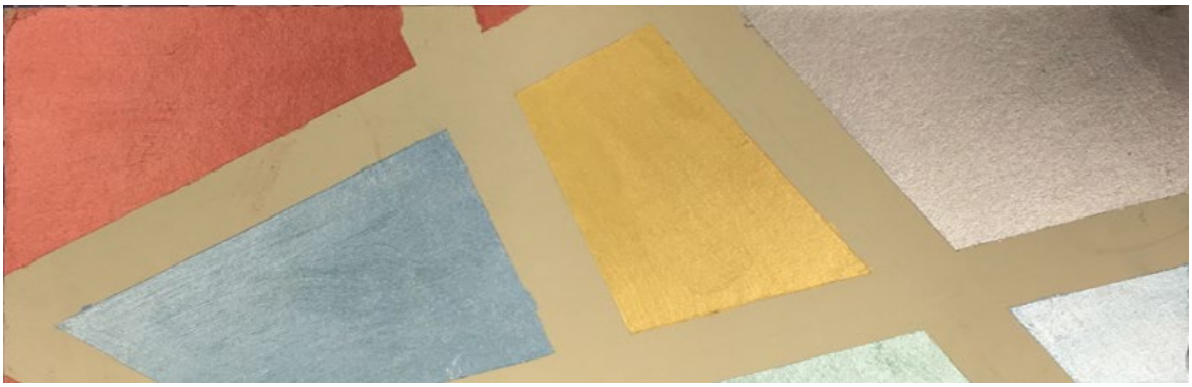
Essex CHAMBERS

MENTAL CAPACITY REPORT: COMPENDIUM

February 2025 | Issue 147



Welcome to the February 2025 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: myth-busting about DoLS and strong words about assessment of capacity of D/deaf people;

(2) In the Property and Affairs Report: revoking Deputyship for a person no longer present in England & Wales;

(3) In the Practice and Procedure Report: litigation capacity and a very clear statement of the ordering of the capacity test, delays in obstetric cases and guidance on neurodiversity before the courts;

(4) In the Mental Health Matters Report: the Mental Health Bill progresses and two important Upper Tribunal cases;

(5) In the (new) Children's Capacity Report: deprivation of liberty before the courts and Parliament, when capacitous consent is not enough, and best interests and the clinical circling of the wagons;

(6) In the Wider Context Report: The Terminally Ill Adults (End of Life) Bill and capacity, CCTV and care homes, and using the arts to be more creative in capacity assessment.

(7) In the Scotland Report: Scottish Government's law reform proposals – the consultation responses, and the OPG digitalises.

There is one plug this month, for a free digital trial of the newly relaunched Court of Protection Law Reports (now published by Butterworths. For a walkthrough of one of the reports, see here.

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.

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

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HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

"On a DoLS" – mythbusting by a (rightly) exasperated Court of Protection

Re EM (Deprivation of Liberty, Care Planning & Costs) [2024] EWCOP 76 (T2) (HHJ Burrows)

Article 5 ECHR – DoLS authorisations

Summary

In this case, HHJ Burrows helpfully busted some disturbingly frequent myths about DoLS. The case concerned a young woman, personalised by the court with the name "Emma," and for present purposes, the central passages of wider relevance are these:

45. Having read the documents in this case, including those concerned with Emma's own wishes and feelings, it seems to me the Court needs to be very clear in the language it uses.

46. The acronym DOL (or DoL) or its plural "DoLs" comes from the wording of Article 5 of the European Convention and refers simply to "deprivation of liberty". The term "DOLS" refers to Schedule A1 of the MCA, otherwise known as the Deprivation of Liberty Safeguards. Emma is therefore subject to an order that authorises her deprivation of liberty, which could be called a DoL or DoLs order. She is not on a DOLS.

47. I hope not to confuse things further by explaining my understanding of the law. The MCA requires decision makers to make decisions for people who cannot make those decisions for themselves, where necessary (see ss 1-4 MCA). That includes issues over residence and care. It enables decision makers to decide on care plans that meet the best interests of the person concerned. That is the starting point. A care plan in P's best interests, and the one which adopts the least restrictive option is what the decision maker must choose. If that plan involves or may involve a deprivation of P's liberty, then it needs to be authorised and will be if it is necessary and proportionate in furthering P's best interests.

48. It can be authorised under Schedule A1 of the MCA if the person is 18 or older and is detained in a care home or hospital. These are the DOLS. If the person is not yet 18 or is somewhere other than a hospital or care home, the Court must decide whether to authorise the care plan under ss 15 and 16 MCA.

49. The inherent jurisdiction has been used in Emma's case to authorise her deprivation of liberty outside a statutory regime. These are also known as DoL or DoLs orders, with good reason.

50. Such authorisation, by any of these avenues, is permissive rather than mandatory. Or put another way, it enables the carer to use restrictions that amount to a deprivation of liberty, it does not require them to do so.

51. Therefore, the expression "on a dol" or "under a dol", whilst perfectly legitimate abbreviations, must be understood properly and within that context. To be "on" or "under a dol" means to be subject to an order (or authorisation) approving and authorising a care plan which allows the carer to use restrictions that amount to a deprivation of liberty in the best interests of P. Clearly, the emphasis here is on the care plan itself and not the legal status of the restrictions that can be used. The care plan to be used is still a decision to be made by the carer/clinician/MDT in charge on the basis of what they consider to be needed in the circumstances that arise, and what is in P's best interests.

52. Unfortunately, when the Court authorises such a care plan that amounts to a "dol" it is seen as being mandatory, like the Court has imposed a prison sentence. That gives rise to an unfortunate misconception on the part of the people who are the subject of these orders that the order, while it remains in place, requires those providing care to keep them actually locked in and locked up.

53. In some extreme cases coming before the National DOLs List and the Court of Protection it is easy to see why the misconception arises, particularly when the options for care are all inadequate, P's behaviour is extreme,

and LAs are fighting a very difficult and seemingly endless battle to keep P safe.

54. However, the principle is always the same. The Court will ask questions like: what is the care plan and how has it been arrived at? What are the risk assessments of alternative plans compared with this one? What does P think? What do other relevant people under s. 4 MCA think? Does the LA/NHS provider (as the case may be) consider the care plan to be the least restrictive option that will address P's needs? What steps are being taken to reduce the need for such an intense care plan? The Court is obliged to scrutinise the answers given.

55. It is important to emphasise though that the care plan is King here. That is how Emma's case should be seen. Considering Dr Khan's engagement with Emma, an attempt is being made to give effect to what Emma wants in her care plan. She wants less restriction. If the clinicians, social workers, and other relevant professionals can work with Emma (and perhaps her family) to devise a care plan that does not amount to a deprivation of her liberty, and that care plan is in her best interests, then the Court will authorise it.

What particularly troubled HHJ Burrows was that:

56. The LA in this case is (I think) planning to move Emma to a place where there will be no need for "a dols". However, through their counsel it was made clear to me that could only happen if I "lifted the dols". This is incorrect. If the LA devises a care plan whereby Emma can move to another place where she will not be deprived of her liberty, there will be no need for the Court to authorise her deprivation of liberty. If a plan is devised at her present placement that does not amount to a deprivation of Emma's liberty, the Court will not need to authorise one.

57. So profound has the language and the law been confused in this area, that these two statements of what should be the blindingly obvious, appear necessary.

58. It is important to remember that the Court is in place to ensure that disputes about capacity, best interests and the proportionality of restrictions are resolved as well as ensuring that there is a consistent scrutiny of a care plan that imposes significant restrictions on P.

59. Once again, however, care planning and the assessments and consultations around that are what is most important. That means Emma is central to the process. By focusing on the Court and the making and un-making of a "dol", Emma and other people in her position are made to feel peripheral to the whole process. Many of them conclude that "getting off the dol" is essential before they can be part of the process. Many feel that when on a "dol" they are filed away and forgotten only to be taken out for scrutiny when someone else makes a fuss.

60. In fact, the whole MCA/Court of Protection process, particularly when concerned with Article 5 rights, is about ensuring that these care planning decisions are constantly reevaluated to ensure that P's best interests are served through the least restrictive option, and P is central to the whole process.

61. At the October hearing, I therefore approved the care plan I was invited to approve at the placement. That care plan amounts to a deprivation of Emma's liberty not because the Court says it does, but because the restrictions imposed under the care plan are said to be necessary, proportionate and in her best interests according to

> *those involved in her care, and they place Emma under continuous supervision and control and she is not free to leave the placement.*
>
> *62. The Court approves the restrictions, it does not create them.*

Separately, HHJ Burrows was exercised by the "serial breaches" by the local authority of directions made in advance of the relevant hearing, and came to the conclusion that the threshold for the making of a costs order had been met:

> *72.* […] *because of the wholesale breaches of the order made to ensure the hearing in September was not wasted. As a result, it was wasted. That non-compliance took place within the context of the earlier complaints made by the OS in July. The October hearing went someway towards ensuring the case was back on track, but that simply emphasises the waste the September hearing was. For those reasons I am satisfied that I should depart from the general rule and make an order for costs against the LA.*

Comment

HHJ Burrows' observations about what DoLS (and orders made by the courts here) actually mean, as opposed to what they are understood to mean, are trenchant. That they were required is, frankly, more than a little depressing.

D/deaf individuals and capacity assessment – a salutary tale

Oldham MBC v KZ (Fluctuating Capacity: Anticipatory Declaration) [2024] EWCOP 72 (T3) (Theis J)

Mental capacity – assessing capacity

Summary

This case is a salutary tale in which a failure to provide a Deaf young man with a suitably equipped translator and/or assessor very nearly had the effect of writing off the abilities he had and seriously underestimating his capacity to make decisions for himself. The Vice President, Theis J, also had to grapple with the role of anticipatory declarations and when they might be permitted under the MCA.

KZ was 20 years old at the time of judgment but had been the subject of proceedings since his late teens. One of five children who appeared to have lived between Pakistan and Spain before moving to the UK, KZ was described as deaf, with a cochlear implant but resistant to its use: he is recorded as preferring to communicate in British Sign Language (BSL), notwithstanding that his parents, with whom he lived for the first half of his life, did not sign at all.

Theis J's judgment describes a number of years of a problematic home life: KZ living in hotel rooms with his father, excluded from placements, exhibiting sexualised behaviours, arrested on stalking offences and considered a potential risk to others. From 2021 onwards KZ is recorded as attending a specialist school with 2:1 carers, some of whom are noted to be BSL trained.

In 2021, applications for deprivation of liberty authorisations were made and capacity assessments were first carried out. KZ was assessed by Dr Lisa Rippon as lacking capacity in all relevant areas – residence, care, contact, engaging in sexual relations and receiving a covid vaccination. In a move a later assessor described as "*frankly astonishing*" (paragraph 95), Dr Rippon was assisted in producing her report by the BSL Level 1 qualified service manager at KZ's placement acting as translator. BSL level 1 effectively means understanding a limited range of simple words and sentences enabling the user to give and follow simple

directions or instructions or provide simple familiar statements or descriptions. It does not obviously equip an individual to provide translation support for an assessment of mental capacity across a broad spectrum of decision-making.

Nonetheless, the Dr Rippon carried out the assessment on KZ and concluded as a result that he was suffering from a "*borderline learning disability*" as well as some autistic features (paragraph 47).

As a result of Dr Rippon's conclusions (and it should be noted that the judgment does not include any criticism of Dr Rippon personally), according to Theis J, proceedings "*nearly concluded in January 2024 on the basis of expert evidence regarding KZ's capacity that stated he lacked capacity in all relevant areas, including residence, care and support and contact*" (paragraph 2).

Following a move to a new placement, concerns were raised regarding the capacity assessment, regarding both the conclusions reached and the manner in which the assessment had been carried out. A further assessment was ordered. This assessment was carried out by a Clinical Psychologist with specific expertise in assessing deaf people, Dr O'Rourke, acting with the support of a Registered Sign Language Interpreter.

Dr O'Rourke's conclusions were markedly different from her predecessor's. She concluded that KZ was "*very far from the diagnosis of a learning disability*" (paragraph 50(1). Rather, she diagnosed KZ as suffering from *"extreme language deprivation"* which, albeit that it did compromise his ability in a number of domains, left undisturbed his capacity to make decisions about his residence and his contact with his parents.

The Vice President gave the following guidance for the assessment of capacity in deaf in future cases.

> *96. As regards wider issues concerning the assessment of mental capacity of Deaf individuals the following should be an essential part of any such assessment. The experience in this case demonstrates the use of a non-specialist expert is not an appropriate substitute for the specialist assessment and risks incorrect conclusions regarding capacity being reached. Where an assessment is required the following considerations should guide any assessment of a deaf individual fluent in BSL:*
>
> > *(1) Any mental capacity assessment of a deaf individual fluent in BSL should ideally be undertaken by an assessor who is suitably qualified to communicate at the relevant level of BSL. If that is not done, there should be a clear explanation why and what measures, if any, are proposed to be in place to manage that gap.*
> >
> > *(2) The assessor should ideally have a background in understanding deafness and engaging with the deaf community. If they don't, there should be a clear explanation why they are undertaking the assessment without such knowledge.*
>
> *97. These essential steps should prevent the difficulties encountered in this case occurring again. They accord with the wider provisions regarding expert evidence in Part 15 Court of Protection Rules 2017 which make clear 'it is the duty of an expert to help the court on matters **within his own expertise'** (emphasis added) (PD15A paragraph 2). There is an obligation on those proposing an expert instruction,*

> *and on the expert themselves, to make sure that expert has the requisite expertise to prepare the expert report being sought.*

Alongside this, the court was tasked with grappling with the issue of when and whether to make anticipatory decisions in the case of an individual, like KZ, who was determined to have decision-making capacity in a number of domains, but to lose it at times of "dysregulation".

Noting the two competing routes to a finding of "longitudinal capacity" by Lieven J in *A Local Authority v PG (by her litigation friend, the Official Solicitor) and an NHS Integrated Care Board* [2023] EWCOP 9 – the longitudinal view taken by Sir Mark Hedley in *Cheshire West v PWK* [2019] EWCOP 57, versus the "anticipatory" approach adopted by Cobb J (as he then was) in *Wakefield Borough Council v DN* [2019] EWHC 2306 (Fam) – Theis J concluded:

1. KZ regularly became dysregulated;
2. He was cared for by a consistent team who would therefore be able to assess whether he had lost capacity in any relevant domain (at paragraph 87).
3. The anticipatory declarations proposed by the local authority were workable according to the care plan they proposed;

The s.16(1) apparent exclusion – ie that it only enables the court to make orders *"**if** a person lacks capacity"* identified by Hayden J in *GSTT v SLAM and R* [2020] EWCOP 4 – was not applicable in circumstances where "*this is not a case where there is a risk that KZ will lose capacity, it is a case where he does lose capacity, albeit it fluctuates*" (paragraph 72).

In those circumstances, Theis J accepted the local authority submission that "*the least interventionist approach to capacity that promotes KZ's autonomy and capacity would be achieved by making an anticipatory declaration as compared to the longitudinal one*" (paragraph 72).

Comment

The trenchant observations in paragraph 97 about the approach capacity assessment of D/deaf people relate to proceedings before the Court of Protection; the observations in paragraph 96 apply across the board.

In relation to the other feature of the case, the Lieven J approach to "longitudinal" assessment has become increasingly popular in cases where local authorities are confronted with high-functioning yet difficult to manage service users. Many practitioners will have found this worrying, given the "off-switch" that it effectively applies to the capacity of individuals who fall prey to heightened emotions and the infamous "dysregulated" behaviour. Theis J's observations regarding the *"least interventionist approach"* that anticipatory declarations provide carry a great deal of attraction – albeit that this kind of approach relies heavily on a highly skilled, consistent care team which, sadly, many individuals do not currently have the good fortune to be cared for by.

It is also not entirely clear whether the anticipatory 'declarations'[1] she made were made on the basis of s.16(1) or s.15, but we suggest that the proposition put to her by the local authority and accepted blurred two conceptually distinct situations:

[1] The word used at paragraph 88.

(1) Where a person, in fact, lacks capacity when their decision-making is assessed across the material time (the *PG* situation). At that point, s.16(1) is in play because the person lacks capacity for purposes of the exercise of the Court's jurisdiction.

(2) Where a person has capacity, but loses it under particular circumstances. At that point, if the person has capacity at the point that they are before the court, s.16(1) simply cannot apply, and the court is reliant upon s.15(1)(c) to make anticipatory declarations as to lawfulness and /or the inherent jurisdiction of the High Court insofar as it is being asked to make any declarations relating to deprivation of liberty.

Sexual capacity and contact

JC v Cornwall Council and ors [2024] EWCOP 75 (T2) (HHJ Cronin)

Mental capacity – sexual relations

Summary

This is another judgment, determined in the autumn of 2024, but only appearing on Bailii more recently, on the question of capacity to engage in sexual relations. JC was a 58 year old with a mild learning disability, who had been found (by agreement) to lack capacity to make decisions about where to live, what care and support to receive, contact with others, use of social media and the internet, and management of their property and affairs. HHJ Cronin noted that there were various considerations that people generally might take into account when deciding whether to engage in sexual relations that are not part of the relevant information identified by the Supreme Court in Re JB – "*that engaging in sexual relations may result in emotional distress or disappointment* […] *and that engaging in sexual relations may result in a negative reputation for promiscuity*".

The issue in JC's case was whether JC (who used the pronouns 'they' and 'them') was able to understand the need to obtain consent before and throughout sexual activity, and to use or weigh that information, as a result of JC's difficulty in recognising subtle signals and body language. JC had a history of predatory sexual behaviour towards children and adults and had asked friends for sex when they had already indicated they were not interested, as well as failing to understand that a friend agreeing to stay overnight was not also thereby agreeing to have sex. An independent expert had carried out the capacity assessment, despite JC only engaging in the assessment in a limited manner, ultimately concluding that JC would not be able to recognise the non-verbal withdrawal of consent during sex, due to autism-like trait. HHJ Cronin accepted that "*non-verbal signals as to consent or refusal or withdrawal of consent are important parts of the relevant information needed to decide to engage in sexual relations. These will include eye contact, averting the eyes, making hand or arm gestures, folding arms, turning away, moving closer, making a face, touching the other person or pushing them away: these are all commonplace in the circumstances of one person approaching another seeking to have sexual relations or in the response of the person approached, both preceding, and during intimacy, and possibly more commonplace than verbal communication.*" HHJ Cronin held that as a result of autistic-like traits and learning disability, JC was unable to understand non-verbal signals, or "*recognising meanings alternative to assumptions made or inferred from other actions (such as agreeing to stay overnight), or meanings inconsistent with JC's own wishes, in behaviours such as K agreeing to stay overnight in JC's property. Since JC cannot understand that information when it is in non-verbal form, they lack capacity to decide to engage in sexual relations.*"

Comment

The thorny issue of capacity to engage in sexual relations continues to trouble the courts, particularly in the context of people who display harmful sexual behaviour and pose risks to others. This judgment, decided before the Court of Appeal's decision in *ZX* (the subject of this webinar by Tor and Francesca Gardner), does not contain any explanation as to how the Official Solicitor contended that it was consistent with accepting JC lacked capacity in respect of contact to argue that JC lacked capacity in respect of sexual relations. An inability to understand other people's motivations and behaviour other than by direct verbal information appears likely to lead to the same result in both areas of decision-making. There were in this case very clear examples of JC failing to understand such non-verbal information and reaching the wrong conclusion about consent as a result. It will be important to consider such evidence in similar cases, to avoid leaping too quickly from a diagnosis of autism or autism-related traits to an inevitable conclusion that P lacks capacity to make decisions about interactions with other people.

PROPERTY AND AFFAIRS

Short note: deputyship and the court's jurisdiction

In *Re P (Property & Affairs Deputyship: Jurisdiction)* [2024] EWCOP 77 (T2), HHJ Burrows confirmed that the Court of Protection has the power to revoke a property and affairs deputyship (and, we would add also, a health and welfare deputyship) irrespective of whether the person is still in the jurisdiction: see paragraph 33. The judgment also contains some useful consideration of what to do where the person appears to have been removed from the jurisdiction and their whereabouts are unknown – whilst not strictly relevant to the question narrowly before the court, it is clear that HHJ Burrows was very concerned about P's welfare, and was taking steps to get the matter transferred to the High Court for further consideration. In such cases, we note that it is vitally important that (in lay terms) the court gets a move on, because habitual residence is not fixed at the point of the application being issued, and can be lost simply by passage of time (see *Re PO*). At that point, the High Court (but not the Court of Protection) retains a nationality-based inherent jurisdiction to protect British nationals – although this is not without its complexities (see *Re XS* and *Re Clarke*).

Private Member's Bill – Lasting Powers of Attorney

The Labour MP Fabian Hamilton has put forward a Private Member's Bill concerning Lasting Powers of Attorney. It has had its first reading, and its long title is self-explanatory:

> *A Bill to make provision about Lasting Powers of Attorney; to place duties on banks in respect of Lasting Powers of Attorney; to make provision about the powers of the Office of the Public Guardian to investigate the actions of an attorney; to require the Secretary of State to review the effectiveness of the powers of the Office of the Public Guardian to investigate the actions of an attorney and of its use of those powers; to make provision about the duties of care homes in respect of Lasting Powers of Attorney; to require an attorney to notify the Office of the Public Guardian of the death of a donor; to require the Office of the Public Guardian to take steps to promote the facility to request a search of its registers of powers of attorney; and for connected purposes.*

Although it will go forward to Second Reading, it is unlikely to progress given that (unlike what became the Powers of Attorney Act 2024, which also started as a Private Member's Bill), it does not have Government support.

PRACTICE AND PROCEDURE

Litigation capacity and a very clear statement from the Court of Appeal about the ordering of the capacity test

MacPherson v Sunderland City Council [2024] EWCA Civ 1579 (Court of Appeal (King, Asplin and Birss LJJ))

Mental capacity – litigation

Summary

This is the latest judgment in the long running Court of Protection proceedings about Ms MacPherson's daughter. The matter came before the Court of Appeal on an appeal brought by Ms MacPherson against an order made by Poole J on 22 January 2024 sentencing her to an immediate custodial sentence for a total of four months, for contempt of court. The first instance judgment can be found at [2024] EWCOP 8. This however was not the first order for a custodial sentence that the Court had made against Ms MacPherson in the COP proceedings. She had previously been sentenced in January 2023 for contempt for 28 days, suspended for 12 months. Poole J's judgment in relation to the 2023 committal proceedings can be found at [2023] EWCOP 3.

Despite Ms MacPherson having issued her application to appeal the January 2024 order in March 2024, there were significant delays in the appeal being able to progress. It was therefore not until November 2024 that Ms McPherson's legal team (two counsel and one solicitor), were able to have a remote conference with her. All members of the legal team expressed concerns about her capacity to conduct the appeal proceedings. She was therefore invited to participate in a capacity assessment. She refused this invitation in what was described by the Court of Appeal as '*strong terms*'.

The lawyers therefore made an application to the Court of Appeal under CPR 35.4, for permission to instruct an expert to undertake a desk top report into Ms MacPherson's capacity to conduct the appeal proceedings. Permission to do so was granted, and a consultant psychiatrist filed a desk top report in which he stated that on the balance of probabilities Ms McPherson's lacked the capacity to conduct the proceedings.

The Court of Appeal then convened a hearing of the appeal, which Ms MacPherson attended remotely, along with the local authority and the legal team who had raised the concerns about her litigation capacity. The Court of Appeal was at pains to emphasise the diligence with which it was made clear to the court that Ms MacPherson's previous legal team were not acting upon her instructions or making submissions to the court, but were there to assist the court, by providing information and setting out the options available to it to progress the appeal.

Three options were put before the court. The first option was for the Court of Appeal to declare that Ms MacPherson had litigation capacity. The second option was for the Court of Appeal to declare that Ms MacPherson lacked litigation capacity. Both of these options were dismissed swiftly by the court on the basis that there was not a sufficient evidential basis for the court to come to a conclusion one way or another. The third option did however find favour with the court. This was for the Court of Appeal to make a s.48 MCA declaration that there was 'reason to believe' that Ms MacPherson lacked capacity to litigate, and to then transfer the determination of that matter back to a Tier 3 Judge of the COP, with a view to the matter then being returned to the Court of Appeal to hear the substantive appeal.

The Court of Appeal considered the powers that it had to make such an order both under the COP

rules and under the CPR (which of course governs procedure in the Court of Appeal). In short, the Court of Appeal took the view that the both sets of rules gave them the all the powers of the first instance court, and in particular gave them the power to refer any issue to the first instance court for determination.

Comment

The challenges posed where a client appears to lack the capacity to conduct proceedings – for both the lawyers, and the court – were recently emphasised in the Civil Justice Council's November 2024 report. The instant case shows the importance of getting it right, on the basis of the right evidence. The lawyers in the instant case also took scrupulous steps to alert the court to the potential that their client lacked litigation capacity (by contrast, we note, to those in *Aslam v Seeley* [2025] EWHC 24 (Ch), where the court identified that "*the decision of the claimant's lawyers* […] *to keep their concerns* [about litigation capacity] *up their sleeve, only revealing them when required to do so by a direct question from the court, was a serious error of judgment*" (paragraph 11).

More broadly, the Court of Appeal in this case was at pains to emphasise the importance of capacity assessments complying with the approach set out by Lord Stephens at paragraphs 66 and 79 of his judgment in *A Local Authority v JB* [2021] UKSC 52, namely that the proper approach to the determination of capacity should be considered in the following order:

i) Whether P is unable to make a decision for himself in relation to the matter (s.3 MCA 2005 – the functional test).

ii) Whether the inability to make a decision is "because of" an impairment of, or disturbance of the functioning of, the mind or brain (s.2(1) MCA 2005 – the 'diagnostic' or mental impairment test).

The Court of Appeal noted that, while this approach was contrary to paragraph 4.11 of the current MCA Code of Practice (which stipulates that the first stage of an assessment is to identify the impairment and then go on to consider the functional test), a new draft Code (dated June 2022 but not yet implemented) adopts the *JB* approach. The Court of Appeal was clear that:

> *Regardless of the fact that the new Code has not yet been implemented, all assessments should comply with the Supreme Court approach (see Hemachandran v University Hospitals Birmingham NHS Foundation Trust [2024] EWCA Civ 896 para.[140](iii)).*

The Court of Appeal's very clear direction that capacity assessments should comply with the ordering of the test set out in the MCA (and confirmed in *JB*) rather than the Code of Practice, is very helpful, but only reinforces how problematic it is that progress on updating the Code is stalled. In the meantime, this unofficial update highlights the (many) paragraphs that should not be followed because case-law has confirmed that they do not accurately reflect the requirements of the MCA 2005.

The only part of the judgment that might raise eyebrows was the view taken by the Court of Appeal that they could rely upon the provisions of rule 20.13 of the Court of Protection Rules 2017 to cloak themselves with the necessary power to remit the question of the appellant's litigation capacity to a Tier 3 Judge. The Court of Protection Rules 2017 are conventionally understood only to apply within the Court of Protection, and hence the provisions of Part 20 (appeals) to apply only in relation to 'internal'

appeals within the Court of Protection. Appeals which escape the gravitational pull of the Court of Protection are conventionally understood to be governed by the CPR (if in the Court of Appeal), and the Supreme Court rules (in the Supreme Court): see, for instance, *Cheshire West and Chester Council v P (No 2)* [2011] EWCA Civ 1333 at paragraph 3, where Munby LJ noted that "[i]*t is common ground that although this is an appeal from the Court of Protection the Court of Protection Rules do not apply*." However, and for the avoidance of any doubt, this does not mean that the Court of Appeal in Ms MacPherson's case lacked the power to do what it did, given that (as King LJ herself noted), it had the equivalent power to do so under rule 52.20(1) of the CPR.

Short note: obstetric cases and the Court of Protection – the need for timeliness (again)

Peel J in Leicestershire Partnership NHS Trust & Anor v PQ *[2024] EWCOP 73 (T3)* has reiterated the need for timely applications to be made in the context of cases involving birth arrangements:

> *7. The applicants have known about PQ's pregnancy since week 20, and have long been aware of her mental health history, including potential capacity issues. The application before me should have been made far sooner than the date upon which full term was reached and the birth was due. I understand that the applicants failed to take legal advice until the last moment. As a result, they did not follow the judgment of Keehan J in NHS Trust v FG [2014] EWCOP 30, and in particular the annex thereto, which sets out in clear terms what is required of applicant Trusts in cases concerning obstetric care. Regrettably, almost none of the stipulated steps were taken, including making an application no later than 4 weeks before the due date.*
>
> *8. When the application was made on Thursday 28 November 2024, it was inevitably accompanied by a request for a hearing that day or the next because of the perceived urgency. The court was placed in an extremely difficult position to try and arrange a listing. It came before me the next day, Friday 29 November 2024. Papers trickled in during the morning. There was no bundle. I had a flurry of last minute requests for legal representatives and clinicians to attend remotely. The Official Solicitor had not been notified of the application until the day before and had next to no information. She was not able to arrange for an agent to meet PQ. Counsel instructed on behalf of the Official Solicitor said candidly that the Official Solicitor could not advance a positive case. Counsel for the applicants invited the court to proceed to a full hearing, with oral evidence, to enable the CS, if approved, to take place at 4.30pm that day. All of this was, to put it mildly, unsatisfactory, as well as being unfair to the subject of these proceedings, PQ.*
>
> *9. In the end, I decided to adjourn from Friday 29 November 2024 to Monday 1 December 2024. By good fortune, the medical presentation which was thought to be so urgent on Friday 29 November 2024 (the risk of pre-eclampsia) dissipated over the weekend and the case, while still urgent, was not at the level of immediate and imperative necessity which it appeared to be.*
>
> *10. The lesson from all of this is for applicant Trusts, when dealing with potential issues about obstetric care, to follow the guidance of Keehan J scrupulously. Failure to do so is likely to create the difficulties which faced me in this case, at a time when judicial resources are under enormous strain. As I have already said, failure to do so is unfair to the patient and likely to be contrary to their best interests.*

Guidance documents

Two important guidance documents have been published which purport to relate to family proceedings, but which are equally relevant to practitioners before the Court of Protection.

The first is practice guidance from the President of the Family Division concerning the use of Intermediaries, Lay Advocates and Cognitive Assessments in the Family Court. This reinforces the messages of recent cases that the courts consider the appointment of intermediaries to be a last resort:

> *12. Vulnerability covers a wide spectrum. Only towards the far end of the spectrum will there be cases where an intermediary is necessary for the giving of evidence. Only at the very far end of the spectrum will there be cases where an intermediary is required for the whole of a hearing and only in the very rarest of cases will an intermediary be necessary to enable the party to give instructions in advance of a hearing or be required for conferences.*

The practice guidance places an obligation on practitioners to familiarise themselves with the Advocates Gateway and in particular, Toolkit 132, which relates to vulnerable witnesses in the Family Court – materials which are equally relevant for proceedings before the Court of Protection.

The second guidance comes from the Family Justice Council, and addresses neurodiversity in the Family Justice System, ahead of specific guidance for the judiciary to be published later in 2025. As it notes in its opening section:

> *The evidence available suggests that neurodivergence is overrepresented among court users and the fact that it is often underdiagnosed is likely to further mask its prevalence in those accessing family justice. Failure to recognise and take into account neurodivergence impacts children and families within the Family Justice System in two key, and intertwined, ways:*
>
> *(a) Assessments undertaken before, during and after proceedings, or as part of dispute resolution; and*
>
> *(b) Barriers to participation in proceedings, which in turn restricts access to justice and to a fair trial.*
>
> *Failure to recognise and accommodate neurodivergence within the Family Justice System leads to parties, witnesses and children not being able to fully participate in proceedings and dispute resolution, potentially compromising their Article 6 and Article 8 of the European Convention of Human Rights (ECHR) and/or Article 12 of the United Nations Convention on Rights of the Child. A lack of recognition and unmet support needs can also lead to distressed behaviour, which can significantly impact proceedings through a lack of understanding and tolerance.*

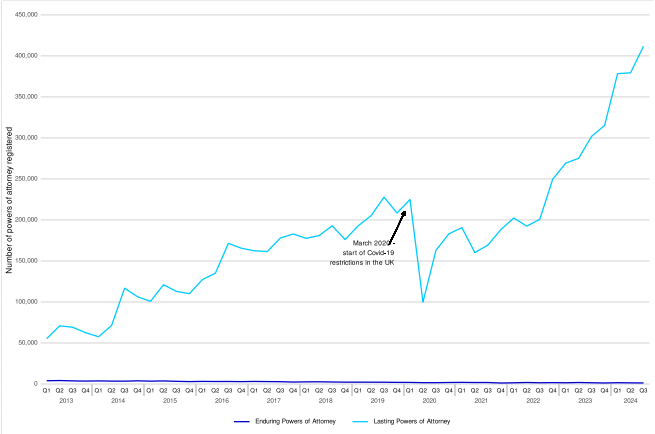
The guidance includes best practice guidance on identifying needs and making adjustments.

Family Court Statistics Quarterly: July to September 2024

The most recent set of statistics published do not include full Court of Protection statistics "*due to a transition to a new system and data platform*," the publication noting that "[t]*hese series will be reinstated as soon as possible*."

However, from July to September 2024, there were 411,880 LPAs registered, the highest in its

series and up 36% compared to the equivalent quarter in 2023:



Inherent Jurisdiction (under 18s)

During this quarter there were 371 applications to the High Court to authorise deprivations of liberty. Almost all of these children were teenagers; 58% aged between 13 and 15 and 31% aged between 16 and 18 years. There were 278 orders issued, of which 129 were a final order.

MENTAL HEALTH MATTERS

Mental Health Bill progresses

The Mental Health Bill continues to make steady progress at Committee stage in the House of Lords. This stage allows peers to scrutinise the detail of a Bill, but traditionally no votes are taken, We refer interested readers to the excellent summaries by Tim Spencer-Lane of the contents of the relevant debates on each day: day one (14 January); day two (20 January); day three (22 January); and day four (27 January) (at least one further day is required, but has not yet been confirmed). Of particular interest to readers wearing capacity hats were the debates on days 1 and 3.

On day 1, the Government made clear that it understands, and accepts, that the removal of learning disability and autism from s.3 MHA 1983 does not rule out the use of DOLS. The potential concerns around this area (and the interface more broadly between the two Acts) also featured heavily in the oral evidence session held by the Joint Committee on Human Rights as part of its scrutiny of the Mental Health Bill on 29 January.

On day 3, the Government made what might seem to be the slightly surprising assertion that the functional test (i.e. the test of the ability to understand, retain, use and weigh relevant information and to communicate a decision) had been ruled out by the courts in relation to those under 16. This would come as considerable news to Cobb J (as he then was): see *Re S (child as parent: adoption: consent)* [2017] EWHC 2729 (Fam). In doing so, he regarded it as "appropriate, and indeed helpful to read across to, and borrow from, the relevant concepts and language of the Mental Capacity Act 2005".[2]

Upper Tribunal cases

Two recent Upper Tribunal cases have made important points about procedure before the Mental Health Tribunal.[3]

IN v St Andrews [2024] UKUT 411 (AAC) concerned a tribunal's decision making around whether to adjourn or to proceed with a hearing from which both the patient and the patient's appointed representative are absent, as well as what the tribunal must say in its reasons to clear the required hurdle of 'adequacy'. UTJ Church gave guidance as to what to do when a patient with a representative appointed under Rule 11(7)(a) of the FTT rules makes a capacious decision not to engage with their representative to provide instructions. He made clear that the patient should not be left unrepresented and the representative should conduct the hearing on the basis that their implicit instructions are to test the legal test for the patient's continued detention. He made clear that, where a patient's liberty is at stake, and where the patient will be neither present nor represented at the hearing, there is a significant risk that the disposal of the proceedings will involve an unlawful interference with the patient's Article 5(4) rights. In such circumstances, if a tribunal is to proceed to dispose of the appeal, UTJ Church made clear that it must explain specifically how and why it concluded that doing so was in the interests of justice. It is not enough to simply state that it decided that it was so.

In *JB v Elysium Healthcare* [2025] UKUT 009 (AAC), UTJ Church considered whether medical treatment which is considered to be appropriate

[2] *Re S (child as parent: adoption: consent)* at paragraph 16. A similar approach was taken by MacDonald J in *An NHS Trust v ST (Refusal of Deprivation of Liberty Order)* [2022] EWHC 719 (Fam).

[3] Both involved Arianna, so she has not been involved in the notes.

for a patient can properly be said to be "available" to him if the hospital in which he is detained has the resources to provide it but is not willing to do so. He reiterated that *"as established both in Rooman v Belgium [2019] ECHR 105 and SF v Avon and Wiltshire [2023] UKUT 205 (AAC), [2024] 1 WLR 1540, appropriate medical treatment cannot be said to be "available" to a patient if the detaining authority is unwilling to provide it*." The Tribunal had been under a misapprehension as to whether or not it was, in fact, available, and the decision had to be remitted to them so that a decision on whether detention should be upheld could be made on the proper factual basis.

Introduction

In light of the ever-increasing (and rightful!) focus on legal capacity issues concerning those under 18, we have decided to introduce a stand-alone section to cover such matters.

Deprivation of liberty and children – the courts

Several developments before the courts merit note here:

1. The Court of Appeal are to hear / have heard (depending upon when you read this) the appeal against the decision of Lieven in *Re J*, in which she held that local authorities could consent to the confinement of children subject to care orders.

2. The Supreme Court held in *The Father v Worcestershire City Council* [2025] UKSC 1 that *habeas corpus* is (save in wholly exceptional cases) to challenge any deprivation of liberty to which a local authority's actions under a care order might give rise. The Supreme Court made clear in its judgment (unusually involving a litigant in person, the appellant father) that it was not seeking to prejudge the outcome of the appeal in *Re J* (see paragraph 35).

3. Another in the Lieven J-inspired line of challenges to *Cheshire West* can be found in *Re V (Profound Disabilities)* [2025] EWHC 200 (Fam), in which HHJ Middleton-Roy identified that:

> *13. People with disabilities have the same human rights as those without disabilities. 'V's profound disabilities place a duty on the State to make reasonable accommodation and cater for his particular needs. The measures put in place by the Local Authority to support 'V', on a proper fact-specific analysis, form part of 'V's care provision. 'V' is undoubtedly under close and constant supervision. However, in this Court's judgement, the measures implemented by the Local Authority are not actions of the State which deprive 'V' of his liberty. They are designed to meet his care needs. There are many aspects of 'V's care which may intrude on his privacy, with specific justification, but they are not, in this Court's judgement, interferences with his important right to liberty and security of person under Article 5 of the European Convention on Human Rights.*
>
> *14. Respectfully, this Court disagrees with the submission that there is any material distinction of the principle in SM[4] this current case. The young person, 'V' who is at the centre of this case, requires support because of his profound disabilities. In practical terms, 'V' cannot leave his care placement of his own volition, due to his enduring disabilities. For 'V', the reason he can't leave his care placement and requires intimate support is because of those disabilities, not by reason of any action of the State. For the same reasons articulated by Lieven J in SM, the facts of this case show that the State is not depriving 'V' of his right to liberty and security of person within the meaning of Article 5 ECHR. 'V's Article 2, 3 and 5 rights are not infringed by the restrictions necessarily implemented by the Local Authority to supervise him, monitor him and provide for his personal care.*

We make the observation that precisely the same arguments as set out here were roundly rejected by the majority of the Supreme Court in *Cheshire West*, and

[4] Ie. the decision of Lieven J in *Re SM* [2024] EWHC 493 (Fam).

endorsed again in *Re D* (which was not referred to by Lieven J in *SM*, nor by HHJ Middleton-Roy in the instant case). It is not obvious, one might think, why the fact that the person in question is 14, as opposed to 44, should make any difference – not least because there is also no reason to think that the care arrangements for them will change as they turn 16.

4. The President of the Family Division has set out public-facing Practice Guidance (January 2025) for cases transitioning from the National DOL List ("NDL") to the Court of Protection. The Practice Guidance is based on the internal guidance used by judiciary and court staff with respect to such cases, which was referred to in the October 2023 NDL national listing protocol guidance. Importantly, the Practice Guidance now published makes clear that in cases involving 16/17 year olds where a decision is taken that further consideration should be undertaken by the Court of Protection, what should happen is not a transfer, but rather fresh proceedings in the Court of Protection, with the original papers in the NDL proceedings being released into those new proceedings.

Deprivation of liberty and children - Parliament

Children's Wellbeing and Schools Bill, which passed its second reading in the House of Commons on 8 January, would amend s.25 Children Act 1989 significantly to expand its scope. The amendment (in clause 10) is not entirely easy to read in isolation, so Alex has prepared an unofficial version of s.25 Children Act 1989 as it would look with the amendments contained in clause 10. The Explanatory Notes to the Bill provide in material part that:

> *6. The Bill seeks to amend section 25 of the Children Act 1989 to provide a statutory framework for the authorisation the deprivation of liberty of children in a different type of accommodation – one that is not a secure children's home ("SCH"), but which is primarily to be used to provide care and treatment for a vulnerable, complex cohort who may need restrictions which deprive them of their liberty (i.e. that the totality of the restrictions means that the person is under continuous supervision and control and not free to leave of their own accord).*
>
> *7. Currently, the only statutory framework for depriving a child of their liberty on welfare grounds (outside other relevant legal frameworks such as in relation to mental health) is via section 25 of the Children Act 1989. This power enables a child to be placed or kept in accommodation provided for the purpose of restricting liberty (a SCH). A core feature of a SCH is that it should be designed for, or has as its primary purpose, prevention of a child from absconding or causing harm to his/herself or others. Other, highly therapeutic accommodation designed for a child would have as its primary purpose the care and/or treatment of the child, as opposed to prevention of absconding or harm, and so cannot currently be used to deprive a child of their liberty via section 25 of the Children Act 1989.*
>
> *18. The effect of this legislative change would be to provide an alternative statutory route to authorise the deprivation of liberty of a child in a more flexible form of accommodation, bringing more deprivation of liberty cases under a statutory framework via s.25 Children Act 1989, with clear criteria for access, mandatory review points and parity with SCH in terms of access to legal aid.*

These amendments have to be read against the current situation, captured most starkly by the Children's Commissioner for England in her recent report. Focusing purely on the wording of the Bill, amongst the matters that the House of Lords will no doubt be considering at Committee stage are:

1. How far the change plugs the current gap that is being met by the High Court under the inherent jurisdiction, given that the test for children in "relevant accommodation" is whether they are likely either to abscond (and suffer significant) harm, or whether, if they are kept in any other description of accommodation they are likely to injure themselves or other persons. Put another way, is "injury" wide enough to capture all the types of harm that are currently being addressed by the High Court's inherent jurisdiction in non-absconding cases?

2. Article 5 ECHR compliance. This is addressed in the human rights memorandum, but two specific, additional, issues that fall for consideration are:

   (a) The need for specificity as to the basis upon which deprivation of liberty is justified in any given case. The European Court of Human Rights is clear that deprivation of liberty can only be justified on one of the exhaustive list of grounds contained in Article 5(1). In the case of a child, this could be Article 5(1)(d) (educational supervision) or Article 5(1)(e) ('unsoundness of mind'). The nature of the evidence required to justified the different limbs is different (in particular, medical evidence being required for the latter, but not the former). It may well be that these are matters which fall to be left to the Family Procedure Rules in due course, but they are a matter which need to be considered by Parliament.

   (b) That Strasbourg has made clear that detention on the basis of Article 5(1)(d) "*must take place in an appropriate facility with the resources to meet the necessary educational objectives and security requirements" (Blokhin v Russia* [2016] ECHR 300). In similar vein, Strasbourg has also made clear that detention on the basis of Article 5(1)(e) must be in an appropriate place, and to be accompanied by appropriate treatment. In *Rooman*, the court also emphasised that the appropriateness of the placement had to be judged by reference to the needs of the individual in question, rather than by the category of accommodation generally. These requirements would apply equally to the High Court considering an application under an amended s.25 CA 1989 as it does in the context of detention under the Mental Health Act 1983.

3. How this regime would interact with the jurisdiction of the Court of Protection to authorise deprivation of liberty for those aged 16 and 17 lacking the relevant decision-making capacity.

The courts, consent and the capacitous young person

O v P [2024] EWCA Civ 1577 (Court of Appeal (Sir Geoffrey Vos, MR, Sir Andrew McFarlane and King LJ)

Other proceedings – Family (public law)

This case concerned a 16 year old who was born female but had started to identify as male at the age of about 12 (we therefore use the male pronoun here). His parents disagreed about the processes that should be followed to address his gender dysphoria – his mother applied to the court for a prohibited steps order and a best interests declaration. At first instance, the mother sought an adjournment for her application for 6 months pending an assessment by a private clinic. The father opposed the adjournment on the basis that the proceedings were causing the young person distress. The court dismissed the proceedings. The mother appealed successfully to the Court of Appeal.

Sir Geoffrey Vos, MR, giving the lead judgment, crisply identified at paragraph 2 that:

> *It is useful at the outset to distinguish between three possible issues with which the courts have to deal. First, there is the issue of whether a child under 16 is **competent** to consent to or to refuse medical treatment (see Gillick v. West Norfolk and Wisbech AHA [1986] AC 122 (Gillick), and more recently, R (Bell) v. Tavistock and Portman NHS Foundation Trust [2021] EWCA Civ 1363, [2022] 1 All ER 416 (Bell v. Tavistock)). Secondly, there is the issue of whether a child (but also an adult) has mental **capacity** to consent to or to refuse medical treatment (see sections 1-6 of the Mental Capacity Act 2005). Thirdly, there is the issue of what is in a child's **best interests**. This issue arises once the presumption as to the **competence** of a child over 16 to consent or refuse medical treatment is engaged (see section 8 of the Family Law Reform Act 1969 (FLRA 1969), which provides that a child over 16 can give consent in the same way as an adult, and no further consent is required from parents or guardians). Despite section 8, the court still retains the right to override consent given or withheld by a child over 16 on welfare or **best interests** grounds in very limited and well-defined circumstances (see Re W (A Minor) (Medical Treatment: Court's Jurisdiction) [1993] Fam 64 (Re W)).*

He went on to hold that:

1. The issue in the proceedings, given that the child was 16 and had capacity to make his own medical treatment decisions, was whether now or in the future the court should override any consent the young person gave to cross-sex hormone treatment.

2. Earlier decisions by the courts in this area, including *Bell v Tavistock*, were made in a different regulatory landscape, before puberty blockers were banned by the government. The judge at first instance did not place enough weight on the rapidly changing regulatory environment or the fact that the assessment by the private clinic was not capable of satisfying the good practice recommendation of the Cass Review as to the need for cases to be discussed by a national multi-disciplinary team.

3. It was entirely possible that there would be a disagreement as to best interests when the assessment was completed, and the judge at first instance had been wrong to suggest that there was no realistic basis on which the court, in the future, might override the young person's consent. Authorities such *as Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64 make clear that the court may override such consent, if that is necessary to protect the young person from grave and irreversible mental or physical harm. That was a question of fact for the court to determine in each case.

Sir Andrew McFarlane, giving a concurring judgment, emphasised at paragraph 46 that:

> *It is important to stress that the court's best interests jurisdiction with respect to consent to medical treatment given by a competent person who is over 16, but under 18, is not a general welfare jurisdiction. As was made plain in Re W (A Minor) (Medical Treatment: Court's Jurisdiction) [1993] Fam 64, the court will only override the consent of a competent young person, who is over 16, where it is necessary for the court to intervene to protect them from 'grave and irreversible mental or physical harm' (Nolan LJ p 94). Each case may turn on its own facts and, whilst the issue of law was not in direct focus in this appeal, I agree with My Lord that the administration of cross-hormone treatment is not in a special legal category in this regard.*

Comment

The issues that arise where a child does not identify with the gender assigned to them at birth continue to exercise the courts, as they do wider society. This case was decided the day after the Court of Appeal allowed the appeal in *C (A Child) (Change of Given Name*) [2024] EWCA Civ 1582, where, amongst the factors leading to the appeal being successful was the fact that the judge at first instance had fallen into the trap of considering it as a 'gender' appeal, as opposed to "*a case involving a change of name in respect of a capacitous young person who is shortly to reach the age of 16 years*."[5]

O v P was, by comparison, squarely, a 'gender' appeal.The exercise of the court's inherent jurisdiction to override the capacitous decision of a young person aged 16 or 17 has largely been confined to cases involving the refusal of life-sustaining treatment,[6] rather than consent to medication prescribed by a clinician. The Court of Appeal confirms in this judgment that the court's jurisdiction is not limited to particular types of treatment decision, and that if there is a substantive best interests dispute against an evolving background of medical and policy guidance in a contested area, the court should not shy away from determining the issue.

The decision is also of use for confirming clearly that, post-16, questions of *Gillick* competence fall away (see paragraph 3). The issue in terms of whether the child is cognitively able to make their own decision is therefore governed by the MCA 2005; but that is not the end of the story given that children's legal capacity is limited – as here – by their age.

Short note: treatment refusal and the older child

Re C [2024] EWHC 3331 (Fam) (decided in the autumn, but making its way onto Bailii more recently) was a judgment arising from an urgent application made to provide life-saving insulin to a 17 year old girl (C), who was considered to have the capacity to make decisions about her medical treatment. She had type 1 diabetes and a history of poor compliance with her diabetes care. By the time the matter came before the court, there was thought to be a risk to C's life if she was not provided with insulin. Indeed, she went into diabetes keto acidosis during the hearing.

Following *NHS Trust v X* [2021] EWHC 65 (Fam), Arbuthnot J held that there is a "*duty on the court to ensure so far as it can that children survive until adulthood*." While she acknowledged that there were risks to C of having the treatment because of the level of restraint, she had "*no doubt*" that it was in C's best interests for her to have the

[5] Paragraph 64. It is perhaps a little odd, given the constitution of the Court of Appeal (including King and Baker LJJ) that it described the child in question as 'capacitous,' rather than 'competent,' given that they were 15.

[6] An example being the C case we cover below.

treatment against her wishes. The application was therefore granted.

Of note, perhaps, is the fact that this was a situation where C's parents were supportive. There was clearly no doubt in the Trust's mind, however, that it was necessary for an application to be brought, rather than seeking to rely upon their consent. This was undoubtedly right, because C's parents could not consent to the confinement required to bring about the treatment, involving extensive physical restraint of C. We would also suggest that, even had such restraint not been in contemplation, the Trust would have been on very thin ice indeed seeking to rely upon parental consent to override the refusal of a capacitous 17 year old. Lady Hale described that proposition in *Cheshire West* as "controversial;" we suggest that it is not merely controversial, but actively improper.

Best interests and clinical circling of the wagons

Birmingham Women's and Children's Hospital NHS Foundation Trust v KB & Ors [2024] EWHC 3292 (Fam) (High Court (Family Division)(Morgan J)

Other proceedings – Family (public law)

Summary[7]

This case concerned a 10 year old girl with a rare genetic condition which had affected her since birth and caused profound disability. She had development delay and was unable to speak or sit independently. She had impaired vision but her hearing was intact. She was fed artificially. Her older brother had the same condition and had died shortly after his first birthday. At the time of the hearing, F had been in intensive care for over a year, following an infection and then the displacement of her nasogastric tube which cause her to aspirate. The treating doctors sought declarations that it was no longer in her best interests to receive ventilation, but instead for her to be extubated and allowed to die. She had previously had a number of PICU admissions, sometimes requiring invasive ventilation. Her parents opposed the application, but the Guardian supported the Trust. Unusually in such cases, there was an alternative option to the child simply remaining in intensive care until she died – her respiratory needs were sufficiently stable for her to have a tracheostomy and to be discharged home on long term ventilation. The court held that it was in F's best interests to receive long term ventilation at home. The burdens to her were from the medical interventions required to keep her alive, such as suctioning, rather than her underlying condition. There were some risks from having a tracheostomy, and F was at the more severe end of patients who were cared for at home on long term ventilation. There would be a period of some months before long term ventilation was established and she could return home. But she was likely to have views about her continued treatment that aligned with her parents, in light of their religious and cultural beliefs, and she had a level of conscious awareness that meant she could feel pain, but she could also benefit from being with her family and enjoying activities such as spending time in the garden with them or on short outings.

Morgan J found that the senior clinicians at the Trust had previously underestimated F's ability to experience pleasure, having regard to the parents' evidence and the notes of other professionals such as play facilitators who had spent time with F and who had reported many examples of her expressing pleasure and

[7] Katie having been involved in the case, she has not contributed to this.

excitement earlier in her admission. At the time of the hearing, Morgan J found that F was able to respond to her family and other people, including by smiling, and was more responsive when they or others spoke to her in her first language, and that she was able to experience pleasure, albeit in a limited way – as had been the case throughout her life due to her disabilities.

Morgan J did not accept that there was clear evidence of significant neurological decline over the period of the admission, noting that there were other possible explanations for a change in F's presentation and a lack of evidence to show there had been marked neurological decline.

Morgan also expressed concern about the transparency of decision-making by the Trust and the failure to keep minutes of MDT meetings at which parents are not present, identifying at paragraph 141 a real risk that:

> *Consciously or otherwise, most likely otherwise, if a professional has arrived already at a conclusion in their own mind that a child's best interests are served by palliative care path to death, there is, as I see it, a real risk that that may affect the lens through which things like awareness and responsiveness are viewed. Assessment of those aspects is more subjective and less susceptible to calibrated measurement than other physiological assessments. There is in my judgment a danger that that risk is magnified when a group of people who have arrived at the same view following discussions reinforce each other. As it happens, there has been a want of transparency as to how decisions have been made and the discussion which has led to them. That is not satisfactory but it is a subtly different point to the anxiety I have, surveying the totality of the evidence that is before me, about how awareness, responsiveness, and benefits have been weighed in the balance by those looking at Fatima's life, who have already reached a decision to invite the Court to declare it lawful for that which sustains it to be withdrawn.*

Comment

It is relatively unusual for there to be two treatment options in respect of an application to withdraw invasive ventilation – often the position is that there is no realistic prospect of the patient leaving intensive care or being discharged from hospital. Morgan J found the decision to be finely balanced, but ultimately decided that the benefits of life to F had been undervalued, not just by the treating doctors but also – notably – by the Guardian.

Morgan J was clear that, although the medical evidence of the burdens of treatment was relevant and important, the wider considerations about the child's quality of life, having regard to emotional and psychological factors, had to be fairly considered, and set in the context of the child's previous life experiences.

THE WIDER CONTEXT

Terminally Ill Adults (End of Life) Bill

The Public Bill Committee convened to consider this Bill held – unusually for Private Member's Bill – oral evidence sessions between 28 and 30 January. Unsurprisingly, given that clause 3 of the Bill simply cross-refers to the MCA 2005, the concept of capacity, its fitness for purpose, and extent of understanding by practitioners of the test, all featured extensively in the oral evidence (including that given by Alex), as well as in the written evidence that has been submitted and started to be published.

One statement by Professor Sir Chris Whitty is likely to have provoked some eyebrows to rise, namely that his "*the Mental Capacity Act clearly makes the point that the more severe the decision, the greater the degree of capacity that has to be assumed before people can actually take that decision.*" With respect, this is not accurate. Before the MCA 2005 came into force, courts had made statements to the effect that the common law contained a 'sliding scale' of capacity.[8] However, the MCA 2005 itself is silent on this, and, indeed, in its work leading to the Act, the Law Commission identified that "[w]*e have some difficulty with the idea that there should be a 'greater capacity' as opposed to an ability to understand more, or more significant, information. We do not consider that more than a 'broad terms' understanding is required*."[9] Cases decided under the MCA 2005 have emphasised in the medical treatment context that what is required "*is a broad, general understanding of the kind that is expected from the population at large* […] *We should not ask more of people whose capacity is questioned than of those whose capacity is undoubted*."[10]

The Supreme Court has confirmed that where there are "serious grave consequences" to a decision, it is particularly important that the person understands (and can retain, use and weigh) that information.[11] But, being pedantic, that it is not saying that there is need for a "greater degree of capacity," but rather a need for people considering capacity to be considering the question with particular care.

The complexity of autonomy is also highlighted – in a different – context in the decision in *TM' v Bonne Terre Ltd* [2025] EWHC 111 (KB), considered by Alex on this post on his website.

Line by line consideration of the Bill starts on 11 February, and it is likely that considerable focus will be placed on clause 3. In the meantime, this resources page may be useful in terms of keeping abreast of developments.

And, in other developments, the Assisted Dying Bill proposed by Alex Allinson MLC passed its final stage before the Legislative Council on the Isle of Man. The Bill will now go back to the House of Keys to consider the amendments made by the Legislative Council and, if they accept them, the Bill will then be sent for Royal Assent.

CCTV and care homes – a helpful perspective from Northern Ireland

MB v The Northern Health and Social Care Trust et al [2024] NIFam 10 (High Court (Rooney J))

Other proceedings – civil

[8] See *Re T* [1992] EWCA All ER 649 at paragraph 28 and *Re MB* [1997] EWCA Civ 3093 at paragraph 30.
[9] Law Commission *Mentally Incapacitated Adults and Decision-Making: Medical Treatment and Research*, Consultation Paper No.129 (HMSO 1993) at paragraph 2.16.
[10] *Heart of England NHS Foundation Trust v JB* [2014] EWCOP 342 at paragraph 26.
[11] See *A Local Authority v JB* [2021] UKSC 52 at paragraph 78.

Summary

This case in Northern Ireland, decided in the summer of 2024, but which recently appeared on Bailii,, concerned an application for an interim declaration that it was in P's best interests for CCTV cameras to be installed in his private apartment of a care home. P lacked capacity to make the decision and had 2:1 support 24/7 to reduce the likelihood of him engaging in behaviours of concern. During the night, staff sat in the lounge outside his bedroom with its "saloon" style doors kept ajar. The issue was whether it was in P's best interests for the CCTV to be switched on in the private areas of his bedroom and bathroom.

P had sustained a number of injuries, including bruising to his chest, arm and legs, of which the staff were unaware of the cause. On one occasion, he sustained significant injuries to his face, nose, neck and eyes which the family was told were self-inflicted. They were horrified and no satisfactory explanation had been provided by the care home. CCTV from the other areas of the apartment showed incidents of distress and significant self-injury during which the carers – only feet away – did nothing to intervene or attempt to distract P. Moreover, staff records of the incidents did not reflect the CCTV footage, exposed substandard and unacceptable care, without any effective attempts of intervention or distraction.

In evaluating P's Article 8 ECHR rights, Rooney J had to balance whether turning on the CCTV in his bathroom and bedroom, to be viewed only if necessary for safeguarding reasons, was a necessary and proportionate interference with his right to respect for privacy in order to protect his health. In *Bank Mellat v HM Treasury (No.2)* [2013] UKSC 39, Lord Reid formulated the test for justification in four questions, which Rooney J addressed on the facts of P's case:

1. "*whether the objective of the measure is sufficiently important to justify the limitation of a protected right*": in this case, the objective was to protect P's health, physical and mental welfare.

2. "*whether the measure is rationally connected to the objective*": the provision of CCTV was plainly rationally connected to that objective.

3. "*whether a less intrusive measure could have been used without unacceptably compromising the achievement of the objective*": this was the critical question in this case. The authorities proposed a number of additional safeguarding measures, namely: (a) an Interim Protection Plan; (b) Trust staff from the Positive Behaviour Support team and the Community Learning Disability team would carry out frequent visits with P; (c) a team would provide oversight of the Protection Plan to ensure support to care staff in the home in relation to safeguarding concerns; (d) there would be enhanced implementation of the Positive Behaviour Support Plan and oversight by the Trust.

4. "*whether, balancing the severity of the measures effects on the rights of the persons to whom it applies against the importance of the objective, to the extent that the measure will contribute to its achievement, the former outweighs the latter*".

Insofar as the third limb of the justification test was concerned, Rooney J held that:

> *57.* […] *it is my decision that an interim declaratory order should not be made at this stage to extend the operation of CCTV coverage to P's bathroom and bedroom. In coming to this decision, I am persuaded that the above-mentioned additional safeguards constitute less intrusive measures*

which should be capable of protecting P and providing him with high quality care, while preserving his private rights within his bedroom and bathroom.

Comment

The use of CCTV is becoming an increasingly prevalent issue in health and social care. This decision, with its use of the 4-part test of necessity and proportionality, provides a useful worked example to help navigate consideration of the necessity and proportionality of proposed Article 8 ECHR interferences where there are legitimate safeguarding concerns. In England, the CQC has published guidance on the use of surveillance in care services, along with seven principles it uses to determine the human rights implications, namely:

1. Safeguarded: Recording equipment has appropriate safeguards (Reg 12 and 13 of HSCA 2014 Regs);
2. Secured: Recording equipment is housed securely and be appropriate to the purpose for which it is used (Reg 15 of HSCA 2014 Regs);
3. Privacy: Privacy and dignity of people is at the heart of any considerations when deploying recording equipment (Reg 10 of HSCA 2014 Regs);
4. Involved: People must be involved in decisions when using recording equipment in private rooms (Reg 9 & 11 of HSCA 2014 Regs: i.e. have appropriate consent and follow the MCA 2005 principles);
5. Lawful: Recording equipment has a specific legal basis for its use and complies with all relevant legislation and codes of practice (Reg 17 of HSCA 2014 Regs: i.e. GDPR, HRA 1998, ICO, SCC);
6. Trained: Staff are trained on the use of the recording equipment (Reg 18 of HSCA 2014 Regs);
7. Transparent: Recording equipment is used in a transparent manner (GDPR article 5 principles).

The Information Commissioner has also published guidance to assist with data protection issues. Given the very stark nature of the interferences with Article 8 rights involved in such cases, we strongly advise that legal advice is sought, and that applications to court are considered wherever there is any doubt as to whether the use of CCTV is justified.

"I got on the bus in one life and woke up in another": Pilot Project

When she was 17, Grace Currie sustained a catastrophic ABI after a road traffic accident and was told by doctors she would never be able to work or live independently, to give or receive emotion or affection, to be left alone, and would be a passive recipient of care for the rest of her life. Ten years later, she graduated from Chester University with a First-Class honours degree in Fine Art, exhibits her work across the UK and lives in her own home with her fiancé and Billy the cat. Grace receives support but is its architect, and was keen to explore the role of art in social work practice.



'Rage'

The UN Convention on the Rights of Persons with Disability considers communication to be a core aspect of accessibility. Article 21 requires States to "*take all appropriate*

measures to ensure that persons with disabilities can exercise the right to freedom of expression and opinion, including the freedom to seek, receive and impart information and ideas on an equal basis with others and through all forms of communication of their choice…". To that end, in this project 52 social work students in focus groups at the Universities of Chester, Keele, Birmingham City and Warwick explored how Grace's experience could affect social care practice. Nearing the end of their degree, many reported that they had received no, or very limited, teaching about acquired brain injuries. Could social care professionals recognise the power of art as a means of expression in their practice? Could they incorporate visual art into their social work practice in assessment and ongoing work with clients?

A video of this 'Work in Progress' project portrays Grace's use of art to express herself, and the embedding of art in the students' study. The full report by Dr Sandra Dowling is available here. The key learning points from the project were:

1. Having an acquired brain injury does not mean that life is over, it is perhaps different, but can still be just as productive, engaged, creative and fulfilling if people are heard and given the support they need to live the life they want.
2. Visual art has the power to communicate emotions, desires, intentions when there is an attentive listener who is open to understanding the meaning behind the image.
3. Methods of communication are diverse. Non-verbal methods are valuable when words are not available or not enough.
4. Social work students would benefit from learning about diverse methods/non-verbal forms of communication during their training.
5. Social workers are open to embracing new approaches to communication in conducting assessments and in interaction with clients.

The MCA and the Sexual Offences Act 2003 – a problematic blurring?

In the context of the (extremely complicated) decision of Martin Spencer J in *Samrai & Ors v Kalia* [2024] EWHC 3143 (KB), concerning allegations of sexual abuse against a guru at a Hindu Temple, he had to consider the proposition that some of the claimants lacked capacity to give consent to sexual relations for purposes of s.74 Sexual Offences Act 2003. The proposition was advanced (at paragraph 297) that:

> *the test to be applied should be that used in cases of sexual offences: "...a person consents if (s)he agrees by choice, and has the freedom and capacity to make that choice" (see s.74 of the Sexual Offences Act 2003). Mr Jones submitted that none of the First to Fourth Claimants either had, or understood themselves to have, a choice and/or the right to refuse the Defendant's demands upon them. Accordingly, they lacked capacity, applying the dictum of Mrs Justice Parker in London Borough of Southwark v KA and Ors [2016] EWHC 661 (Fam): "The ability to understand the concept of and the necessity of one's own consent is fundamental to having capacity: in other words that P knows that she/he has a choice and can refuse." Mr Jones submitted that the Claimants' freedom to consent (or to refuse consent) was "impaired by the grooming, manipulation, control, and subservience that they allege. The Defendant, they would say, engineered each Claimant's dependency upon him, and each*

> *Claimant was required to submit sexually to him for that dependency to be satisfied. And if that's right, any purported or conceptual consent cannot have been genuine." He submitted that this can be the case, and was the case, even though they did not lack mental capacity within the terms of the Mental Capacity Act 2005. In this context, the religious aspect is, he submitted, critical: "If all these Claimants truly believed that to get closer to God they had to obey every command of the Defendant, and that they were led to believe by him that that was a necessary component of getting closer to God and being pure and being spiritual and all the rest of it, then they did not know that they had a choice, they in effect had no choice, and they did not know that they could refuse, they in effect could not."*

At paragraph 311, Martin Spencer J found that:

> *I am unable to accept that, applying the test for consent in s.74 of the Sexual offences Act 2003 (see paragraph 29*[7] *above), Ms Samrai lacked the freedom and capacity to consent. Ms Samrai joined the Temple as an adult in her 20s who had been married and who had a young child. She therefore had some experience of the world and of men, and would have understood that she had a choice whether or not to consent to sexual intercourse. I find that, when Ms Samrai met the Defendant at hotels, as she described, she went voluntarily and knowing that the purpose was for them to have sexual intercourse: she was not an automaton and retained her free will and ability to choose. In this regard, I accept the following comments made by Professor Maden in his report on Ms Samrai:*
>
> > *"From a psychiatric perspective, RS like all the other three Claimants is highly unusual because I have never before encountered adults denying responsibility for so many of their own actions and choices. In the absence of any impairment of the mind or brain required by the Mental Capacity Act 2005 to allow one to overturn the assumption of mental capacity, there is no psychiatric explanation for this behaviour, which was never apparent to any treating clinician. The only non- psychotic psychiatric diagnosis in which denial of responsibility for one's actions is a major feature is dissocial or antisocial personality disorder.*
> >
> > *I have of course encountered cases in which there has been coercion of adults into sexual activity. This would ultimately be a matter for the Court but in my experience it arises only when there is considerable control and restriction of freedom - as the ICD11 definition of cPTSD implies. It is not something that arises from simply asking people to do something while they are living and working at liberty."*

We would make the short observation that, as developed by Alex and his co-author, Allegra Enefer, in this paper, it is not obvious that the test for capacity to consent in the Sexual Offences Act 2003 is the same as that in the MCA 2005, and that it is not obvious that the 'diagnostic' element is, in fact, part of the test at all.

A litigation friend is not a party

Tendring District Council v Secretary of State for Work and Pensions & Anor [2024] EWCA Civ 1509 (Court of Appeal (Nicola Davies LJ, Stuart-Smith LJ, Cobb J))

Other proceedings – civil

This matter concerned an attempt to pursue a claim against a person whose role in proceedings had been as the representative of a

person who lacked capacity to defend himself in an application in the First-Tier Tribunal. It related to the recoverability of an overpayment of Housing Benefit. The people involved were 'AB' and his wife, 'CD.' CD received Housing Benefit on behalf of AB as his DWP appointee; she had also been his MCA deputy for a period of time until the Court of Protection discharged her appointment. AB's litigation capacity and discharge from these proceedings had been considered in a separate Court of Appeal decision ([2024] EWCA Civ 1248).

Tendring District Council appealed a decision of Judge Perez sitting in the Upper Tribunal, Administrative Appeals Chamber ('UT') which overturned in part a determination of the First tier Tribunal ('FTT') that an overpayment of £67,421.79 of Housing Benefit was recoverable from both 'AB' and his wife, 'CD'. In the Upper Tribunal, a decision was taken that the overpayment was recoverable from AB only, and not CD. Tendring Council argued that the payment should be recoverable from CD.

The background to this matter was a fraud investigation into AB's benefits (as Housing Benefit had been collected despite AB and CD jointly owning the relevant property between 2000-2012). The fact of their ownership of the property was not disclosed by AB or CD; AB had initially made the claim, but after AB suffered a stroke in 2007, CD acted on his behalf. The incident resulted in CD's criminal conviction and sentence of imprisonment. Attempts were first made to recover the funds from AB (of approximately £67,000) and no funds have been paid by either AB or CD. Following protracted proceedings, the Upper Tribunal found that AB was liable for the Housing Benefit overpayment but CD was not. In the Upper Tribunal, Judge Perez found:

1. The local authority had not notified CD that the overpayment was recoverable from her personally (with AB's decision notice dating to 2012).
2. CD had never been issued with a decision notice that Housing Benefit was recoverable from her.
3. CD had maintained that she had been litigating in the FTT on behalf of AB, and had not had an opportunity to present her own case.

In the Court of Appeal, the local authority argued that there was a recoverable overpayment from CD arising from relevant regulations, and CD had notification of decisions relating to AB which were sent to her. "*The Benefit Decision Notices should be read as notification to CD in relation to a claim registered in the name of AB, as AB and CD are husband and wife and Tendring had to nominate one claimant*" (paragraph 38(d)).

The Court of Appeal noted at that outset that "*the fundamental difficulty for Tendring is that its documentation, which is the only evidence of its asserted decision to recover overpayment, indicates that the person against whom the claim for overpayment was being made was AB. We also note that before the FTT, the Secretary of State made the point that Tendring had wrongly understood that AB and CD could be jointly and severally liable in respect of an overpayment claim*" (paragraph 49). Housing benefit can be claimed by only one person; here, it was AB who claimed it. While the decision notices were addressed to CD, they were directed at AB, and it was AB who had been overpaid housing benefit. The Court of Appeal agreed with the Upper Tribunal that there had been no decision to recover the overpayment from CD. Subsequent correspondence and statements referring to a joint liability held by AB and CD "*cannot overcome the fact that a single decision was made to recover from the claimant AB. In our judgment, the UT was correct to conclude that narrating a different*

position retroactively […] *cannot change the original decision*" (paragraph 54) Tendring's 'mindset' that it was trying to recover from both AB and CD also fell "*far short of the sound evidential basis required to satisfy the court that there was a specific decision to recover overpayment from CD or any notification of such a decision to her*" (paragraph 55).

The Court of Appeal also considered CD's authority to represent AB's interests in the tribunal and Court of Appeal, where AB lacked capacity to conduct proceedings as a result of his stroke. The judgment summarised the position:

> *59. It appears that neither the FTT nor the UT formally ruled on AB's litigation capacity, and/or on his need for a representative or litigation friend, in order for him properly to participate in the proceedings before the tribunals. The issue of litigation capacity was not as far as we know even investigated; in any case where there is reason to suspect a lack of capacity an investigation would and should generally be the practice…Within this litigation, before the FTT and/or the UT, CD was never formally appointed as AB's Litigation Friend.*
>
> *60. The Deputyship status which CD had acquired by orders of the Court of Protection in January 2008 and in March 2014 in relation to AB's property and financial affairs (the latter order in similar terms to the former, but joining the parties' son as an additional Deputy) did not expressly confer on CD any rights to conduct litigation for or on behalf of AB. Expert medical opinion prepared in late-2014 revealed that AB was sufficiently capacitous to grant a Lasting Power of Attorney to CD and the parties' son in relation to his property and financial affairs; such a document was therefore executed in early 2015 and registered with the Office of the Public Guardian in June 2015. The Lasting Power of Attorney did not give CD (as attorney) the power to litigate on AB's behalf…While we have no doubt that CD conscientiously fulfilled her duties as a Deputy and as an Attorney for AB outside of the tribunal system, we do not believe that the duties imposed on her by the court orders or the Lasting Power of Attorney extended to conducting litigation on AB's behalf.*

The Court of Appeal thus considered that it was unclear who had been acting for AB in the previous proceedings were no one had been formally appointed to do so, and AB lacked capacity to conduct proceedings. Noting that the Tribunals were more informal and that '[t]he orders and decisions/reasons which have been made in the FTT and UT in this case reassure us that the judges were acutely aware of the need for AB's interests to be protected, and were alert for any risk that they were not' the lower courts appear to have taken CD as AB's 'representative' "*and acquiesced in the informal arrangements which were long established by the time of the 2022 UT determination against which this appeal is brought*" (paragraph 65). However, CD was never a party to these proceedings in her own right, and it was not sufficient for the local authority and tribunal to have treated CD as a 'de facto party' and 'made clear' that Tendring was pursuing CD specifically to allow recovery. The Court of Appeal found that:

> *75.* […] *Tendring's submissions fail to take properly into account the following points:*
>
> *i) As a non-party, CD did not have the opportunity to avail herself of independent legal representation before the tribunal;*
>
> *ii) As the UT observed (when considering the fleeting appearance of a*

representative for AB by his appointee, CD):

"… being involved, even intimately involved, in another person's appeal does not of itself mean that the person who is not a party must, when instructing a representative for the appellant, be taken to have put every point that the non-party wished to make in defence of the non-party. Giving instructions for someone else is simply not the same as giving them for oneself… indeed, in the present case, instructions given on [AB]'s behalf would necessarily be different from those given on [CD]'s behalf…"; (Emphasis by underlining added);

iii) It is recorded by the UT that CD had informed the UT that AB's wider family were effectively instructing her, and it was "not she who was making decisions on [AB]s' behalf";

iv) CD had a right not to incriminate herself when giving evidence before the tribunal. A representative acting in AB's best interests may however have wanted to ask her questions which may have incriminated her. CD could not realistically fulfil that role;

v) There was at least the potential for a conflict of interest between AB and CD, as to liability for the return of the overpayment, and/or enforcement of any award; this had been flagged by CD at an earlier stage of the process;

and finally, for present purposes, as the UT observed:

vi) "… without [CD] being a party to the appeal, there could not be a binding adverse result on her. The solution was in Tendring's gift; Tendring could have rectified the position by making a decision that the housing benefit overpayment was recoverable from [CD]."

At all times, CD was exercising "'*vicarious' functions on behalf of AB, and was not participating in the litigation in her own right. Put shortly, she was not a party to nor treated as a party to the proceedings*" (paragraph 76). Where the remedy was sought against CD, "*it was incumbent upon Tendring to ensure that it could make good its demand against her*" (paragraph 77). The appeal was dismissed.

Comment

The length of the summary above shows just how complicated things can get if (to be blunt) basic steps are not taken at the outset to work out (a) whether a party has litigation capacity; and (b) if they do not, what to do to make sure that the litigation can proceed properly.

Care home costs

Two recent cases have flagged up the extent to which the system is under strain.

In *The Julie Richardson Ltd & Anor v Oxfordshire County Council* [2024] EWHC 3233 (KB), two care homes, the Julie Richardson Limited and Banbury Heights, brought claims against Oxfordshire County Council ('the local authority') for unpaid care home fees for two individuals, on the basis that the local authority was legally obligated to pay these fees pursuant to the Care Act 2014. The local authority made a strike-out and summary judgment application on the basis that the individuals had respectively:

1. In the case of JS, been financially assessed and found to be a self-funder; and
2. In the case of MH, family members had refused financial assessment by refusing to provide required financial information, and

OCC were thus entitled to treat MH as a self-funder.

The claims had originally been brought in the District Registry 2021, and had a lengthy procedural history, which eventually led them to a one-day substantive hearing of the strike-out application in the KBD in November 2024.

The care homes alleged that they had an 'underlying contract' with the local authority, and had cared residents previously placed with them by the local authority. The claims related to two individuals, MH and JS.

1. MH was placed in Banbury Heights by the local authority in 2015; it was agreed she required a care home placement. The local authority paid for her care and support for approximately 7 months, after which time she was treated as a self-funder. Her brother arranged for the payment of her care home fees for approximately two years, after which time he stated that her funds were exhausted. The care home continued to care her pending a financial reassessment by the local authority.

2. JS was placed in Banbury Heights by NHS intermediate care in 2018, but with her care funded by the local authority for the first 12 weeks (due to the 12-week property disregard). She was then assessed as being a full self-funder. In 2020, her family paid £50,000 in what would likely have been a debt owed to the care home for her care, and her family asserted that she was again financially eligible for support under the Care Act 2014. The local authority undertook a financial assessment, and agreed to backdate payments for JS's care to the date after the £50,000 payment. However, this left a period of approximately 9 months' worth of care for which time the care home had not been paid.

The care home argued that the local authority was liable to pay for the care which had not been paid for privately. It was common ground that both JS and MH had eligible needs under the Care Act 2014, and required care and support to meet those needs. It was argued that the local authority had a duty to conduct financial assessments, and a duty to meet needs from the time that the person met the financial threshold. It was argued that the local authority had been unjustly enriched at the expense of the care home for the unpaid periods.

The strike-out application proceeded on the basis that there was no 'underlying contract' between the local authority and care homes, but instead were numerous specific funding agreements in respect of particular individuals. The local authority argued that "[t]*he idea of a statutory obligation arises from mistakenly assuming that because the Defendant has obligations to individuals under the Care Act 2014 it therefore also has obligations to the homes that accommodate them. The Care Act creates no funding obligations*" (paragraph 29). The local authority also argued that "*the private provider bears the risk of the private funding running out and that the exclusivity principle as set out in O'Reilly & Ors v Mackman & Ors [1983] 2 AC 237 means that the proceedings brought against Oxfordshire CC (whether in the original form of the Particulars of Claim or in the amended form) are abusive because any claim ought to have been brought in judicial review proceedings*" (paragraph 37).

HHJ Walden-Smith, sitting as a High Court Judge, concluded that the local authority had a statutory duty to assess whether JS and MH had needs for care and support, what those needs were, and to meet eligible needs under s.13 Care Act and the Eligibility Regulations. HHJ Walden-Smith found that for the periods for which the care home sought repayment, neither MH or JS

'had funds,' and that there was thus a s.18 Care Act obligation to meet needs. The needs were being met by the care home, and there was a shortfall in payment between what was being provided by the local authority and what was being provided by family.

HHJ Walden-Smith found that there was no obligation to use judicial review, and noted the Court of Appeal decision in *Richards v Worcestershire CC, South Worcestershire Clinical Commissioning Groups* [2017] EWCA Civ 1998 where Jackson LJ, giving the judgment of the court, refused to allow an appeal against the decision of Newey J. (as he then was) refusing to strike out a private law claim in similar circumstances to this case. HHJ Walden-Smith also noted the authority of *Surrey County Council v NHS Lincolnshire Clinical Commissioning Group* [2020] EWCA Civ. 3550, Surrey County Council successfully brought a private law claim in restitution against the Defendant, NHS Lincolnshire Clinical Commissioning, to recover sums paid by the Council for the costs of accommodation and care of JD, a young man with autism spectrum disorder.

HHJ Walden-Smith found that '"*Oxfordshire CC have been enriched to the extent to which the Julie Richardson and Banbury Heights have provided care and accommodation for Mrs Hayward and Mrs Smith, to whom Oxfordshire CC owed statutory duties*" (paragraph 44). She concluded that

> *45. This determination is based upon fundamental equitable principles which robustly protect the rights of those who fill in the gap that was created by Oxfordshire CC not fulfilling their statutory duty. The factor making the enrichment of Oxfordshire CC unjust is rooted in public law. The right to restitution and the obligation to make restitution are part of the private law of obligations. Just as there is no requirement that the time limit for judicial review applies to the tort of misfeasance in public office, so also it should not apply to claims seeking restitution against public bodies.*

HHJ Walden-Smith concluded that it was "strongly arguable that Oxfordshire CC have been unjustly enriched by reason of the Julie Richardson and Banbury Heights fulfilling the statutory duties of Oxfordshire CC" (paragraph 46). She dismissed the summary judgment and strike-out applications.

This matter came before the court as a summary judgment and strike-out application, and the summary of the Care Act is relatively high-level. However, we would consider that there is likely more nuance than appears to have been recognised in the judgment as to whether MH and JS were eligible under s.18 Care Act (particularly JS); several of the relevant points interact with the capacity of the person to make their own care arrangements, or engage in a financial assessment. In this regard, we note that:

1. S.18 Care Act sets out a number of criteria to trigger the duty to meet needs for care and support. A person must have eligible needs, be ordinarily resident (or present but of no settled residence) and either there is no charge for meeting needs, or insofar as there is a charge, one of three conditions are met. It is important to note that charges can be made on income or capital. While the judgment appears to assert that there was no charge for meeting needs, it would appear unlikely that pensioners living in care homes would not have had to pay the vast majority of any pension income towards their care, as well as a tariff income. S.18 would thus only be triggered if one of the three conditions were met:

a. Condition 1 is that 'the local authority is satisfied on the basis of the financial assessment it carried out that the adult's financial resources are at or below the financial limit.' The financial limit is defined in the Care and Support (Charging and Assessment of Resources) Regulations 2014 as £23,250, which has not been adjusted since the implementation of the Care Act nearly a decade ago.

b. Condition 2 is that the local authority has financially assessed and concluded the person is above the financial limit, but the adult nonetheless asks the authority to meet the adult's needs. As set out below, this only applies for self-funders in the community, not in care homes.

c. Condition 3 is that 'the adult lacks capacity to arrange for the provision of care and support, but there is no person authorised to do so under the Mental Capacity Act 2005 or otherwise in a position to do so on the adult's behalf.'

2. There is a general exception to s.18 eligibility for self-funders living in care homes in s.3 of The Care Act 2014 (Commencement No. 4) Order 2015 (UKSI 2015/993). It states that:

> *3. 1st April 2015 is the day appointed for the coming into force of section 18(1)(a) and (c), (2), (3), (4), (6) and (7) of the Act (duty to meet needs for care and support) except insofar as it imposes any duty on a local authority to meet an adult's needs for care and support by the provision of accommodation in a care home in a case where Condition 2 in section 18(3) is met.*

3. If the individuals in this case had individuals either authorised under the MCA or 'otherwise in a position' to make arrangements for their care and support, there was no s.18 Care Act duty to these individuals for so long as they were self-funders.

4. It does not appear to us that prior to the period that the £50,000 payment was made in JS's case, she actually ceased to be a self-funder. She plainly had £50,000 in assets, and there is no provision in the Care Act charging regulations to 'net out' unsecured debts against assets for the purposes of determining financial eligibility. However, if no one was making arrangements for her care and support (by failing to pay bills or secure her care), it is possible that a s.18 Care Act obligation might have risen by this route. It is, however, difficult to see any real fault on the part of the local authority if neither the family nor the care home was alerting the local authority to this situation.

5. It is also not clear what consideration had been given to the local authority's argument that it had no obligation to fund care where there had been a refusal of assessment, which would appear to us to have been a relevant consideration as to whether a s.18 obligation actually arose. Under Regulation 10 of the Charging Regulations, a refusal of financial assessment by the adult can be a lawful basis for the local authority to treat the person as being above the financial limit (and thus falling outside of Condition 1 of s.18 Care Act):

> *10.—(1) A local authority is to be treated as having carried out a financial assessment in an adult's case and being satisfied on that basis that the adult's financial resources exceed the financial limit where—*
>
> *(a)the adult has refused a financial assessment; or*
>
> *(b)the authority has been unable to carry out a full financial assessment because of the adult's refusal to co-operate with the assessment and the local authority nevertheless decides to meet some or all of the adult's needs for care and support, or for support.*

6. However, the local authority must always be alive to the capacity of person to engage in financial assessment, and it is very difficult to see that a refusal to engage by family members with no MCA authority to act on behalf of the person could be treated as the person refusing assessment.

In *(SARCP) v Stoke-on-Trent City Council* [2025] EWHC 18 (Admin), an association of care home providers brought a challenge to a decision by the local authority to set a below-inflation uplift in care home fees. The local authority had a contract with providers dating to 2021 that set out a mechanism for annual adjustment of standard rates, which was to take place following consultation with the providers (which had a minimum uplift of 1.4%). The Council initially wanted to have no uplift; however, when it was pointed out that this was contrary to the contract, the Council agreed to made an uplift of 1.4% (following a year in which the CPI rose by 2.3%). The care home providers suggested that due to the effects of inflation and other factors in the costs of care, a 9% increase should be made. The judgment included the context that the local authority's budget had shrunk almost 30% in real terms from the 2010-11 fiscal year to the 2023-24 fiscal year, and its support from central government had fallen from 42% of its budget to 10% of its budget (without any corresponding increase in its Council Tax, as it is a relatively poor area). Adult social care had been relatively protected in budget cuts; the judgment states at paragraph 21 that "*the Defendant is being squeezed by growing demand with which its budget cannot grow to keep up*." Most care homes in the area (including the vast majority of those caring for residents placed by the local authority) signed an agreement accepting the rates.

An application for judicial review was brought on primarily the basis of inadequate consultation, failure to consider material considerations and failure to follow statutory guidance.

HHJ Tindal, sitting as a High Court Judge, found that pre-Care Act case law on care home rate-setting continued to be relevant, and particularly noted that "*the authority is also entitled to take into account its own resources, provided its fees do not set an 'arbitrary ceiling', especially if that ceiling undermines the provider's ability to provide the agreed care packages with the agreed quality of care*" (paragraph 42(a)).

After determining preliminary issues regarding the availability of an alternative remedy, the standing of the Claimant to bring the application (with a conclusion that the Claimant did not have standing to bring an Article 8 ECHR challenge on behalf of the residents of the relevant care homes) and whether there was a sufficient public law issue for this claim to appropriately be brought as a matter of public law rather than private law, the HHJ Tindal considered the standard of review for a decision of this nature. HHJ Tindal found at paragraph 63 that "*it will take a very clear case of irrationality, having made full allowance for that respect, to justify interference*

with an authority's decision on standard fees for care homes…"

Consultation: HHJ Tindal found that while there was no statutory right to consultation, there was a legitimate expectation of consultation created by the local authority's promise to consult, and there was a 'long-established prior practice' of consulting the provider association about contracts and feels which created a legitimate expectation it would again be consulted. The consultation had also been promised as being on *Gunning* principles, while proposals were still at a formative stage. HHJ Tindal found that the local authority had failed to conscientiously consider the evidence gathered in the consultation, breaching the fourth *Gunning* principle. "*I have no statement from the decision-maker to explain what they knew (and Mr Tomlin's knowledge or reasoning cannot be attributed to them: NAHS - even if they were less senior than him as it appears), or how they 'conscientiously considered the consultation', even if that had been admissible to amplify their reasoning*" (paragraph 73). HHJ Tindal did not reach a decision as to whether to quash the consultation and order it re-run in light of its findings on the other grounds.

Failure to follow guidance and/or consider relevant statutory factors: After confirming that it may be open to a local authority to depart from statutory guidance if there are 'good reasons' for doing so, HHJ Tindal noted that it was not suggested by the local authority that there were such reasons in this case. The Claimant relied on the following points in Annex A of the Care and Support Statutory Guidance:

> […] *…4) Local authorities should also be mindful of their duties under Section 1 of the Care Act 2014 to promote individual wellbeing'…*
>
> *11) In all cases the local authority must have regard to the actual cost of good quality care in deciding the personal budget to ensure that the amount is one that reflects local market conditions… In addition, the local authority should not set arbitrary amounts or ceilings for particular types of accommodation that do not reflect a fair cost of care. Guidance on market shaping and commissioning is set out in Chapter 4..*
> *34) Arrangements will need to be reviewed from time to time, for example in response to …a change in provider costs…….*

It was argued that the local authority failed to have regard to the actual cost of good quality care; and/or set arbitrary amounts or ceilings for particular types of accommodation that do not reflect a fair cost of care, or change in provider costs.

HHJ Tindal agreed. While accepting that these were not the only relevant considerations (and a local authority was free to consider other sources of income for the care homes, and its own resources), he also noted the importance of the s.5 Care Act 'market-shaping' duty, which requires a local authority to have regard to: *"(d) the importance of ensuring the sustainability of the market; and (e) fostering continuous improvement in the quality of services and efficiency and effectiveness with which they are provided*," as well as the new guidance in paragraphs 4.31 and 4.35 CA Guidance Fordham J summarised in *R(CNE)* at paragraph 12:

> *(i) First, there is the importance of local authorities assuring themselves and having 'evidence' that contractual fee levels are appropriate to provide the delivery of agreed care packages with agreed quality of care (para 4.31).*
>
> *(ii) Secondly, there is the importance of local authorities understanding that a reasonable fee level allows for a reasonable rate of return by independent*

providers that is sufficient to allow the overall pool of efficient providers to remain sustainable in the long term (para 4.31). [Lavender J in R(Care England) at [6] called this and s.5(2)(d) CA 'the sustainability factor']

(iii) Thirdly, there is the point that local authorities must not undertake any actions which may threaten the sustainability of the market as a whole - the pool of providers able to deliver services of an appropriate quality - by setting fee levels below an amount which is not sustainable for providers in the long term (para 4.35).

HHJ Tindal made robust findings at paragraph 77 that the local authority's:

[d]*ecision utterly failed to take into account any of this relevant CA Guidance, even leaving aside the Claimant's consultation response discussed under Ground 1. The Decision did not refer to any statutory guidance expressly or impliedly, still less explain how it considered a 1.4% uplift was consistent with it. This is reflected in five quite separate failures to follow guidance, any one of which individually would have vitiated the Decision, but together plainly do so:*

a. Firstly, in setting a fee increase of 1.4%, the Decision did not expressly or implicitly 'have regard to' the actual cost of good quality care' under para.11 Annex A (or what evidence it relied on for that under para.4.31 CA Guidance), if only to explain how that was outweighed by other factors such as over-capacity in the residential care home market or the Defendant's budgetary constraints, as Mr Tomlin's Cabinet reports had done.

b. Secondly, the 1.4% minimum uplift in Clause 1.4% effectively acted as an 'arbitrary ceiling' on the Decision rather than a 'contractual floor', since it reflected inflation of 1.4% three years earlier and lacked justification as to its consistency with having regard to 'the actual cost of good quality care'.

c. Thirdly, the Decision did not just 'take into account' the contractual minimum uplift in Clause 18.3, it appeared to focus exclusively on the contractual dimension of the relevant Decision rather than the duty under s.78 CA to have regard to the statutory guidance. Like the Defendant's argument on 'the public/private law divide', it focussed on the contractual dimension to the exclusion of the statutory and guidance dimension.

d. Fourthly, whilst the Defendant 'did not want to lose any provision from the local market' and mentioned potential packages of support, it failed to acknowledge that a reasonable fee level (as opposed to other mitigating measures) allowed for a reasonable rate of return to allow efficient operators to remain sustainable in the long-term as required by para.4.31, or at least explain why that factor was outweighed by others such as budgetary ones.

e. Fifthly, the Decision implicitly recognised that the sustainability of the market was at risk by acknowledging the risk of loss of provision and by offering support. However, it failed to recognise that the decision to limit fee uplift to 1.4% was the action threatening that sustainability, again if only to explain how it was outweighed by countervailing factors like budget.

> *Therefore, I uphold Ground 4 as the Decision failed to follow the CA Guidance.*

HHJ Tindal made similar findings with respect to the market-shaping duty, which the court found must be a 'relevant consideration' in setting the care home rates. He found the following at paragraph 79:

> [E]*ven if I am wrong on Ground 4, the Decision's lack of 'due regard to the actual cost of care' and 'the need to avoid setting arbitrary cost ceilings' in the sense in paras.5.2.4 and 5.2.7 LAC (2004)20 are implicitly 'statutory factors' to be taken into account under s.5(2)(d) and (e), which the Defendant failed to do. Alternatively, the Decision failed to take into account expressly statutory factors:*
>
> *a. Firstly, the Decision failed to take into account its duty under s.5(1) to promote the efficient and effective operation of a market with a view to ensuring a variety of providers and high-quality services…*
>
> *b. Secondly, whilst the Decision acknowledged the risk of some providers leaving the market and so the impact on market sustainability, it failed to take into account under s.5(2)(d) the importance of ensuring the market remained sustainable, e.g. by setting fees at sustainable level, not just offering other support* […]
>
> *c. Thirdly, the Decision failed to have regard under s.5(2)(e) to the importance of fostering continuous improvement in the quality of care services and indeed the ability of providers to comply with CQC standards and improve quality given the pressures on overheads by low fees* […]
>
> *d. Fourthly, the Decision failed to have regard under s.5(2)(f) to the importance of fostering a workforce able to deliver high-quality care, in particular by failing to have regard to how a 1.4% rise in fees could absorb a 9.8% rise in the National Living Wage when staff costs were typically c.70% of actual costs of care* […]
>
> *e. Finally, the Decision failed to have regard under s.5(4) of the importance of promoting the well-being of care-home residents due to the 'indirect impact' on them of Defendant fees not covering the provider's actual costs of care, either inhibiting providers from meeting all their needs and/or leading them to increase the level of 'top-ups' from residents or their families* […]
>
> *Therefore, insofar as it adds anything to Grounds 1 and 4, I also uphold Ground 2.*

HHJ Tindal additionally found the decision was irrational in light of the lack of any reasoning for the 1.4% uplift.

SCOTLAND

AWI reform: developments from Scottish Government

In the November 2024 Report we explained our understanding of the timetable for the proposed Adults with Incapacity (Scotland) (Amendment) Bill, if it is to be enacted before the Parliament goes into recess ahead of the 2026 elections to the Parliament. In the December Report we explained our concerns that despite the extraordinarily tight timetable, there had by then been no further developments. However, it now seems that a slightly more relaxed timetable is possible. The latest from Scottish Government is that: "A Bill to update and modernise the Adults with Incapacity Act is expected to be introduced during the 2024-25 parliamentary year". It is a reasonable guess that introduction may take place right at the end of that year, which does have the advantage of giving time for that work on drafting the Bill to continue until then. That work includes an analysis of the responses to the Government's consultation which ended in October 2024. That analysis has now been published, and is the subject of Jill's article below. Beyond that, Scottish Government states that it is still unable to confirm specific timings or Bill content, noting that these will be "subject to Parliamentary privilege in the first instance". Scottish Government has however commenced a series of meetings "with the main stakeholders in this area to discuss progress".

Previously in "an update on mental health law reform" issued on 18th December 2024, Scottish Government referred to the "key priority work to consider various aspects of the definition of 'mental disorder' as it relates to compulsory care and treatment". Work on that commenced in November 2023. Scottish Government has confirmed that it is working to analyse the evidence gathered, with a view to "potentially consulting on initial reforms in 2025". Other topics on which consultation is likely cover "named persons, advance statements and data gathering". All of these issues are relevant to adults with incapacity legislation. In particular, "mental disorder" is the gateway to AWI provisions and procedures. It has not been explained how this work at a rather more relaxed pace with a focus on mental health legislation is to be coordinated with immediately necessary AWI reform.

Finally, our December Report included an item on the career of Kirsty McGrath with Scottish Government, following her leaving the post of Head of Unit, Mental Health and Incapacity Law, on 20th November 2024. Amy Stuart has now been appointed to that post, with her formidable task including carrying forward the various areas of reform outlined above.

Adrian D Ward

Adults with Incapacity Amendment Act Summary and Analysis of Response to Consultation

The Scottish Government has published a Summary and Analysis of responses to its recent consultation on proposed amendments to the Adults with Incapacity (Scotland) Act 2000 (AWIA). As the document contains full and clear information on the consultation questions, responses and analysis there is little point repeating them here and readers are therefore referred to the Summary and Analysis for such detail. However, some broad, but certainly non-exhaustive observations, can be provided.

1. *AWIA principles*

There was general support for updating the AWIA principles to require that all practical steps are taken to ascertain and follow the person's will

and preferences before any action is taken under the Act. However, there still needs to be agreement on areas such as what exactly constitutes 'all practical steps' and when it would be 'impossible in reality' to give effect to the adult's will and preferences. More work is also required in terms ascertaining the efficacy and effectiveness of various forms of supported decision-making to ensure that an adult's rights, will and preferences are given effect on an equal basis with others, although it is clear that independent advocacy was very much promoted in many of the consultation responses as a means of support. One of the Scottish Government's priorities in its Delivery Plan October 2023- April 2025 accompanying its Programme of Reform on Mental Health and Capacity Law is 'Supporting decision-making and strengthening access to Independent Advocacy'. To this end it will review existing practices and then decide whether a national framework or approach is required. We await more information on progress here.

Interestingly, the number of responses supporting these updated principles to ascertain and follow a person's will and preferences taking precedence over other AWIA principles only slightly exceeded those indicating that this should not be the case. It seems that the main concern for this latter group of respondents was that giving priority to an adult's will and preferences might sometimes be in conflict with keeping them safe from harm and emergency situations. However, these situations and giving priority to an adult's rights, will and preferences are not antithetical. As was discussed in the Scottish Mental Health Law Review final report, the objective of effective supported decision-making (which includes advance planning) is to cement the exercise of legal capacity across capacity/incapacity assessments by ensuring that in the vast majority of cases a person's rights, will and preferences are respected even where at the material time the person is unable or unwilling to communicate these and others must step in and make decision and act on their behalf.

2. *Adjusting and revising time limits, reports and forms to increase efficiency, including less delays*

The proposals to change existing timescales and deadlines for actions taken under the AWIA, and to simplify forms were generally well received by respondents. However, this was with the proviso that measures to remove unnecessary bureaucracy (which of course is to be lauded!), improve efficiency and reduce delays were not at the expense of an adult's rights and freedoms. Proportionality is required and sometimes detail and time is required to ensure our rights are properly protected. This observation is made here in its more general context but is particularly relevant to the proposed changes around guardianship.

3. *Changes regarding Attorneys and Public Guardian supervisory and other powers*

The proposed changes regarding attorneys in terms of powers and granting and certifying capacity were largely agreed by respondents. The proposed extended Public Guardian supervisory and other powers in relation to attorneys were also agreed.

However, whilst there was overall support for clinical psychologists being able to assess and certify capacity for the purposes of powers of attorney, respondents were evenly split on whether paralegals should be able to undertake such assessments, and there was a range of views about others who might also perform this task.

4. *Access to funds and management of residents' finances*

The proposed changes were essentially to tidy up and rationalise the operation of these measures under the AWIA and were largely agreed by respondents.

5. *Authority to medically treat*

The proposals about the authorisation and removal of adults to hospital for physical illness treatment or diagnostic tests were largely agreed by respondents. The same went for the proposals regarding assistance with appealing against such a move, against treatment and restriction measures once at hospital and support for such appeals, with independent advocacy support strongly featuring in the responses.

Similarly, the proposals for preventing an adult from leaving hospital (including certification by a second medical practitioner) and time limits on an adult's stay in hospital (to end once treatment has ended, as well as clinician reviews every 28 days of the necessity to continue to stay with sheriff court approval being required after 3 months for any continued stay).

It was also largely agreed that whilst an appeal against treatment made to the Court of Session is pending clinicians can treat the adult where it is necessary to alleviate serious suffering. However, a number of respondents were naturally concerned about, and asked for, clarity around what is meant by 'serious suffering'.

6. *Guardianship*

It is not entirely clear whether or not respondents were comfortable with the proposal that there be a single medical report to support guardianship applications and concerns were expressed about the efficacy of this. However, as with the granting of powers of attorney, there was also general support for assessment of capacity to be undertaken by clinical psychologists here.

Again, whilst there seemed to be general support for Mental Health Officer (MHO) reports in relation to guardianship applications to be made more concise, and for sheriffs to be afforded the same level of discretion to late MHO reports (currently required within 30 days) as they are in the case of late medical reports, issues of expediency over the adult's rights and freedoms were expressed.

7. *Safeguarders and curators*

Most respondents were in favour of the introduction of statutorily required training for and regulation of safeguarders and curators.

8. *Authority for research*

There was general approval of the proposals to better facilitate research involving adults with incapacity. However, issues such as respecting the will and preferences of adults even where assessed as lacking capacity and weighing up equality and discrimination when including or excluding adults with incapacity from opportunities to participate in research must be considered.

9. *Deprivation of liberty*

Finally, we come to the long unplugged *Bournewood/Cheshire West* gap. There was some support for the proposals, including power of attorney power to consent to a deprivation of liberty on behalf of the adult. However, it is clear that more information on how these will be presented and operate is required before a value judgement on their ECHR and CRPD compliance can be made.

The consultation also asked respondents about (a) issues and experience relating to adults with incapacity being supported in hospital, despite being deemed to be no longer in need of hospital care and treatment; (b) difficulties or challenges with using care setting for those no longer

determined as requiring acute hospital care and treatment; and (c) moving patients from an NHS acute settings to a community based care settings. It is hoped that the responses to this will have alerted the Scottish Government to the fact that the deprivation of liberty issue, or finding ways around its ECHR challenges, is not confined to simply remedying hospital bed-blocking problems.

Conclusion: nuances not numbers please!

We now await the Bill with the amending legislation to be introduced into the Scottish Parliament. It will be interesting to see what the Bill actually contains and how it reflects and addresses the consultation responses, and adopts the human rights lens recommended by the Scottish Mental Health Law Review in its final report. Moreover, a certain amount of terminology remains to be clarified.

Many are acutely aware that amendment to improve the operation and rights protections of the AWIA is long overdue, and some of the proposals will definitely take us closer to this. That being said, we hope that due attention will be given to the detailed observations and comments made in the consultation responses and not simply reliance on numbers or resourcing concerns. Additionally, if the Scottish Government are serious about giving effect to not only ECHR but also rights such as those in the UN Convention on the Rights of Persons with Disabilities then, in terms of future-proofing, it would be worth its while to frame AWIA amendments at this stage with this in mind.

The extent to which the AWIA, and any amendment of it, both meets the adult's needs and respects all their human rights is certainly reinforced by legislation but, of course, it is only part of the answer. Accompanying systemic change that ensures that individual's needs are seen and assessed in the context of the entirety of that person's life and gives priority to their will and preferences in practice is also required.

Adequate resourcing is required as well, and the Summary and Analysis makes references throughout about concerns raised by respondents about resourcing of the changes intended to be brought about by the proposals. However, rather than seeking to justify limited, or no, action to achieve the objectives of the proposed AWIA amendments it is suggested that we remember that a lack of resources is not an excuse for human rights violations, that the Scottish Government has a clear not to violate international human rights and that where progressive realisation of rights is permitted there must be a clear pathway towards this. Moreover, there may be relatively low cost or resource neutral options available, including rethinking how and where services and support are provided. It might also be argued that the unremedied deficiencies in existing provision create enormous pressures on the time of practitioners, the most valuable of resources, which is at a substantial cost to the public purse and thus the Scottish Government cannot in fact afford to not make necessary changes and improvements.

Jill Stavert

OPG new management system for powers of attorney

In March 2021 Scottish Government launched its "Digital Programme" with the vision of "a modern public sector, open to collaboration and transformation", with aims including "making it easier for people and projects to access shared, high-quality digital solutions designed around the people who use them". This was a particularly welcome initiative for the Office of the Public Guardian (OPG). Over recent years it has become increasingly evident that the demands of OPG's workload were outstripping

the capabilities of existing systems, with resulting increasing pressures on staff and management, and increasing turnround times.

It is against that background that OPG's digitalisation programme received significant funding, and preparatory work began mid-2021. Active development commenced in October 2023. The work has been organised into two successive workstreams, in relation to each of the principal registration functions of OPG. Powers of attorney formed the first workstream. Guardianship orders, intervention orders and the Access to Funds scheme will together form the second workstream, with development due to commence in March 2025.

The replacement system for powers of attorney went live on Tuesday 28th January 2025, following two years of design, planning, implementation, and testing. For OPG internally, staff will at last find themselves working with an innovative, effective and fit-for-purpose system, upon which they will be receiving ongoing mandatory training, enabling them to work with greater efficiency, progressively reducing current backlogs and delays. For practitioners and other users of POA registration services, the overall longer-term experience will be of improved effectiveness and efficiency. Actual permanent changes so far as applicants are concerned will be minimal. The main transitional work was done on 24th – 27th January, when the old case management system was unavailable, ahead of the new system coming into effect on 28th January. Beyond that, some system enhancements will be delivered through to the end of March 2025, after which further improving efficiencies will be effected, and any temporary workarounds in use during the transition period will be removed.

The permanent changes are these. Upon submission of a registration application, a written acknowledgement will be issued by OPG allocating a reference number which will apply whether the POA is accepted for registration or rejected. In the case of rejected applications, that reference will be maintained for six months. Any re-submitted application after that will receive a fresh reference. The individual reference will consist simply of a number. The number will be preceded by "PG" and followed, in the case of powers of attorney, with "POA". It is understood that a similar pattern will be followed during the second workstream: "PG" followed by a number, followed by letters indicating the type of measure.

The short-term transitional arrangements involve a "workaround", mainly of internal operational concern. However, applicants who have submitted a power of attorney using OPG's electronic power of attorney registration facility (EPOAR), which does not meet registration criteria, will receive both an initial email, individually drafted by staff, then after an interval a second email. The first email will set out the reasons for rejection, and will explain what to do next. The second email will be automatically generated and will (again) advise that the application has been rejected. Work to stop issue of that second email could only commence once the new system was in operation. It is anticipated that the adjustments needed to stop automatic issue of the second email will be completed by the end of March.

The Public Guardian and her staff, following efforts to maintain a service during Covid, are to be congratulated for bringing their modernisation programme this far; to be followed by the ensuing workstream "throughout 2025 and 2026". Fiona Brown, Public Guardian, has continued the policy of her predecessor of always being willing to provide clarification and assistance towards drafting of relevant items for the Report, and we are particularly grateful that she has done so for the purposes of this item

despite the enhancement of her personal workload around the introduction of the new system.

Adrian D Ward

Mental health moratorium: worrying inadequacies in understanding and drafting

Concerns are raised by the history and terms of the Bankruptcy and Diligence (Scotland) Act 2024 ("the 2024 Act") for a moratorium on debt recovery action against "debtors who have a mental illness", and the proposed Debt Recovery (Mental Health Moratorium) (Scotland) Regulations 2025 ("the proposed Regulations") recently introduced to implement those provisions. The concerns relate to an apparent lack of understanding of even the basics of existing adults with incapacity and mental health legislation, and how they require to be applied in a manner that is compliant with human rights obligations. One can only hope that such deficiencies will not be apparent when the proposed Adults with Incapacity (Scotland) (Amendment) Bill is introduced, and that – whatever might be views about what is contained in the Bill and what is omitted – it will at least be competently drafted.

The purpose of relevant provisions of, and envisaged by, the 2024 Act is laudable. It is to provide a moratorium on enforcement action against debtors in defined circumstances.

The relevant provisions in the 2024 Act are brief. Section 1(1) provides that: "The Scottish Ministers must by Regulations make provision establishing a moratorium on debt recovery action by creditors against individuals who have a mental illness". Sections 1(2) and (3) list the topics that may be addressed in the proposed Regulations. Section 1(4) provides that the proposed Regulations shall be subject to the affirmative procedure. Section 2 contains details of that procedure for this purpose. Section 3 provides for review by Scottish Ministers of the operation of the provisions. The remainder of the 2024 Act is, in general terms, concerned with amendment and updating of the Bankruptcy (Scotland) Act 2016.

There are immediate concerns on discrimination and general human rights grounds, and on the practicalities, raised by the limitation in the 2024 Act to "individuals who have a mental illness". It is not clear that there was any evidence base for that limitation. It is not clear why the moratorium should be available only to people with a mental illness, and not to other people with disabilities who might be equally in need of, and able to benefit from, the proposed moratorium. No case appears to have been made out why it is appropriate to insist that the pressures upon an individual should become intolerable to the point when a diagnosable mental illness develops, rather than that preventative use of the moratorium should be available earlier.

The proposed Regulations would provide that the moratorium should be available if a debtor's circumstances meet both proposed "debt criteria" and proposed "mental health criteria". Those criteria are set out in Regulation 4(2). An individual meets those criteria if a "mental health professional" has confirmed that the individual is subject to a specified range of compulsory measures under the Mental Health (Care and Treatment) (Scotland) Act 2003, or is "voluntarily or otherwise receiving an equivalent crisis, emergency or acute care or treatment in hospital or in the community from a specialist mental health service in relation to a mental illness of a serious nature". "Mental health professional" is defined as meaning a mental health officer, a responsible medical officer, a community mental health nurse, or a mental health professional of equivalent standing and professional qualification. While this limitation might be

appropriate for a patient receiving voluntary treatment, it is unclear why the time of a mental health professional should be subject to the demand to certify a matter of public record – even if one can be found who is able and willing to do so.

It is surprising that neither the proposed Regulations, nor the consultation document accompanying them, mention the Adults with Incapacity (Scotland) Act 2000 ("the 2000 Act"), the Adult Support and Protection (Scotland) Act 2007 ("the 2007 Act"), the European Convention on Human Rights ("ECHR"), or the UN Convention on the Rights of Persons with Disabilities ("CRPD").

There is a flaw in the provisions of the criterion relating to voluntary patients. An individual who is in debt suffers a significant mental health crisis. The crisis may well be triggered, or partly triggered, by enforcement action, or the threat or prospect of it. If the moratorium is to be of any use, it needs to be put in place very rapidly. Simultaneously, the individual may be referred to a "specialist mental health service". In anything other than a quite extreme mental health crisis, the individual will be unlikely to have been moved up the queue for referral to a "mental health professional" practising in a "specialist mental health service" quickly enough for a moratorium to achieve the desired result. Moreover, the term "specialist mental health service" seems intended to exclude mental health services generally, and to be limited to those that are "specialist", though it is unhelpful that the term is not defined, particularly if its use in the Regulations is intended to be wider than ordinary language would indicate. By way of example, the individual may have gone to see (or have been persuaded to go and see) a general practitioner, or may have been picked up by the police and be seen by a duty "police surgeon". This may have resulted in an immediate referral to mental health services, but the urgent need for the moratorium may arise before the individual has actually come under the care of a specialist mental health service. It would seem that, as well as tidying up the language around these provisions, Regulation 4(2)(b) should be extended beyond "receiving" care from a specialist mental health service to having been referred to a specialist mental health service. To be robust, the Regulations would probably require to answer the question: "Referred by whom?", and the answer would need to reflect practical realities.

Regulation 5 proposes that an application for a mental health moratorium may be submitted by a money adviser where:

(a) that individual or, where appropriate, their legal representative has consented to the application being made, and

(b) a mental health professional has confirmed to the money adviser in writing that the individual meets the mental health criteria and the debt criteria.

The proposed definition of "legal representative" is startling. It is given in proposed Regulation 2. It reads:

> *"'Legal representative' means any guardian or power of attorney of the individual appointed or entitled to act for an adult during an adult's incapacity, if the legal representation is recognised by the law of Scotland."*

Giving that role to "any guardian" would be contrary to the 2000 Act in that no guardian would be entitled to act as such except within the powers that have been conferred upon the guardian. Section 64(3) provides that a guardian can act as a person's legal representative "in relation to any matter within the scope of the power conferred by the guardianship order". The

definition in Regulation 2 is plainly incompetent when it provides that: "'legal representative' means any … power of attorney". A power of attorney is a document, not a person, and cannot do anything in the role of attorney. Appointees under an intervention order are not mentioned at all. The lack of any effective inclusion of attorneys, and of any mention at all of appointees under intervention orders, points to likely challenge on grounds of discrimination, the comparator being a guardian with relevant powers. Suitable wording for the definition would be: "Any appointee holding relevant powers under a guardianship order, intervention order or power of attorney". Also, the words after the comma in the definition are incomplete: it is not clear why that provision should not follow the method used in section 1(7) of the 2000 Act, and elsewhere in the 2000 Act.

Poor drafting also creates uncertainty, and the risk of avoidable dispute, by the wording of Regulation 5(2)(f)(i), which requires the consent to the application for a moratorium that should be contained in a signed statement from "the individual or, where appropriate, their legal representative confirming that they understand the effect of a mental health moratorium and consent to the application." Does the word "they" mean the individual, or the legal representative, or both? The legal representative, if properly defined, would not be able to act unless the individual was incapable of acting in the matter. It seems that there need to be two separate provisions here. Firstly, the individual applies on the basis that the individual can competently do so. In that case, is it considered adequate for an individual to self-assess the individual's competence to make the application, including the individual's understanding? It would be contrary to human rights requirements to presume incapacity because of diagnosis of a mental disorder, but it is doubtful whether it would be appropriate to assume capacity in the particular circumstances in which an application for a moratorium should be made. If the legal representative makes the application, then there would need to be at least an assertion, and possibly evidence, that the individual cannot competently do that. Would it really be necessary for the legal representative to demonstrate the representative's understanding, or would that be an unreasonable and potentially unlawful hurdle?

As regards cessation of a moratorium, the present wording of the proposed Regulations could be interpreted to result in a situation that the moratorium could cease upon the current specialist mental health treatment ending, in a situation where it would be predictable that the consequences of ending the moratorium would trigger another mental health crisis, with the individual caught in a "revolving door" of successive moratoriums. Additionally, in this context there appears to be a drafting error in Regulation 15(1) in that the mental health criteria are defined as alternatives, so it would appear that the wording should be that none of the mental health criteria continues to be met.

Adrian D Ward

"Medical condition" and "mental condition"

The term "mental condition" would appear to be limited to a condition that is a "medical condition", in the decision of Lady Poole sitting in the Upper Tribunal in Social Security Scotland v BM, 2024UT58; Ref. UTS/AS/24/0058, also reported at 2024 SLT (Tr) 157. That point does not appear to have been relevant to the outcome, but raises questions as to whether there is a potential for limitation of "mental conditions" to those that are "medical conditions", with possible incorrect interpretations wherever the terms "mental condition", "mental impairment", or similar are interpreted or applied.

Social Security Scotland determined that BM was not entitled to Adult Disability Payment ("ADP"). They held that inter alia BM scored insufficient points for the daily living component of ADP. BM appealed to the First-tier Tribunal, which held that he did score sufficient points for the daily living component. The element that took him above the threshold was the descriptor for ability to make budgeting decisions unaided. Social Security Scotland appealed successfully to the Upper Tribunal on grounds including that point.

The descriptor in relation to budgeting activities is descriptor b in daily living activity 10 in the Disability Assistance for Working Age People (Scotland) Regulations 2022 (SSI 2022/54) ("the ADP Regulations"). Lady Poole held (correctly, it is suggested) that although the descriptors in the ADP Regulations do not explicitly refer to "a physical or mental impairment" or similar, the limitations described in the descriptors must nevertheless be shown to be a consequence of "a physical or mental impairment". Regulations 5 and 6 of the ADP Regulations specify that entitlement only arises if:

> *"the individual's ability to carry out daily living [or mobility] activities is limited [or severely limited] by the individual's physical or mental condition or conditions."*

Section 31 of the Social Security (Scotland) Act 2018 empowers Scottish Ministers to give disability assistance where:

> *"an individual's eligibility in respect of a given period depends on the individual having, during that period, (a) a physical or mental impairment …" (Chapter 1 paragraph 1(1) of schedule 5 to the 2018 Act)*

However, Lady Poole said that:

> *"The ADP Regulations made under the 2018 Act give effect to this provision by restricting eligibility to cases where inability to carry out specified daily living activities results from medical conditions."*

Inadvertently, no doubt, she took us into the disputed territory of whether, for example, autism or a learning disability are "medical conditions". Documents such as Scottish Government's Consultation of 21st December 2023 on the proposed "Learning Disabilities, Autism and Neurodivergence Bill" narrate the strong views in many quarters that such conditions are not "medical" conditions. There appeared to be a consensus that, at the very least, the assessment or diagnosis of any such condition should be "professional" rather than "medical". More broadly, the general debate is likely to continue, but at the level of individual cases there remains a risk of relevant categories, for any particular purposes, being interpreted as excluding people whose condition or impairments are not strictly "medical". That could, for example, result in relation to any definition drawn from the definition of persons with disabilities in the UN Convention on the Rights of Persons with Disabilities ("physical, mental, intellectual or sensory impairments", or any one or more of those elements).

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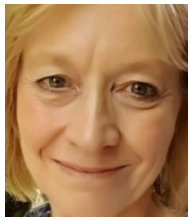
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Conferences

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

Alex also does 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 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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