MENTAL CAPACITY REPORT: THE WIDER CONTEXT

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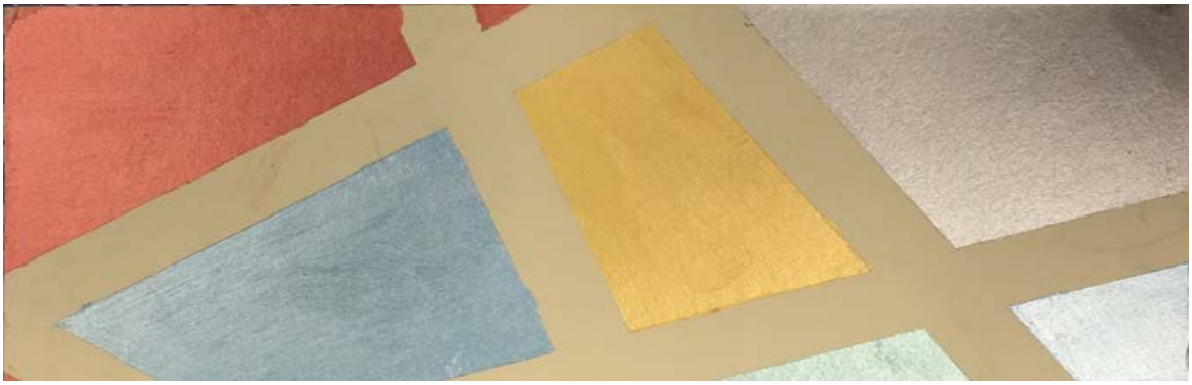

Welcome to the February 2024 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: medical treatment dilemmas of different hues, how risky can the court be, and capacity in context;

(2) In the Property and Affairs Report: useful guides for those creating LPAs and an Australian take on balancing risk and (false) hope in the context of scamming;

(3) In the Practice and Procedure Report: medical evidence, mental disorder and deprivation of liberty, and the approach to propensity evidence;

(4) In the Wider Context Report: the new framework for care home visiting in England, an important consultation on capacity in civil litigation, new core ethics guidance from the BMA, and the Circuit Court rolls up its sleeves in Ireland;

(5) In the Scotland Report: discrimination narrowly avoided, and a case posing questions about compensation for unlawful detention.

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.

The sharp-eyed amongst you will have noticed that there was no third edition of the informal Court of Protection Law Reports series at the start of this year: this is because there will shortly be announced exciting news about their future – watch this space.

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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.

Contents

Updated guidance note on deprivation of liberty and those under 18

We have updated our guidance note on this (remarkably thorny) topic, to be found here.

Care home and hospital visiting in England: the new framework from 6 April 2024

Following on from its consultation on visiting in care homes and hospitals in England, the DHSC has (1) published its response; and (2) laid before Parliament the relevant regulations to embed that response.

In material part, the summary of the response provided as follows:

> *The majority of responses supported the government's proposal to introduce a fundamental standard on visiting.*
>
> *The government will now work with CQC to develop and introduce a new fundamental standard. This will focus on visiting, against which CQC will assess certain registered settings as part of its existing inspection framework. We intend to lay the necessary regulations in Parliament to introduce this additional standard as soon as possible. We will also work with CQC to publish the necessary guidance to the health and social care sector to ensure this new standard is clear and upheld.*
>
> *Through this new standard, CQC will be able to specifically include visiting considerations as part of its wider regulatory assessment of providers. This could include using civil enforcement powers in line with its published enforcement policy when it is necessary and proportionate to do so.*
> *Of the themes we observed within our consultation, respondents cited that they found government guidance unclear, and that strict visiting times and complicated complaints processes were some of the barriers to visiting in health and care settings. Legislation will*

therefore help to create a consistent understanding of what is acceptable across all relevant providers. We will also seek to make guidance on the complaints process clearer for when issues do arise.

Some respondents expressed concern that through the provision of a standard and accompanying guidance, 'exceptional circumstances' or 'reasonable explanations' (where a provider may restrict visiting) may actually provide the conditions for more restrictive practices, which is contrary to our intention. We recognise that there will always be some, very limited, circumstances in which visiting cannot be facilitated by the provider to maintain the safety and wellbeing of service users and staff. However, we do not plan to include a list of these circumstances in the statutory instrument itself. We are clear that visiting is critical to the health and wellbeing of everyone.

While the majority expressed clear support for a consistent approach across CQC-registered settings, we recognise concerns raised by sector representatives about the requirements for some health and care settings potentially putting individuals at increased risk. For this reason, we intend to exclude services for substance misuse and inpatient detoxification or rehabilitation services from the requirement. This reflects the complex circumstances and risk of relapse for a vulnerable person, and visiting is already carefully considered within care plans in these settings. Supported living settings and 'extra care' housing schemes will also not be in scope of the regulation. These settings generally exercise 'exclusive possession', in which the individual has a tenancy agreement and they can decide who visits. All guidance will clearly set out the scope of this new regulation.

We intend to address concerns about residents of care homes being discouraged to take visits out of the home by overly burdensome restrictions upon their return. A care home is a person's home, and we will be including a provision in regulations that residents should be encouraged to take visits out of the care home to support their wellbeing.

We have received clear support and heard the positive impact that this policy would have, particularly for service users and their loved ones, with powerful personal testimony. The range of support provided by many visitors, which often extends beyond companionship to a 'care supporter' role and advocate, is fundamental.

Some have called for this right to be protected within new, primary legislation. Given the overwhelming support in this consultation, and the role of CQC as the regulator in England, the government believes the most proportionate and appropriate way in which to protect and enable visiting is to now move to introduce a new CQC fundamental standard on visiting. This puts visiting on the same level as other fundamental standards, such as that which requires providers to meet the nutritional and hydration needs of service users.

A new fundamental standard on visiting provides a standard to be enforced by CQC as part of its existing civil enforcement powers. This will highlight the importance of visiting to providers and all stakeholders, and ensure that providers account for the vital role that visiting plays.

One part of the response did rather leap out at us – the assertion that those in supported living

settings and extra care housing schemes generally exercise 'exclusive possession,' and in which the individual has a tenancy agreement and they can decide who visits. As a bald proposition this is distinctly questionable, and we might suggest not obviously a very sound foundation upon which to exclude those in such placements from the regulation – many of whom may very well be in places which could well change (in effect) overnight from a care home to a supported living placement without any actual change for the individuals concerned.

The regulations (The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2023) track through the commitments in the consultation response. This instrument inserts a new fundamental standard, namely new regulation 9A (visiting and accompanying in care homes, hospitals and hospices), into the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This fundamental standard requires that service users (defined in regulation 2 of the 2014 Regulations as "a person who receives services provided in the carrying on of a regulated activity") are, unless there are exceptional circumstances, facilitated to receive visits to care homes, hospitals and hospices and, in relation to service users who are provided with accommodation in a care home, are not discouraged from taking visits out of the care home. It also requires service users to be enabled to be accompanied at a hospital or hospice when attending as an outpatient.

As the Explanatory Memorandum notes (at paragraph 6.5):

> *"Exceptional circumstances" will be assessed on the circumstances of each case and will carry its ordinary, restricted meaning as interpreted by cases such as R v Kelly [2000] 1 QB 198 "We must construe exceptional circumstances as an ordinary, familiar adjective and not as a term of art. It describes a circumstance which is such as to form an exception, which is out of the ordinary course, or unusual, or special, or uncommon. To be exceptional, a circumstance need not be unique, or unprecedented, or very rare; but it cannot be one that is regularly, or routinely or normally encountered." The Department considers that an example of an exceptional circumstance might be where a visit would pose a significant risk to the health, safety or wellbeing of a service user or an employee of the provider.*

New regulation 9A(2) also sets out a requirement that the taking of 'visits out' out of a care home must not be discouraged (unless there are exceptional circumstances). The Explanatory Memorandum notes at paragraph 7.7 that:

> *Though residents cannot legally be prevented from leaving care homes (except in certain cases such as where the person lacks the relevant capacity and is subject to the Deprivation of Liberty Safeguards), we understand that during the pandemic a range of restrictions were placed on residents wishing to leave the care home, particularly upon their return, and that these discouraged service users from taking visits out. The intention is that service users must not be discouraged from leaving the care home premises to support their wellbeing and participation in their community. In practice, this will mean, for example, that providers should not impose unreasonable rules on returning after a visit out that would discourage service users from taking a visit out and effectively act as a restriction.*

Importantly, new regulation 9A(4) makes it clear that a service user is not required to receive any visit, take a visit out of a care home, or be

accompanied, if they do not wish to be. If a service user does not have capacity to consent, they are not required to receive a visit, or be accompanied, if it would not be in their best interests to do so.

Regulation 9A applies to mental health hospitals. However, Regulation 9A(4) will not require or enable a registered person to do anything that is not in accordance with any court or tribunal order or with any provision in, or made under, the Mental Health Act 1983, the Mental Capacity Act 2005 and so far as relating to high security psychiatric services, the National Health Service Act 2006. The Explanatory Memorandum explains that "[t]*he purpose of this is to ensure that the requirements in this instrument do not conflict with provisions made in or under the legislation listed and to avoid any unintended consequences*." Specifically in relation to mental health hospitals, however, it is perhaps worth noting that there is no provision of the MHA 1983 which directly relates to the control of visiting other than those providing for visits in private by, for instance, Second Opinion Appointed Doctors (a point slightly glossed over in Chapter 11 of the Code of Practice to the MHA 1983). It is therefore perhaps not entirely obvious what provisions of the MHA 1983 are going to be in play here.

New regulation 9A will not apply to a registered person in respect of the regulated activity of 'accommodation for persons who require treatment for substance misuse' or in respect of any detoxification services for substance misuse (which may take place in a hospital setting). This is achieved by excluding these services from the definition of 'relevant regulated activity' in new regulation 9A(6). As the Explanatory Memorandum makes clear:

> *These services are excluded because it is common for an individual in a substance misuse residential rehabilitation or inpatient detoxification service to go without visitors for a period while undergoing treatment or rehabilitation, to support their treatment. Limiting visits according to risk and being able to maintain a safe drug and alcohol free environment is fundamental to their operation. Other activities which the CQC regulates, such as personal care; management of blood and blood derived products and transport services; and triage and medical advice provided remotely, are also excluded from the definition of 'relevant regulated activity' as visiting and accompanying are not relevant in respect of these activities.*

It is perhaps striking that the Government has not prepared a full impact assessment, on the basis that it considers that there is no significant, impact on business, charities or voluntary bodies. The Explanatory Memorandum notes at paragraph 12.2 that:

> *Costs have been estimated for care home settings where the central estimate of the quantified cost to business is £526,000 in year 1 of the appraisal period. This figure is an estimate of the staff administration and familiarisation costs of facilitating visitors for the care home settings that are not currently accommodating visits in any circumstances. This annual figure is expected to decrease over time, as the number of care homes reporting not allowing visiting has been broadly decreasing.*

The CQC are now consulting on the guidance on visiting with a closing date of 20 February 2024.

Capacity in civil proceedings consultation – help wanted

The Civil Justice Council has published a consultation on Procedure for Determining Mental Capacity in Civil Proceedings which will

run for 3 months until 17 March 2024 at 23:59. The consultation paper can be found online here.

As the Working Group on the project, including Alex, has identified, the problem is that:

> *The CPR makes no provision for cases in which a party's capacity is in doubt: how the issue is to be identified, investigated or resolved. The provisions regarding the appointment of a litigation friend also assume that there is a person suitable, able and willing to undertake the role.*
>
> *The issue was identified more than 20 years ago in Masterman-Lister v Brutton ("Masterman-Lister") when Kennedy LJ observed that neither CPR 21 (nor the preceding provision, RSC Order 80) made any provision for "a judicial determination of the question whether or not capacity exists". Kennedy LJ recommended that the Rules Committee consider the issue, but held that meanwhile: "courts should always, as a matter of practice, at the first convenient opportunity, investigate the question of capacity whenever there is any reason to suspect that it may be absent …"*

The Consultation Paper briefly summarises the discussions of the working group, the main issues identified and some provisional proposals for change. Not all of the proposals were agreed by the whole working group and all will be revisited in light of the consultation responses.

The CJC wishes to hear from a wide range of consultees, not only from people with significant experience of issues of mental incapacity and/or the civil justice system but also from those with more limited experience of specific issues or procedures.

Responses should be submitted by PDF or word document here. Please use the cover sheet available here.

As part of the consultation process, there will be a seminar on 1 March 2024: to register, please see here.

The Care Act, charging and capacity

In this 'in conversation with,' Alex is joined in his shed by Arianna to talk about her new book, Social Care Charging, and then to look at the issues which arise where decisions about charging and care planning are taking place in relation to those with impaired decision-making capacity.

BMA Core Ethics Guidance

The BMA has replaced its textbook, *Medical Ethics Today* (3rd edition published in 2012), with a new online resource bringing together its core ethics toolkits in a single, easy to search and navigate resource (with an easy to remember URL – www.bma.org.uk/core-ethics). This makes its guidance much more accessible to members – at any time of the day or night – and makes it much easier to update, as individual 'chapters' (toolkits) can be updated as and when the need arises. (The individual toolkits are also still available on the website as stand-alone documents.) The Mental Capacity Act toolkit (covering England and Wales) has been updated and new toolkits have been produced on mental capacity in Scotland and Northern Ireland.

Remote assessments and MHA renewals – the High Court rules them out

In *Devon Partnership NHS Trust v SSHC* [2021] EWHC 101 (Admin), handed down on 22 January 2021, the Divisional Court held that "the phrases "personally seen" in s. 11(5) MHA 1983 and "personally examined" in s. 12(1) require the physical attendance of the person in question

(i.e. the doctors and the Approved Mental Health Professional) on the patient.

In *Derbyshire Health Care NHS Trust v SSHC & Others* [2023] EWHC 3182 (Admin), Lane J has held that, despite somewhat different language being used, the same approach applies to renewing detention, CTOs and guardianship.

The Trust sought declarations that:

1. The responsible clinician is not required to undertake a face-to-face examination of the patient before making a community treatment order ("CTO") under section 17A(1);

2. The word "examine" in section 20A(4) should not be interpreted as meaning a face-to-face examination, so that a remote examination of the community patient by the responsible clinician before the latter extends the CTO may be sufficient; and/or

3. The word "examine" in section 20(3) and (6) should not be interpreted as meaning a face-to-face examination, so that a remote examination of the patient by the responsible clinician before the latter renews the authority for detention for hospital treatment of a patient under section 3 or guardianship in the community under section 7, may be sufficient.

Lane J declined to make the first declaration sought because it had not arisen on the facts of the actual case before him, which (in a slightly complicated fashion) involved an interested party who had been placed on a CTO following personal examination, and then remotely renewed during COVID. Lane J observed that he "*should not be taken as in any way questioning the fact that, in the light of Devon, there is uncertainty in respect of section 17A. This Court must, however, resist the temptation to venture outside the limits of its ability to give sound and effective declaratory relief*" (paragraph 82).

In relation to the second and third declarations, Lane J effectively transposed the reasoning from *Devon* to the renewal situation. In response to a submission that the word "examine" could be subject to an updating construction, he identified at paragraph 112:

> *on the state of the evidence, the claimant cannot show that there is the necessary societal consensus that an examination conducted by telephone or video conferencing will always be of the same high quality as one involving the physical co-location of clinician and patient. As I have sought to explain, Parliament's intention was to demand, as a general matter, an examination of such quality. Accordingly, the claimant cannot rely upon the "updating" or "always speaking" principle of statutory construction as a reason for this court to grant the remaining two declarations.*

NHS England guidance on meeting the needs of autistic adults in mental health services

In December 2023, NHS England published guidance on meeting the needs of autistic adults in mental health services.

The Guidance appears to have been prompted by the realisation that not only are the number of adults diagnosed as autistic in England rising rapidly, but also that they have a higher prevalence of mental ill health compared to the general population. The aim of the guidance is "*to help drive our collective efforts to bring about improvements in the provision of mental health care for autistic adults in all mental health services. It will support staff working in mental health to better understand and feel confident about meeting the needs of autistic people who access their services.*" One of the key aims of the guidance is to provide earlier, well-targeted

community support, in order to avoid admissions and long stays in mental health inpatient units.

The guidance uses four levels of stepped mental health care that can be provided for autistic adults - demarcated by the acuteness and type of mental health need they are designed to treat and support. The four levels are: Level 1: Staying well in the community; Level 2: Planned mental health care; Level 3: Crisis care; and Level 4: Inpatient care.

The guidance provides that mental health services should:

1. ensure services are accessible and acceptable to autistic adults
2. support access to meaningful activity
3. facilitate timely access to autism assessment, when clinically indicated
4. use evidence to guide intervention choice
5. assess and proportionately manage risk
6. monitor and minimise the use of restrictive practices
7. support cohesive transitions
8. consider the physical health needs of people accessing mental health services

To achieve this, all ICBs should:

- develop a local commissioning strategy to ensure appropriately adjusted and tailored mental health provision is available for autistic adults, informed by local and national statistical data
- develop and maintain a well-trained workforce

A detailed examination of the guidance is beyond the scope of this report, but it is useful to look at two aspects of the guidance. First – the requirement to make services accessible and acceptable to those with autism. This part of the guidance is detailed. It requires ICBs to make reasonable adjustments both at a service level (so for example considering the lighting in a service, or ensuring that the written information is accessible to someone with autism, or that booking appointments can be made without the need to make phone calls), as well as on an individual basis.

The guidance on item 6, monitoring and minimising the use of restrictive practices however, is less detailed. It grapples with the systemic issues, for example, it requires ICBs to look at the community systems available for autistic adults (together with the local authority and third sector partners) that can "*foster positive emotional wellbeing and reduce the need for higher level services for escalating mental health needs*." However there is little guidance on how to reduce the use of these practices on an individual basis. Such measures could include, perhaps, the wider use of positive behaviour support plans, ensuring that the person's sensory needs are being met in their environment, and where appropriate protecting their legal rights by making applications to the Court of Protection to ensure that the restrictive measures are lawful.

Short note: the European Court of Human Rights: mental health detention and Articles 3 and 5 ECHR

Strasbourg means what it says in relation to the tightening of the criteria for admission and detention in the context of mental disorder that has been a feature of its case-law since *Rooman*

v Belgium [2019] ECHR 105.[1] This has bene made very clear in its first judgment of 2024, *Miranda Magro v Portugal* [2024] ECHR 1. The case concerned a Portuguese man who had bene convicted on charges of criminal damage, making threats and sexual harassment he was sentenced to a "preventive detention measure" on the basis of a serious mental illness and held in a prison hospital. The applicant did not dispute that he had a serious mental health condition at the time, but complained of the conditions of his detention, and submitted that he should have been held in a psychiatric facility in order to have access to the requisite medical care. He complained under both Articles 3 and 5 ECHR.

In relation to his claim under Article 3, the ECtHR noted that:

> *80. In this connection, the Court observes that the Government in the present case did not provide any evidence, such as medical reports or a copy of the applicant's individual therapeutic plan, attesting that he had received individualised, continuous and specialised care and follow-up treatment, and that appropriate therapy and medication had been prescribed and provided to him (compare Strazimiri v. Albania, no. 34602/16, § 108, 21 January 2020). For instance, no information has been provided to indicate that he had regular and continued psychiatric follow-up aimed at adequately treating his illness, preventing its worsening, or carrying out preparatory work towards the applicant's release and reintegration into the community. **The Court notes, therefore, that the Government have failed to demonstrate that the applicant received the therapeutic treatment required by his condition** (see Murray v. the Netherlands [GC], no. 10511/10, § 106, 26 April 2016; Rooman, cited above, §§ 146-47; and Strazimiri, cited above, §§ 108-12; and contrast Moxamed Ismaaciil and Abdirahman Warsame v. Malta, nos. 52160/13 and 52165/13, § 95, 12 January 2016), as it has not been shown that the administration of drugs with long-lasting effects was complemented by the implementation of a comprehensive treatment strategy. In circumstances such as these, where the Government have failed to refute the applicant's consistent allegations with convincing evidence, the Court is prepared to accept the applicant's account of the conditions of his detention in the psychiatric unit of the Caxias Prison Hospital (see the case-law quoted in paragraph 74 above).*
>
> *81. The Court accepts that the very nature of the applicant's psychological condition rendered him more vulnerable than the average detainee and that his detention in the conditions described above may have exacerbated to a certain extent his feelings of distress, anguish and fear. In this connection, the Court considers that the failure of the authorities to provide the applicant with appropriate assistance and care has unnecessarily exposed him to a risk to his health and must have resulted in stress and anxiety (see, mutatis mutandis, Sławomir Musiał v. Poland, no. 28300/06, § 96, 20 January 2009)* (emphasis added)

The court therefore found a violation of Article 3 ECHR.

[1] See also for another sign of the changing context, the resolution on mental health adopted by the European Parliament (i.e. the EU representative assembly) of 12 December 2023, and the detailed calls therein for steps to reduce coercion in mental healthcare, although without going so far as to call for the abolition of compulsory admission and / or treatment.

Turning to Article 5 ECHR, the court found that, at first sight, the detention met the three minimum criteria under Article 5(1)(e) were met, as the applicant had been diagnosed with a mental disorder warranting detention, and detained pursuant to a procedure prescribed by the law (paragraph 91). However, that was not the end of the story:

> *92. […] the Court notes that the conditions in which a person suffering from a mental health disorder receives treatment are also relevant in assessing the lawfulness of his or her detention within the meaning of Article 5 of the Convention (see Rooman, cited above, §§ 194 and 208). In order to determine whether the detention of the applicant as a "person of unsound mind" has been "lawful" in the present case, the Court, taking into account its findings under Article 3, will assess the appropriateness of the institution in which he was detained, including whether an individualised treatment plan was put in place. Such a plan should have taken account of the specific needs of his mental health and have been aimed specifically, in so far as possible, at curing or alleviating his condition, including, where appropriate, bringing about a reduction in or control over the level of danger posed, with a view to preparing him for possible future reintegration into society (ibid., § 208).*
>
> *93. The Court notes that between 14 April and 18 October 2021, the applicant, who was found to be not criminally responsible, was detained in the psychiatric unit of the Caxias Prison Hospital (see paragraph 14-15 above); the prison hospital is primarily aimed at serving the ordinary prison community suffering from mental illness and is not part of the health system (see paragraphs 39 and 47 above). The Court accepts that the mere fact that the applicant was not placed in an appropriate facility does not, per se, render his detention unlawful (see Rooman, cited above, § 210). However, the Court reiterates that keeping detainees with mental illnesses in the psychiatric ward of ordinary prisons pending their placement in a proper mental health establishment, without the provision of sufficient and appropriate care, as appears to have been the case with the applicant, is not compatible with the protection ensured by the Convention for such individuals.*
>
> *94. Having considered the submissions of both parties and in view of its findings in paragraphs 77-82 above, the Court is not convinced that the applicant was offered appropriate treatment or that the therapeutic environment he was placed in was suitable for his condition. In this connection, the Court reiterates that the level of care provided must go beyond basic care. **Mere access to health professionals, consultations and the provision of medication cannot suffice for treatment to be considered appropriate and thus satisfactory under Article 5 of the Convention** (see Rooman, cited above, § 209). Also, as already found in paragraph 80, the Government did not present the therapeutic plan for the applicant or other documents in this respect. Furthermore, having regard to the applicant's state of health and special vulnerability, the Court also takes note of the impact his detention had on him, namely in aggravating his state of confusion and fear owing to the restrictive and anti-therapeutic environment that detention in a prison facility entailed.* (emphasis added)

The court therefore found there was a violation, also, of Article 5 ECHR.

Rooman has been domesticated in England & Wales (surprisingly) recently in *SF v Avon and Wiltshire Mental Health Partnership* [2023] UKUT

205 (AAC). There are also interesting moves afoot in Wales to seek to draw a more direct statutory link between detention and treatment, and we anticipate that this case may well be referred in that context.

It is perhaps, though, important to emphasise that it would be very unlikely that the Strasbourg court would be sympathetic to anyone seeking to rely upon this (important) tightening of the criteria to deny care to a person seeking it.

Short Note: the EU and the CRPD

The Second Chamber of the Court of Justice of the European Communities considered aspects of the UN CRPD in the context of employment age discrimination. A 28-year-old student with disabilities was being assisted to recruit a personal assistant who should be 'preferably between 18 and 30 years old' as the assistant would need to ensure that her highly personal needs in relation to her social life as a university student were met. The issue was whether this was discriminatory on age grounds.

In *AP Assistenzprofis* [2023] EUECJ C-518/22, the court took into account Article 19 CRPD (the right to independent living) which contained "*specific requirements to enable persons with disabilities to live with the same autonomy as others and with choices equal to others*." The court held that this must be interpreted as not precluding an age requirement for personal assistants which took account of the wishes of the person with disability, provided such a measure was necessary for the protection of the rights and freedoms of others.

The decision perhaps illustrates the growing traction of the CRPD when interpreting domestic and European law.

IRELAND

In the Matter of Joan Doe [2023] IECC 10

Prior to the end of 2023 the Circuit Court in Dublin delivered its first written judgment under the Assisted Decision-Making (Capacity) Act 2015. This may have been surprising to some because, historically, it was most unusual for the Circuit Court to deliver written judgments. Between 2016 and 2022 there were a total of 20 written judgments of the Circuit Court over the seven-year period. Although there were nine in 2023, perhaps indicating a change in the usual practice.[2]

This written judgment in question, *In the Matter of Joan Doe* [2023] IECC 10, concerned a dispute between Joan Doe's siblings and the Health Service Executive ('the HSE') as to whether the siblings were suitable to act as Decision-Making Representatives ('DMR') for Joan Doe. The HSE contended that the siblings were unsuitable and an independent panel DMR ought to be appointed.

By way of background, Joan Doe is a widow, without children, in her late sixties. Her assets consist of a primary residence, an apartment, some savings and an income from three pensions. She has a diagnoses of frontotemporal dementia and a history of mental illness with significant episodes of suicidal ideation. Ms. Doe's brother, John Doe, gave evidence that "*the Relevant Person suffered from OCD for many years. However, in 2011 something went wrong. He said at that time she had a series of admissions to a Mental Health Service and "she*

[2] See: https://www.courts.ie/search/judgments/%22%20type%3AJudgment%22%20AND%20%22filter%3Aalfresco_radio.title%22%20AND%20%22filter%3Aalfresco_Court.Circuit%20Court%22.

has never been well in the same sense since 2011". John Doe looked after Ms. Doe's property and finances for her since 2014/2015, and has lived in her home rent free since 2021, as Ms. Doe came home from her assisted living accommodation each weekend, and someone had to be there.

A suitable person

One of the most interesting features of the judgment, in my view, is that the court opted not to rely on the relatively straightforward suitability criterion. Section 38(2) of the ADMCA provides that the court may make an order appointing a 'suitable person' to act as DMR, suggesting that the court, having heard evidence in a case, could make findings based on the evidence that the proposed DMR is simply unsuitable. Instead, the court in this case opted to make findings pursuant to 38(5) that there were conflicts of interest and pursuant to 38(6) that certain members of the family did not have the requisite financial acumen to take on the role.

It is striking that the court opted to do this as opposed to making a finding, for example, that none of the siblings were suitable people because they had engaged in acts such as calling the treating psychiatrist a "bitch", intimidating the treating psychiatrist, failing to provide financial details to the social worker, or accepting ongoing cash payments from the Relevant Person. Given the extent of responsibility afforded to DMRs, their fiduciary duty, their obligation to comply with the Code of Practice for DMRs, and in the present case, liaise with the treating medical team with whom there had been a fundamental breakdown in the relationship, in all of the circumstances one might conclude that the siblings were simply unsuitable.

Will and Preferences

In considering making any intervention under the Act, which includes appointing a DMR, the court must not only take account of, but also give effect to, in so far as it is practicable to do so, the past and present will and preferences of the relevant person. In considering this issue and balancing any expression of will and preference against the person's incapacity, the court held, at par. 6.10, that it "*must be mindful of the fact that a person not having the ability to make a decision on a particular matter, does not mean that their wishes are to be totally disregarded*."

The court goes on to hold, at par 6.11, that "*while the court is mindful of the fact that the right to have a voice heard and respect the will and preference of the Relevant Person, it is not the only consideration. The court must also consider the issues of vulnerability and how that can be best dealt with*". The ADMCA sets out what the Circuit Court is obliged to consider when determining an application pursuant to section 38 to appoint a DMR. In addition to the guiding principles the court is obliged to consider the factors set out in s 38(5) of the Act, which include the person's will and preferences, preservation of family relationships, the existing relationship with the proposed representative, their compatibility, the representative's capability, and assessment of potential conflicts of interest. Further, s 38(6)(a)–(d) provides that when considering the appointment of a decision-making representative for a relevant person's property and affairs, the court must consider the complexity of the individual's financial affairs, the expertise needed to manage them, the capability of the proposed representative, and the financial support available to them.

In addition to considering "issues of vulnerability" the court found, at par. 6.13, that *"while the court has to be very respectful of respecting the past will and preferences of persons who lack capacity, it*

has to also be conscious of the need for effective safeguards to prevent abuse". The legislative framework is drafted with the clear aim of preventing abuse by those who perform the role of DMR. DMRs are accountable to the Director of the Decision Support Service and ultimately the Court. It may be the case that the court may find that a proposed DMR has a conflict of interest which results in a finding that they are unsuitable pursuant to section 38(5)(f), however the imposition on the court to impose 'effective safeguards to prevent abuse' in appointing a DMR is an interpretation of the ADMCA arising from this case.

While it is evident from the summary of the independent solicitor for the Relevant Person that the Relevant Person's *present* will and preferences were unascertainable, it is interesting that the court did not make any findings as to the Relevant Person's *past* will and preferences. It is not known whether there was any indication from the decisions previously made by the Relevant Person that she would want any of her siblings to be appointed as her DMR, or what weight the court placed on Ms. Doe allowing her brother to take care of her property and finances for the previous eight or nine years. While it may remain the case, having determined that the Relevant Person's past will and preference would indicate that any one of the siblings would be preferred by the Relevant Person, that the court could conclude that such sibling(s) are unsuitable.

Objectivity

In refusing to appoint the siblings as DMRs, the court, at par. 9.2, held that the Relevant Person's siblings "*cannot objectively deal with financial, medical and care decisions on behalf of their sister*". The requirement for a DMR to objectively deal with relevant decisions does not appear in the ADMCA or the Code of Practice for DMRs. Section 3.6 of the Code of Practice sets out how a DMR ought to consider options. The standard set out in the Code is, in my view, subjective in that the responsibility to make decisions, either independently or jointly with the relevant person (ss 3.6.4 and 3.6.5) necessitates a subjective interpretation and application of the individual's preferences to specific, often varied, circumstances.

The determinative factors

In reaching the decision that none of the four siblings of Joan Doe were suitable as DMRs under the ADMCA, the court considered several factors. Regarding John Doe, the treating psychiatrist reported a confusion in his understanding of the roles of advocate and decision-maker. Further, Mr. John Doe's residence in the Relevant Person's property and the expected inheritance from her estate raised concerns. There were serious issues around his handling of the Relevant Person's medication, including an instance of withholding medication and resistance to sharing financial information necessary for the Fair Deal Scheme.

James Doe's financial dependence on the Relevant Person, evident from a regular standing order of €25 per week and contributions to the cost of a holiday on which the Relevant Person went, was also problematic. June Doe's suitability was questioned due to an alleged assault on a nurse manager and her admission of using derogatory language. Joy Doe was considered to lack the necessary skills to act as a financial DMR.

Finally, the family, as a whole, was viewed critically. The court referred to the evidence of the treating psychiatrist regarding the family's inability to care for the Relevant Person at home, and the psychiatrist's experiences of threatening and intimidating behaviour from the family, particularly from Mr. John Doe. Concerns about

the administration of medication by the family were also raised by Dr. AB.

Conclusion

It remains to be seen whether the courts here will develop any case law around the weight to be attached to a Relevant Person's will and preferences, the priority or weight to be attached to each of the guiding principles and whether there ought to be any order of preference in the appointment of DMRs. For practitioners, this case provides some helpful guidelines as to the type of issues that will influence a court in refusing to appoint family members as DMRs. Though, no doubt, there is much more to come.

Emma Slattery BL

Comment

From a (very interested) external perspective, one of the striking features of the judgment was its deliberate emphasis upon the fact that will and preferences are not the sole determinant of decision-making under the 2015 Act. This is self-evidently correct from the terms of the legislation itself, which – contrary to some of the 'messaging' around it – is not solely about will and preferences, rather, and tracking Article 12 CRPD, it is about respect for will and preferences, but also the other rights in play, including the right to be safeguarded against exploitation, violence and abuse.

Alex Ruck Keene

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Conferences

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

Alex is 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.

Peter Edwards Law has announced its spring training schedule, here, including an introduction – MCA and Deprivation of Liberty, and introduction to using Court of Protection including s. 21A Appeals, and a Court of Protection / MCA Masterclass - Legal Update.

Adrian will be speaking at the World Congress of Adult Support and Care. This event will be held at the Faculty of Law of the University of Buenos Aires from August 27-30, 2024. For more details, see here.

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 March. 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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