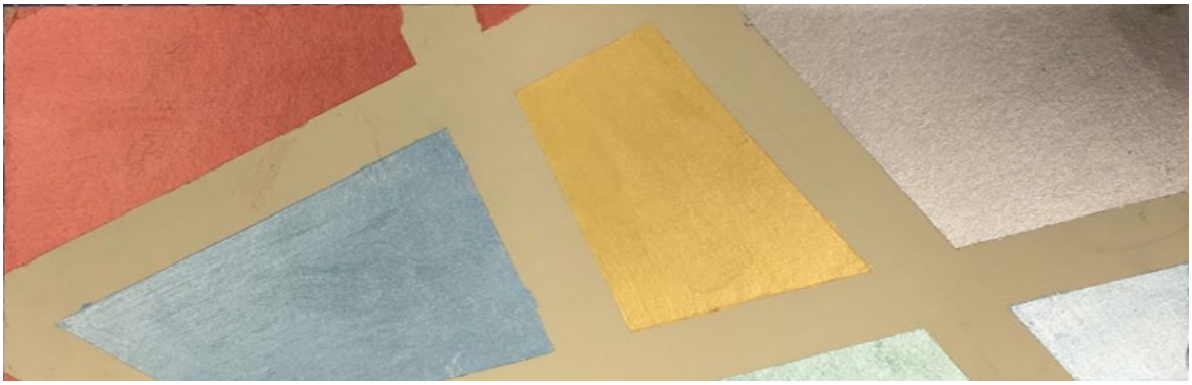

Welcome to the May 2025 Mental Capacity Report. It is our 150th issue, and, to mark this, Tor and Alex have recorded a discussion reflecting on how the report (then the newsletter) came to be back in 2010, and on how the law and practice have evolved since then. The first issue of the newsletter they discuss can be found here.

Highlights:

(1) In the Health, Welfare and Deprivation of Liberty Report: new and updated guidance notes;

(2) In the Practice and Procedure Report: naming clinicians (and other professionals), and cross-border deprivation of liberty;

(3) Section 63 MHA 1983 and diabetes, and the Mental Health Bill progresses to the Commons;

(4) In the Children's Capacity Report: the Court of Appeal explains why local authorities cannot consent to the confinement of children in their care;

(5) In the Wider Context Report: the other party's interest in litigation capacity, how far landlords are supposed to go in hoarding cases, and a new Convention on the rights of older adults on the cards?

(6) In the Scotland Report: AWI reform update and cross-border deprivation of liberty – Scottish reflections what is appealable in the AWI context.

As there were no developments meriting specific reporting in the property and affairs field this month, we do not have a Property and Affairs report.

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

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

Contents

The Court of Appeal explains why local authorities cannot consent to the confinement of children in their care

The Court of Appeal announced on the day of the hearing of the appeal against the decision of Lieven J in *Re J: Local Authority consent to Deprivation of Liberty* [2024] EWHC 1690 (Fam), that it would allow the appeal. On 29 April, it gave its reasons for doing so (*J v Bath and North East Somerset Council & Ors* [2025] EWCA Civ 478.

The President of the Family Division, Sir Andrew McFarlane explained Lieven J's error at paragraph 52:

> *That error, in short, was to focus on whether, as a matter of domestic law, a local authority may provide 'valid consent' in order to avoid engaging limb (ii) of Storck. If, instead, the focus had been, as it should have been, upon the overarching purpose of Art 5, as determined by HL v UK and Cheshire West, the inevitable conclusion would have been that, irrespective of the domestic law relating to parental responsibility, the State can never give valid consent in these circumstances.*

Lady Justice King agreed and made clear (at paragraph 57) that:

> *Put simply, in order to satisfy the requirements of Art 5, there must be an independent check on the State's power to detain. The local authority is an organ of State which, albeit acting in their best interests, is confining the child. The second limb of Storck requires there to be valid consent to that confinement. It is as Ms Roper submitted (see [35] above), inconsistent with Art 5 for that organ of State to 'both create the conditions in which a vulnerable person is confined and then to be able to give valid consent [to that confinement] so as to remove the case from Art 5.'*

Singh LJ agreed with the President, and at paragraph 58 noted that:

> *This case provides a powerful example of the way in which human rights issues can arise in any legal context. The Human Rights Act 1998, and the Convention rights to which it gives effect in domestic law, constitute the overriding legal framework for the determination of such issues, in whatever jurisdiction they arise. It is important that sight should not be lost of that framework, and the values which underlie the fundamental rights which it seeks to protect, whatever the context in which those issues arise.*

Disclosure of information between Coroners and the Family Court

Joint guidance has been published on this by the President of the Family Division and the Chief Coroner and applies to cases:

a) Involving the death of a child or adult where the circumstances of the death may be relevant to, and/or has the potential to inform, the assessment of risk concerning the subject children in family proceedings.

b) Where an applicant seeks to use samples from a deceased person for the purposes of establishing paternity of a child.

The Guidance set out that '[w]*here there are parallel family and coronial proceedings concerning the fatality of a child or adult, this 2025 Protocol provides guidance on good practice for Family Court Judges and Coroners in relation to information-sharing, disclosure requests and the avoidance of delay*.'

Key points from the guidance (which is likely to be useful also by analogy in cases before the Court of Protection):

- Coronial courts may rely on conclusions reached in the Family Court, and there may be good reasons not to re-hear evidence heard in the Family Court at the inquest.
- Coroners and Family Court Judges, sitting within the same region, are encouraged to meet each other on a regular basis (annually) to discuss issues of mutual interest and establish a local cross jurisdictional network' and lines of communication should remain open.
- Where disclosure is provided between the jurisdictions, whether on a formal or informal basis, it is important to consider the position of any parents who are the subject of proceedings under Part IV of the Children Act 1989. Family Court Judges should consider whether it is appropriate to notify the parents of any intended disclosure between the jurisdictions and to give them the opportunity to object.
- Where abuse or neglect of the deceased is suspected [and a time to receipt of a full postmortem report is likely to be several months], the Pathologist should provide an interim written report for child protection purposes setting out any provisional opinions identifying those matters which, in the opinion of the Pathologist, might indicate or give rise to safeguarding issues…Where parallel proceedings are issued in the Family Court, the information provided to the pathologist and the opinions expressed by them in the interim post-mortem examination report are highly likely to be relevant to the determinations to be made by the Family Court.
- When the Coroner is informed that proceedings in the Family Court are commenced or contemplated, the Coroner should seek to accommodate the timetable of the Family Court proceedings (as far as it is known) and the requirement that care proceedings must be completed within 26 weeks of the date on which the application was issued. The Coroner should usually disclose the outcome of all interim investigations, the interim post-mortem examination report and any further information, witness statements and final or interim reports relating to the cause of death to the Family Court within 20 working days of a request for disclosure of this information from the Family Judge.
- Coroners should note that material provided by the Coroner to the Family Judge cannot be provided on a "Judge to Judge" basis. Material provided to the Family Judge will need to be made available by the Family Judge to the parties in the Family Court

proceedings. The Coroner should notify the Police and the relevant Local Authority of any request for disclosure by the Family Court, setting out the information to be disclosed and the date when disclosure will take place. This will enable the Police and/or Crown Prosecution Service to make timely representations to the Family Court if there is any objection to disclosure.

- The Coroner may decide to adopt the findings made in the Family Court, where they are relevant to the questions that the Coroner is required to answer in fulfilling their statutory obligations.
- Even where the Coroner decides not to adopt findings, the Family Court judgment may assist the Coroner in their investigation. Family Courts can criticise agencies and this can be relevant to whether a death may have been preventable.
- As a result of the confidential nature of family proceedings, the Family Judge should notify the Coroner of the existence of the family proceedings.
- When a Family Court Judge makes a Transparency Order or a Reporting Restriction Order in a case where there is a parallel coronial investigation and/or inquest, a copy of the order should be provided to the Coroner. The Coroner should provide these orders to the media, to ensure that the media is aware that these orders exist and can comply with them.

The Guidance sets out proposed procedures and template forms for disclosure between family and coronial proceedings.

Paying the price of failure

Re Holly [2025] EWHC 465 (Fam) (High Court (Family Division) (Keehan J))

Mental capacity – assessing capacity

Summary

These proceedings concerned a young woman, named as 'Holly' in the judgment. She turned 18 in February 2025 (a few weeks before the judgment was handed down). She had been cared for throughout her life by her maternal grandparents (both parties to the proceedings). Her mother had played no role in her life, and her father was deceased.

Keehan J summarised Holly's difficulties as follows:

> *Holly was diagnosed as suffering from a number of conditions, including autism and foetal alcohol syndrome, and found to exhibit a number of challenging and concerning behaviours, principally self-harming and suicidal ideation.*

She had first been the subject of a DOL order in April 2022, having been admitted to hospital some two weeks earlier. Shortly after this care proceedings were issued and her grandparents agreed to her being accommodated pursuant to s.20 of the Children Act 1989. Thereafter a series of DOL orders were made, authorising Holly's deprivation of liberty at an unregulated placement.

As early as July 2022 the court and the parties were in receipt of a report from a jointly instructed psychology expert who recommended that Holly should have treatment by way of DBT, together with a 12 month (minimum) residential placement at a therapeutic establishment.

This recommendation was accepted by all parties. It will come as no surprise to anyone practicing in this field to learn that no such placement was identified for Holly during her

childhood. Instead, she was deprived of her liberty at three unregulated placements under Court authorised DOL orders. Her time in these placements was punctuated with very serious episodes of self-harm (in which she often ended up in hospital) and other challenging behaviour including "*a very serious incident when she climbed over the rails of a bridge over the M20. This necessitated the closure of a section of the motorway and the attendance of the police to remove her from the bridge. She was taken to hospital for assessment and when there she self-harmed*."

The purpose of the judgment was to set out in public, the very sorry chronology of the local authority's efforts to find Holly a suitable placement, and a critique of the local authority's conduct. A few of the more egregious examples include:

- Moving Holly to another unregulated placement (Unit B), without the prior agreement of her grandparents (who head parental responsibility) or the consent of the Court.
- The Director of Integrated Children's Services authorising the cessation of a search for a registered residential placement for Holly as recommended by the expert, on the basis that Holly was happy at Unit B and the placement 'appeared' to be meeting her needs. This was compounded by the fact that the cessation of the search was not revealed to the court and the other parties for a year. As Keehan J noted "*this decision was made without the consent of or without notification to the grandparents who, unlike the local authority, held parental responsibility for Holly and wished for her to be placed in a residential therapeutic placement*."
- On another occasion ceasing the search for a regulated placement on the erroneous basis that the court had approved Holly's placement at Unit B.
- Failing to disclose (for a year), the fact that Ofsted had issued a cease and desist notice in relation to the use of Unit B.

As Holly approached adulthood, she was assessed as having the capacity to make decisions about her residence and care as well as being able to conduct litigation. This caused the Guardian to make the important point *"that the window for effective intervention with [Holly] is rapidly closing. She is fast approaching adulthood, and she remains a high risk to herself. She is not equipped with the tools that she needs to live independently. In light of the assessment of [Holly's] capacity, it is apparent that there is very limited period of time in which the court will be able to seek to ensure that [Holly] receives the sort of care and support that she urgently requires*."

The local authority in their final statement set out the services that could be offered to Holly as an adult. Keehan J expressed the sincere hope that they would indeed be offered to her, as "*she remains an exceptionally vulnerable young person whose unaddressed and complex needs present a grave risk to her safety and wellbeing*."

In his final analysis, Mr Justice Keehan did not hold back:

> *83. I readily acknowledge that there is an acute lack of provision in England and Wales for children and young people who are very vulnerable and have the most complex needs. They require a considerable array of multi agency resources to enable them to be kept safe, to remain stable and to achieve their full potential in their future lives. There is a particularly chronic shortage of therapeutic residential placements which have the expertise to meet the immediate and longer term needs of this cohort of young people.*

84. I also acknowledge the challenges presented to this local authority in attempting to address the needs of Holly in particular her need for a therapeutic residential placement for sustained therapeutic intervention and for appropriate educational provision. On many occasions she failed to engage with and/or refused to accept the offers of services, therapy, education and support offered to her. None of this should have come as a surprise to any professional experienced in dealing with vulnerable young people with complex needs. At other times she appeared superficially to be happy and settled, but behind this outward display of stability lay the emotional struggles and turmoil of an emotionally and psychologically damaged young person. This should never have been accepted as a sign that all was well or that progress has been made by Holly. The history of this case demonstrated that all so very often these periods of apparent stability were followed by episodes of serious self harm or risky and challenging behaviours which were most recently seen in December of last year and in January of this year.

85. In this context I was dismayed that a significant part of the local authority's position statement for this hearing contained such negative and, in my view, wholly unwarranted criticisms of the grandparents and of the guardian. […]

86. [….] *I have a clear sense of this local authority having taken, at best, a reactive rather than proactive response to providing for Holly's needs and supporting her wellbeing.* […]

87. I recognise and accept that various attempts were made to access mental health and educational services for Holly. However, the searches for appropriate residential placements, […] *were wholly inadequate,* […] *The local authority paid lip service to the recommendations of Dr Bentley but never seriously embraced them or pursued them with any vigour.* […]

88. I can only conclude that this demonstrated a complete lack of commitment by this local authority to providing for the needs of this vulnerable and complex young person.

89. I accept that the proper provision of therapeutic residential placement for Holly with access to mental health services and education provision may not have met or addressed all of Holly's needs and she might well have remained a deeply troubled and vulnerable young person. This local authority denied her the opportunity to take advantage of such a specialist placement or of such specialist therapeutic support to give her the best chance of overcoming her difficulties, to a greater or lesser degree, and to achieving her full potential in her childhood.

Comment

This case is another in a long line of cases in which young people with complex needs are cared for in unregulated and inappropriate placements. As the Guardian noted

> *there are far too many young people who fall between the gap in terms of eligibility for CAMHS Tier 4 provision and the limited number of therapeutic residential placements open to be funded through children's services. There are too few resources for the young people who desperately need them.*

What perhaps marks this judgment out, amongst the many, is the clearly identified and multiple failures on the part of the local authority to effectively search for the type of placement the

expert had recommended for Holly (the Guardian noted that in a 72 week period the only active searches undertaken by the local authority took place over a period of 6 weeks and 8 days, something Keenhan J called wholly inadequate) and to consult with her grandparents (called inexcusable by Keehan J).

What also comes across clearly in this case is the fact that as a result of the failure to provide Holly with timely intensive support, Holly was assessed as now meeting the criteria for an Emotionally Unstable Personality Disorder and had become disillusioned with the therapy and so would be resistant to it. While this support is of course resource heavy, the point was made by the expert that Holly is likely to be a long term user of social services and adult mental health services, and the opportunity had probably been lost to give her the chance to build a life worth living.

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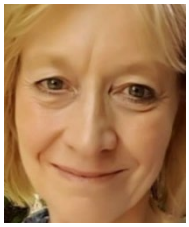

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Conferences

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 May. 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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