HEALTH, WELFARE AND DEPRIVATION OF LIBERTY
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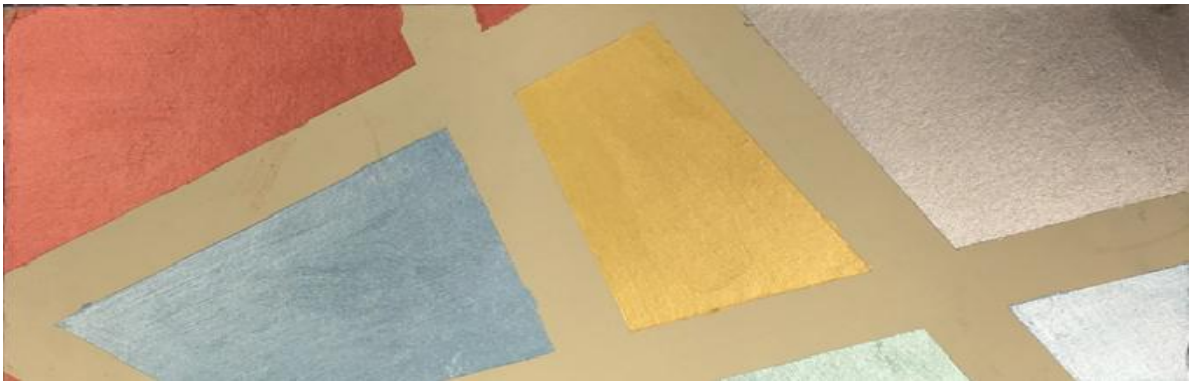

Welcome to the June 2025 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: the court is not a rubber stamp for clinicians and what does it mean to represent P's interests;

(2) In the Property and Affairs Report: Professional Deputy Costs, and paying drug debts for P;

(3) In the Practice and Procedure Report: capacity to conduct proceedings and the costs of inadequate disclosure;

(4) In the Mental Health Matters Report: capacity to conduct Tribunal proceeding, and the independent investigation into the care and treatment of Valdo Calocane;

(5) In the Children's Capacity Report: looking at other options before using the inherent jurisdiction to authorize a deprivation of liberty;

(6) In the Wider Context Report: what happens if you never had litigation capacity and new books;.

(7) In the Scotland Report: AWI reform and the UK Protocol on Judicial Cooperation.

The progress of the Terminally Ill Adults (End of Life) Bill can be followed on Alex's resources page 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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Best interests – Medical Treatment

Summary

In *University College London Hospitals NHS Foundation Trust v PK & Anor* [2025] EWCOP 17 (T3), McKendrick J was asked to decide that continuation of clinically assisted nutrition and hydration ('CANH') through a nasogastric ('NG') tube was not in the best interests of a "much loved family man and devout Muslim." Unlike many of these cases, the 73 year old man, PK, was not in a prolonged disorder of consciousness. He was, however, in a situation following a stroke, exacerbating already existing co-morbidities, where the Trust was concerned as to whether continuing CANH was in his best interests.

The Trust argued that there were greater burdens than benefits to the ongoing treatment, relying on the evidence of both PK's consultant, Dr Turner, and the jointly instructed expert, Dr Hanrahan. The Trust emphasised that PK was nil by mouth and he was experiencing pain every day.

The family's position was very different. As McKendrick J summarised the closing submissions on their behalf:

> *58.* […] *Mr O'Brien submitted the case was never a finely balanced one and this was particularly the case after the conclusion of the oral evidence. He highlighted Dr Christofi's assessment of PK's consciousness* [evidence, from a colleague of Dr Turner, which gave a more positive picture of his consciousness]. *He was critical of the lack of wishes and feelings and religious views in the Trust's written evidence on best interests. He emphasised the fundamental human dignity apparent from PK's interaction with his family. He highlighted the examples from the evidence. He stated part of who PK is as a man continues through his genuine engagement with his family, despite his disability. He submitted the response to Arsenal Football Club* [smiling in response to it being mentioned] *should not be trivialised. He highlighted PK's religion. He highlighted PK's past wishes as evidenced through the family's evidence and in particular AB's evidence about the TV programme* [about assisted dying he watched with his eldest daughter, who said that "he was confused that anyone would want to prematurely end their life, even if in pain or suffering from disability. He turned to his daughter and said: 'only God

> decides when you die.'] *He submitted there was not extensive pain and that any pain was in any event well managed. He submitted there was no evidence PK was affected by the environmental factors on the ward. Lastly he submitted any burdens could 'never' be outweighed by his wishes and beliefs, given the current facts of PK's case.*

The Official Solicitor:

> *59.* […] *largely agreed with Mr O'Brien's case. The Official Solicitor opposes the grant of the declaration on behalf of PK. Ms Powell emphasised that - unlike some cases - PK had never been lost in these proceedings and he was central to every aspect of the case as a man, a husband, a father, a Muslim and a patient. A coda of her submissions was the right to self-determination and that what we wanted for ourselves in such situations has to be highly relevant to the issues the court has to decide. She emphasised the approach of the first instance court in Briggs but noted that unlike the facts of that case, the principles of respecting self-determination were not in conflict with the sanctity of life in these proceedings. She submitted that dying in a manner consistent with his Muslim faith was a very significant benefit for PK. She emphasised that the evidence demonstrates PK continues to be a husband, father, grandfather and Muslim. He has awareness and interacts. She emphasises his past wishes that life be extended and that he receive all treatment. She invited me not to set the bar too high in respect of past wishes as to how patients would want to be treated in the future. In particular she submitted it would erode the principle of autonomy if the court could only give weight to a patient who had accurately and in detail envisaged the circumstances of their future care and opined with a level of specificity. She submitted I should reject, therefore, Dr Turner's evidence that PK had never envisaged being bed bound and fed by a NG tube. She noted the differing medical views on the burdens and that one doctor emphasised pain and another the nil by mouth regime. She suggested that demonstrated neither as quite so burdensome. She identified the magnetic factor as PK's religious beliefs.*

After the clinical and family evidence but before the expert's evidence, McKendrick J declined an invitation by the Trust to make a judicial visit:

> *61. This matter had not been hitherto canvassed. It was strongly opposed by Mr O'Brien and Ms Powell. I concluded that a judicial visit would be of limited purpose having regard to the then Vice President of the Court of Protection, Hayden J's, Practice Note. It could be confusing for PK. I have a detailed account of his situation and a note of a bedside visit made by Mr Michael Sherlock of the office of the Official Solicitor. Whilst there might be benefit to visiting PK to further involve him in the proceedings, this was outweighed by other factors. I declined the invitation.*

Capacity was not in issue, nor did the Trust seek orders to set a ceiling of treatment, or move PK to another facility; the sole issue was whether continuing CANH delivered via the NG tube is or is not in PK's best interests. At paragraph 62, McKendrick J set out his conclusion:

> *After having reflected on, and considered, the oral and written evidence from the clinicians and from the family, I have come to the clear conclusion that it remains in PK's best interests for the NG tube to remain in situ and for him to continue to receive CANH. I can set out my reasons succinctly:*

a. *I do not know what his present wishes are in respect of the NG tube.*

b. *I accept his present feelings are, at the very least, influenced by the enjoyment he receives from being with his family. On balance I infer his feelings would likely dictate that he would want this to continue and for that enjoyment not to be cut short to the 1-3 weeks he would have left if the NG tube were removed.*

c. *I unhesitatingly agree with the family's evidence in respect of PK's past wishes in respect of continuing treatment even in circumstances where pain and disability are present. His daughters' and his wife's evidence on this was clear. It was (rightly) not challenged by the applicant. The discussion around the television programme in July 2024 is a recent and neat example of PK's wish to receive treatment. Furthermore, it sets out his past wish to receive treatment even if in pain or labouring under disability. I entirely accept Ms Powell's submissions that I need not find a patient expresses a wish exactly mirroring their current circumstances and to do so would undermine autonomy. Such are the varied injuries or disabilities that might befall us and such are the range of treatments that medical advancement might offer us, to require a patient to articulate their precise circumstances would be to require an unnecessary level of prediction which is inconsistent with the autonomy this court seeks to protect.*

d. *I find PK's past feelings would include the sentiment that all life is of value and he would have felt anguish and disappointment should his life be shortened by medical intervention. His past feelings were to celebrate life and to enjoy it surrounded by his family.*

e. *I also find his past and present beliefs are deeply rooted in his devout Muslim faith. This stands out from the evidence. He was and remains a devout Muslim. He continues to listen to surahs. His family's evidence is that he believed all life is given by God and no steps should be taken to shorten life, other than those of his God. To that extent his family's evidence is that PK would view it as wrong and contrary to Islam for me to authorise the removal of his NG tube. I reach this conclusion based solely on the evidence of PK's family. I have read and considered the fatwa exhibited to AB's witness statement. I have not had to determine how to give effect to this fatwa and as a result I make no findings as to Islamic teaching on end of life care and treatment. I am only concerned with PK's understanding of Islam and the extent to which his own religious beliefs would comfort him. I agree with Ms Powell's submission that there is a significant benefit to PK of living and dying in accordance with how he understands his devout Muslim faith. Unquestionably, therefore, PK's Islamic beliefs would be likely (highly likely) to influence his own decision whether or not to continue with the NG tube if he had capacity.*

f. *I also find PK's past and present values are deeply rooted in his family life, as a husband, father and grandfather. This has profoundly shaped almost all of his entire adult*

life. The importance of fatherhood is emphasised by the fact he fathered six children. I accept the submission that notwithstanding his reduced consciousness, cognitive decline and physical disability, he remains, from his hospital bed, an active husband, father and grandfather. I accept Dr Christofi's evidence and find that when PK is bright and alert, not tired, he is fully conscious and can interact, communicate (albeit non-verbally) and respond with his family. The value of family life is more than simply having contact with his visiting family members. It is a powerful role he continues to perform as the head of his family. I therefore find that the value of family life is a value that is likely to influence his decision whether or not to maintain the NG tube, if he had capacity. Spending more time with his family is indicative of maintaining CANH via the NG tube.

g. *I am required to take into account pursuant to section 4 (7) (b) the views of anyone engaged in caring for PK. I must take into account Dr Turner's views and the wider views of the Trust. It is also convenient to consider Dr Hanrahan's views. They are principally concerned with four burdens: (i) pain; (ii) the 'nil by mouth regime' and mouth care; (iii) his environment and (iv) the inherent indignity of personal care and being bed bound. The Trust is entirely correct to raise these issues and be concerned by them. I have weighed them carefully. First on pain, I find when immobile PK is comfortable and not in pain. Whilst it is hard to know whether there is underlying pain or discomfort, I accept the medical evidence it is well managed and he receives appropriate pain relief. Should that pain advance, the pain management regime can be altered. PK can grimace when in pain but is not observed to routinely grimace. The opposite is the case: and he is observed to be peaceful and comfortable. I accept he is in pain (particularly given his shoulder injury) if moved, but I find this is short lived and he is carefully and skilfully turned by experienced staff. He need not leave his bed when he has a CXR and this is not likely to be painful. Overall, I find there is limited pain and the highly professional staff take all steps through medication and otherwise to minimise any limited incidental pain. Secondly, the evidence on 'nil by mouth' was fairly divergent between Dr Turner and Dr Hanrahan. I do not think PK feels hunger. His dry mouth is ameliorated by the water given by pipette. He enjoys that. His mouthcare is well looked after. Thirdly, I accept Mr O'Brien's submission that there is no evidence that PK is disturbed or negatively impacted by his ward environment or related sensory issues. Dr Hanrahan was correct to raise them but this was very much at the level of generality and not specific or rooted in the evidence to PK. Lastly the provision of intimate care and being bed bound are burdensome, but I also accept the family's evidence that when PK had carers four times a day at home to help with toileting, he quietly accepted this. This is in line with his beliefs and values.*

h. *I also factor in the fact PK is aware of his surroundings and his environment. I accept he smiles and responds when Arsenal Football Club is mentioned. I accept he can*

follow one stage commands. I accept he smiled when Dr Hanrahan made an error in Arabic. Therefore, I do not accept some of Dr Turner's earlier written evidence on the state of PK's consciousness and prefer Dr Christofi's and the family's evidence that he is conscious at times.

i. *I also place weight in the best interests analysis, on the views of his family who also care for him and/or are interested in his welfare. They all consider the NG tube should remain in situ.*

j. *I also place weight on the fact PK's own litigation friend, as a person interested in his welfare, opposes the Trust's declarations.*

63. *Set out above are the essential and necessary section 4 MCA factors. I also place considerable weight, as I must, on the inherent sanctity of life. The removal of the NG tube is likely to reduce PK's life expectancy, although I accept this is not certain and he is sufficiently frail that he might pass at any time.*

Importantly, McKendrick J made clear that:

64. *I do not accept that which was hinted at in the evidence (but (rightly) not developed by Mr Fullwood) namely, that CANH was futile because PK's functioning will not improve. The NG tube delivering CANH to PK is not futile in circumstances where it sustains his life. I accept the clinical evidence there will, in all likelihood, be no improvement from the October 2024 stroke, but it does not follow from that, that his treatment is futile.*

He further noted that:

65. *I have not overlooked the fact that my conclusions depart from the evidence of the two experienced clinical witnesses. However, as is clear from the case law, whilst I must consider the expert and clinical evidence, the best interests decision is mine alone. I depart from the expert because I place greater weight on PK's past and present wishes, feeling, beliefs and values than the expert does. I do not find the treatment futile. Its burdens do not (yet) outweigh the benefits I have identified above.*

66. *I have firmly in mind, many patients would rather quickly and quietly slip away from a life of artificial hydration and nutrition when bed bound, particularly in circumstances when they are both non verbal and subject to a nil by mouth regime. However, Aintree makes clear that the court's assessment of best interests is rooted in a best interests analysis from the perspective of the particular patient in their particular circumstances. I therefore conclude that it is in the best interests of this devout Muslim, family man, who is often conscious and in limited pain, and who enjoys his family, to continue to receive CANH through his NG tube.*

Comment

This case provides a reminder, should a reminder be needed, that as soon as clinicians put a matter before the court on a best interests basis, it is always open to the court to give a different answer to that which they had reached. It is, in some ways, the *Aintree* case updated for 2025, by reference, in particular, to a granular analysis of wishes, feelings, beliefs and values (both past and present) as distinct factors.

Representing the person's interests in deprivations of liberty

Martinez Fernandez v Hungary - 30814/22 (Article 5 - Right to liberty and security - Involuntary detention and treatment of an elderly woman with dementia : Second Section) [2025] ECHR 124 (27 May 2025)

Article 5 ECHR – Damages

Litigation friend – Family Members

Litigation friend – Official Solicitor

Summary

This case is of interest to litigation friends in the Court of Protection. An elderly woman with moderate dementia was living at home with 24-hour supervision provided by her family and paid carer. She was urgently admitted to hospital feeling unwell and detained in a psychiatric hospital for 6 days. Although she had authorised her son under a power of attorney to represent her during the court review of her hospitalisation, this did not relieve the court-appointed guardian *ad litem* (ie litigation friend) to represent her interests. There were issues regarding the effectiveness of her legal representation and the impact of sedative medication on her ability to meaningfully participate in what was a 17-minute court hearing.

(i) Legal representation

The court noted that the general principles with regard to the deprivation of liberty of persons with mental health issues were summarised in *Rooman v. Belgium* ([GC], no. 18052/11, §§ 190-93, 31 January 2019) and *Denis and Irvine v. Belgium* ([GC], nos. 62819/17 and 63921/17, §§ 134-137, 1 June 2021). Specifically in relation to legal representation it observed:

> *58… Effective participation means, among other things, being able to put forward matters in support of a person's claims… Mental health issues may entail restricting or modifying the manner of exercise of that participation, but they cannot justify impairing the very essence of it, except in very exceptional circumstances, when the person concerned is entirely unable to express a coherent view or give proper instructions to a lawyer…*
> *59… The Court reiterates that the mere appointment of a lawyer who does not actually provide legal assistance in the proceedings does not satisfy the requirements of necessary "legal assistance" for persons deprived of their liberty under the head of "unsound mind", under Article 5 § 1 (e) of the Convention… Meaningful contact between the representative and the applicant is crucial in order to ensure that her legitimate interests are protected and that all her arguments are put and tested, in an adversarial manner. In addition, effective legal representation of persons with disabilities requires an enhanced duty of supervision of their legal representatives by the competent domestic courts…*

The court had "serious doubts that the guardian was able to provide sufficient meaningful information to the applicant":

> *65. In any event, the Court considers that the role of the representative is twofold: not only to inform the person of her rights and to advise her on the most appropriate course of action, but also to explore her wishes and to seek her instructions in order to defend effectively her position and safeguard her interests throughout the proceedings.*

The guardian failed to visit her before the hearing, as required by domestic law, and there was no indication that he had familiarised himself with her situation or circumstances. Although physically present at the hearing, he made no submissions on her behalf and at the end endorsed the hospital's request for involuntary hospitalisation, considering it was necessary for protecting her health. [66] The court noted that the "underperformance of guardians *ad litem* is a systemic problem" in Hungary and contrary to their statutory purpose and role:

> *68. The Court emphasises that such attitude is also incompatible with the requirement of*

> *effective legal representation under the Convention. The Court has already underlined in previous cases that the mere appointment of a lawyer who does not provide legal assistance in the proceedings does not satisfy the requirements of necessary "legal assistance" under Article 5 § 1 (e) of the Convention (see cases cited in paragraph 59 above). The Court has also emphasised that effective representation in cases of this type requires meaningful communication between the representative and the represented person and that the domestic courts exercise close supervision of the legal representatives.*
>
> *69. However, these requirements were not met in the present case. The Court finds that the guardian ad litem unconditionally endorsed the hospital's application without attempting to understand and represent the applicant's wishes. This was a serious defect in her representation in which domestic courts saw no fault and which they made no attempt to remedy.*

(ii) Meaningful participation

As well as the shortcomings in her legal representation, the court further doubted whether, given the tranquilising medication given for restlessness and agitation, the authorities had paid sufficient attention to facilitating her meaningful participation in the proceedings:

> *73. The Court is aware that the primary aim of therapy following a patient's admission is to eliminate his or her perceived immediately dangerous behaviour (see paragraph 25 above). However, it observes that if a patient is given tranquillising medication on or after admission, that may not only make it difficult for the court to benefit from hearing the patient in person so as to properly assess his or her current mental state and conduct, but also may make it difficult for the patient to communicate with his or her representative and to participate actively in the proceedings. Consequently, the issue of medication and its effects requires careful consideration by both mental health professionals and the courts, but the Court sees no evidence that this has been done in the present case.*

Accordingly, the court held that the domestic authorities' failure to comply with their own procedural requirements breached Article 5(1)(e) and awarded EUR 4000 (compensation) and EUR 5000 legal costs and expenses.

Comment

This is a helpful European reminder of how important it is for litigation friends to safeguard P's interests throughout the proceedings by understanding and ascertaining P's wishes, to ensure that they are P's litigation friend, not foe. For a detailed discussion of the issues, see this free academic paper to which Alex and Neil contributed. The case also raises interesting questions, rather than answers, as to the impact of sedative medication on participation in court proceedings. At the least, it requires "careful consideration", both to properly assess the person's mental state and their ability to communicate with the legal representative.

Can a treatment be burdensome if the person is 'totally unaware' of it?

Great Ormond Street Hospital v ZG, KG & MG [2025] EWHC 1042 (Fam) (Trowell J)

Summary

Great Ormond Street Hospital issued proceedings seeking a declaration that it is in MG's best interests for invasive ventilation to be withdrawn. MG, a young boy of 3 years old, was diagnosed with B cell precursor acute lymphoblastic leukaemia in 2024. On the 24 May 2024, after 5 weeks of induction chemotherapy, he had a stroke, leading a catastrophic brain injury from which (in the unanimous view of the clinicians) there was no prospect of recovery. Since his stroke MG has been nursed on ICU unable to breathe for himself, fed by a naso-gastric tube.

The application was contested by both of MG's parents, who wished for invasive ventilation to continue because while MG was alive they believed there was a chance that his condition might change.

Trowell J accepted the view of the clinicians that MG had no consciousness - the clinicians were firmly of the view that MG did not react purposefully to his environment. Trowell J further accepted that MG had no chance of meaningful recovery.

Trowell J then went on to conduct the balancing exercise. The two factors that pointed towards the continuation of ventilation being in MG's best interests were that he would live for longer, and he would continue to be the object of his family's love.

Set against this was that despite MG's lack of consciousness, his invasive treatment was a burden, albeit a lesser burden that it would be if he was conscious. Trowell J also factored into the balance a range of other burdens, namely the likelihood that in the future MG would deteriorate; the burden of being alive with no potential to engage with others; and living on an intensive care unit. The context of the evidence was that MG will die without regaining consciousness. Trowell J concluded that it was not in MG's best interests for ventilation to be continued.

Comment

The issue for the parents was articulated in their written position at the start of the hearing (summarised by the Judge) as:

> *If the doctors are right that MG is totally unaware of his surroundings then it cannot be said that he is suffering, and so how can the burdens of treatment be sufficient to justify the withdrawal of treatment when the treatment is life sustaining?*

The answer to this appears to have been the acceptance by Trowell J of the submission made by our very own Peter Mant KC instructed on behalf of the Trust, that the presumption in favour of preserving life was rebutted in this case because MG's life (with no ability to engage with anybody, no conscious sensations, and facing the inevitability of death with no improvement) is not a life worth living. This factor was sufficient in the Court's view to conclude that the presumption in favour of life was rebutted.

Effective reviews of detention

Spivak v Ukraine [2025] ECHR 136 European Court of Human Rights (Fifth Section)

Summary

Spivak v Ukraine [2025] ECHR 136 is a very helpful and important reminder of the increasing focus that Strasbourg is placing upon non-consensual psychiatric admission and treatment. It is particularly timely for those in England & Wales as the Mental Health Bill is at Committee stage in the House of Commons – a key part of its proposals being tightening of the criteria for both. We summarise its key conclusions in relation to Articles 5(4) and 3 ECHR.

Article 5(4)

The court made clear, as a starting point that:

> *136. The Court reiterates that, under its case law, the person subjected to compulsory medical treatment should have access to a court and the opportunity to be heard either in person or through some form of representation. The Article 5 § 4 review of the lawfulness of the detention is not required to be automatic, but should rather be an*

opportunity for proceedings to be initiated by the patient himself or herself (see Gorshkov v. Ukraine, no. 67531/01, § 39, 8 November 2005, with further references). Article 5 § 4 therefore requires, in the first place, an independent legal device by which the detainee may appear before a judge who will determine the lawfulness of the continued detention. The detainee's access to the judge should not depend on the goodwill of the detaining authority, activated at the discretion of the medical corps or the hospital administration (ibid., § 44).

137. Although it is not always necessary that the procedure under Article 5 § 4 be attended by the same guarantees as those required under Article 6 § 1 of the Convention in respect of criminal or civil litigation, it must have a judicial character and provide guarantees appropriate to the kind of deprivation of liberty in question (see Idalov v. Russia [GC], no. 5826/03, § 161, 22 May 2012). In particular, in the proceedings in which an appeal against a detention order is being examined, "equality of arms" between the parties, the prosecutor and the detained person must be ensured (see Dimitrios Dimopoulos v. Greece, no. 49658/09, § 47, 9 October 2012).

On the facts of the particular case, the court was very concerned as to the ineffectiveness of the regular court reviews provided for under Ukrainian law:

143. In particular, there is no indication that the District Court attempted to scrutinise the reliability of the arguments on the basis of which the applicant - who had been declared free from any psychiatric illness by forensic experts and the Dniprovskyi District Court of Dniprodzerzhynsk - was later diagnosed with a psychiatric disorder by the Dnipro hospital doctors, who controlled his liberty and treatment. At no point was a second independent medical opinion sought in order to confirm or refute the Dnipro hospital's conclusions about the applicant's mental state. The Court has in the past found such an opportunity to benefit from a second, independent psychiatric opinion to constitute an important safeguard against possible arbitrariness in decision-making where the continuation of confinement in compulsory care is concerned (see X v. Finland, cited above, § 169; M. v. Ukraine, cited above, § 66; and Anatoliy Rudenko v. Ukraine, no. 50264/08, § 117, 17 April 2014). In this connection the Court also refers to the CPT's recommendation that periodic review of an order to treat a patient against his or her will in a psychiatric hospital should involve a psychiatric opinion that is independent of the hospital in which the patient is detained (see paragraph 114 above).

Article 3

As the court noted at the outset of its substantive consideration of this issue:

168. According to the Court's well-established case-law, medical intervention to which a person is subjected against his or her will (including for the purposes of psychiatric assistance) may under certain conditions be regarded as constituting treatment prohibited by Article 3 of the Convention. In particular, the Court has held that a measure that is a therapeutic necessity from the point of view of

established principles of medicine cannot in principle be regarded as inhuman and degrading. The Court must nevertheless satisfy itself that a medical necessity has been convincingly shown to exist and that procedural guarantees for the decision exist and are complied with (see, for example, V.I. v. the Republic of Moldova, no. 38963/18, § 95, 26 March 2024; Gorobet v. Moldova, no. 30951/10, §§ 47-53, 11 October 2011; Akopyan v. Ukraine, no. 12317/06, § 102, 5 June 2014; and V.C. v. Slovakia, no. 18968/07, §§ 100-120, ECHR 2011 (extracts), with further references therein).

169. For the purposes of Article 3, ill-treatment must attain a minimum level of severity. The assessment of this minimum level is relative: it depends on all the circumstances of the case, such as the duration of the treatment, its physical and mental effects and, in some cases, the sex, age and state of health of the victim (see, Bouyid v. Belgium [GC], no. 23380/09, § 86, ECHR 2015). In assessing evidence, the Court has generally applied the standard of proof "beyond reasonable doubt". However, proof may follow from the coexistence of sufficiently strong, clear and concordant inferences or of similar unrebutted presumptions of fact (see Yerokhina v. Ukraine, no. 12167/04, § 52, 15 November 2012).

170. The Court has previously noted that the position of inferiority and powerlessness that is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with. While it is for the medical authorities to decide, on the basis of the recognised rules of medical science, on the therapeutic methods to be used (if necessary by force) to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves and for whom they are therefore responsible, such patients nevertheless remain under the protection of Article 3, whose requirements permit no derogation (see Herczegfalvy v. Austria, 24 September 1992, § 82, Series A no. 244).

171. The Court has considered that States have positive obligations under Article 3 of the Convention, which comprise, firstly, an obligation to put in place a legislative and regulatory framework of protection; secondly, in certain well-defined circumstances, an obligation to take operational measures to protect specific individuals against a risk of treatment contrary to that provision; and, thirdly, an obligation to carry out an effective investigation into arguable claims that such treatment has been inflicted. Generally speaking, the first two aspects of these positive obligations are classified as "substantive", while the third aspect corresponds to the State's positive "procedural" obligation (see X and Others v. Bulgaria [GC], no. 22457/16, §§ 178-79, 2 February 2021).

Interestingly, and taking the law further forward than previously, when applying the law to the facts of the case:

174. The Court observes at the outset that one of the fundamental principles in modern medical ethics and international human rights law - as widely emphasised across various international instruments, including

those of the Council of Europe (see paragraphs 111, 117, 119, 120 and 121 above) - is that no medical intervention may take place without the patient's free and informed consent (see also Pindo Mulla v. Spain [GC], no. 15541/20, §§ 137-139, 17 September 2024). This principle is a cornerstone of personal autonomy, as it ensures that individuals maintain control over decisions regarding their medical treatment, with a full understanding of the associated risks, benefits, and alternatives. This principle holds particular significance in the field of mental healthcare, where patients are often in vulnerable situations and at heightened risk of treatments being administered without their full understanding or agreement.

175. The Court acknowledges that the issue of informed consent becomes more complex in cases involving compulsory medical measures imposed by court order. The very concept of "compulsory medical measures" appears to conflict with the principle of personal autonomy. At the same time, the justification for such measures often lies in the need to protect either the individual's health or public safety - considerations that are seen as outweighing and overriding the usual requirement for free and informed consent.

176. Nonetheless, the Court emphasises that even when compulsory medical measures are considered necessary, they must be subject to rigorous oversight to prevent potential abuse and to ensure that the interference with personal autonomy is proportionate and justified. In particular, it is essential that the treatment provided is appropriate and necessary. Without such safeguards, the automatic authorisation of treatment without consent risks undermining the individual's rights in a manner that may be incompatible with the rule of law in a democratic society.

On the facts of Mr Spivak's case, the court found that

189. […] *the Ukrainian legal framework existing at the time fell short of the requirement inherent in the State's positive obligation to establish and apply effectively a system providing protection to patients undergoing compulsory medical treatment in mental care facilities against breaches of their integrity, contrary to Article 3 of the Convention. The absence of proper legal safeguards deprived the applicant of the minimum degree of protection to which he was entitled under the rule of law in a democratic society (see, mutatis mutandis, Herczegfalvy, cited above, § 91, and Narinen v. Finland, no. 45027/98, § 36, 1 June 2004; see also X v. Finland, cited above, § 221).*

Further:

200. In view of the foregoing considerations and on the basis of the available evidence, the Court is not in a position to find that the medical necessity for the applicant's retention in the hospital and his treatment with neuroleptics has been convincingly shown to exist. Moreover, the District Court decision delivered on 13 October 2014, which ordered the cessation of coercive medical measures and which was ignored by the hospital until the Ombudsperson and prosecutor intervened, tends to support this conclusion. The Court therefore

considers that it can draw inferences in support of the applicant's version of events.

201. The Court further observes that neuroleptics are commonly understood to be a class of drugs used to manage psychotic conditions such as schizophrenia, particularly symptoms such as delusions and hallucinations. In light of their significant effects on the central nervous system and the risk of serious side effects - including metabolic disturbances, movement disorders, and sedation - their use raises concerns when there is no confirmed diagnosis of a severe psychotic disorder that may pose a danger to the patient or others. The legal instruments and reports adopted by the United Nations indicate that the administration of neuroleptics without medical necessity may amount to ill-treatment that is prohibited under the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (see paragraphs 120 and 121 above).

202. While the applicant has not claimed that the use of neuroleptics had any long-term or irreversible effects on his health, the Court considers that the mere fact of being subjected to psychiatric treatment with neuroleptics against his will, for almost two years and without proven medical necessity - coupled with a lack of effective legal safeguards against arbitrariness and abuse by the medical staff, and given the immediate cognitive effects of the neuroleptic drugs - was such as to arouse in the applicant a sense of fear, anxiety, and inferiority that was capable of humiliating and debasing him (see and compare Bataliny v. Russia, no. 10060/07, § 90, 23 July 2015). The treatment in issue constituted a fundamental disregard for the applicant's human dignity, amounting to inhuman and degrading treatment within the meaning of Article 3 of the Convention.

The court further found that the very conditions of Mr Spivak's detention gave rise to a breach of Article 3.

Comment

Whilst many of the passages above may be familiar to afficionados of Strasbourg jurisprudence in this area (reviewed comprehensively in this book), the observations in relation to informed consent do take matters further forward. They do, however, not go as far as the CRPD Committee would like – Strasbourg has firmly set its face against the proposition that all treatment must always be consensual, recognising that there may be other interests in play. However, it is clear that (rightly) the court will scrutinise with increasing care and concern (1) the frameworks around such treatment; and (2) the application of those frameworks to the facts of individual cases. The observations in relation to Article 5(4) are also a very important reminder that reviews of detention must actually be effective – and what counts as an effective review will depend upon the circumstances.

Cheshire West redux?

We note with interest the following item from the Supreme Court's website:

A Reference by the Attorney General of Northern Ireland of a devolution issue under paragraph 1(b) of Schedule 10 to the Northern Ireland Act 1998

Its case summary states that the Issue is:

> *Whether the Minister of Health has power to revise the Deprivation of Liberty Safeguards Code of Practice issued under s.288 of the Mental Capacity Act (Northern Ireland) 2016 ('the 2016 Act') so as to provide that, in the context of the delivery of care and treatment, individuals aged 16 and over with impaired decision-making may be understood to be consenting to confinement through the expression of wsishes and feelings, so that their circumstances do not fall within the scope of Article 5 of the European Convention on Human Rights ('ECHR)').*

The 'Facts' section of the post states:

> *Under the Northern Ireland Act 1998, a "devolution issue" (including whether an act of the government of Northern Ireland would be invalid as breaching the rights protected by the ECHR) may be referred to the Supreme Court for determination. The Attorney-General for Northern Ireland has referred the above question to the Supreme Court. The question arises in the context of the provision of care and treatment for persons with cognitive impairments, and how their rights to liberty and security – under Article 5 of the ECHR – are safeguarded. The Attorney-General considers that the proposed revisions to the Deprivation of Liberty Safeguards Code of Practice (the "Code") would adopt an approach to the scope of Article 5 which would differ from that outlined by the Supreme Court in the case of P v Cheshire West and Chester Council & Anor [2014] UKSC 191; [2014] AC 896, but which would nonetheless satisfy the requirements of Article 5. Accordingly, the Attorney-General seeks confirmation that the Minister of Health would have the power to issue the revised Code.*

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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.

Neil is running the following courses, with tickets available here:

- BIA/DoLS refresher training: 26 June 2025, 16 July 2025.
- DoLS Authoriser Training: 4 July 2025
- AMHP/MHA 1983 Legal Update: 10 July 2025

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 July. 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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