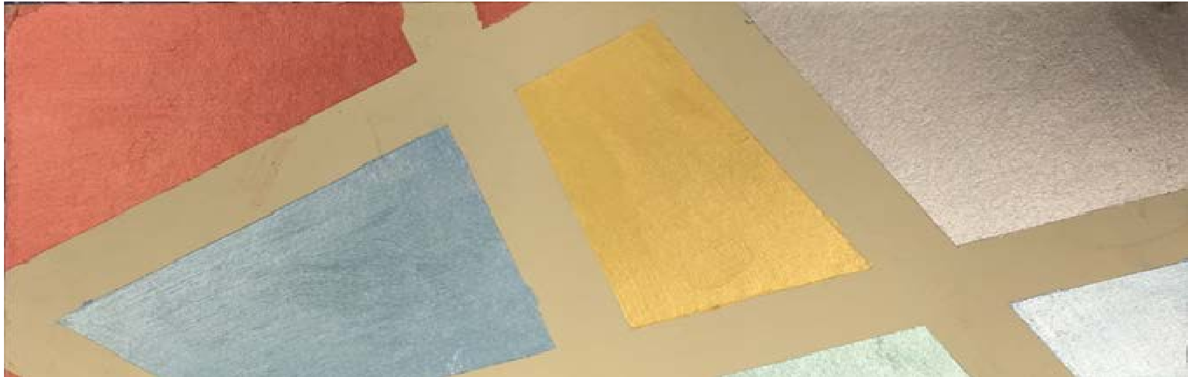

Welcome to the September 2023 Mental Capacity Report, which we think is our largest ever, thanks to judicial hyperactivity over what is usually the (relatively) quiet summer period. Highlights this month include:

(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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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. <u>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.</u> 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* [1] *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 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:

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

> *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,[2] 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 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*

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

> *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,[3] 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…"*
>
> *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*

[3] 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.

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[4] – 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

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

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 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.[5]

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 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

[5] 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.

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[6]

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 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

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

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,[7] 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.[8]

News from Australia

An important development in Australia merits note, in the form of the Research Report published in July 2023[9] on *Restrictive practices:*

[7] *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.

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

[9] 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)

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 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.

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

Adrian Ward: adrian@adward.co.uk

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

Jill Stavert: j.stavert@napier.ac.uk

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

Conferences

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 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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