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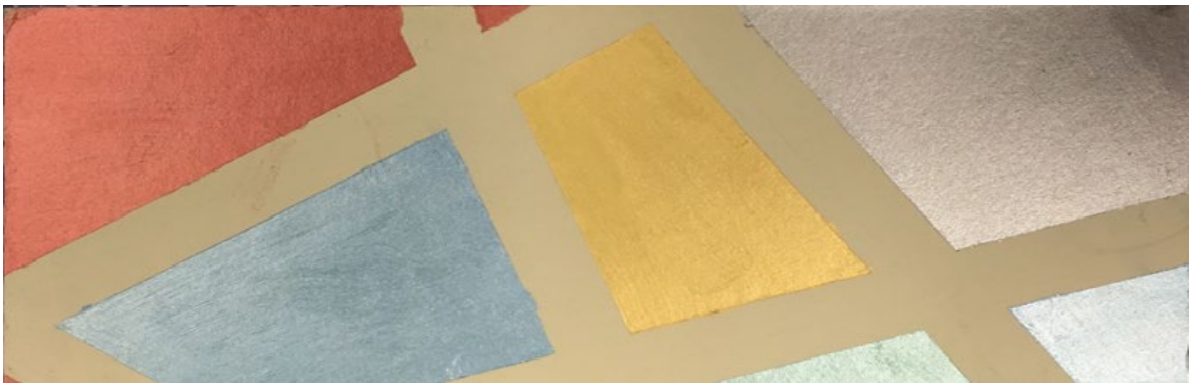

Welcome to the June 2025 Mental Capacity Report. Highlights this month include:

(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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HEALTH, WELFARE AND DEPRIVATION OF LIBERTY

Best interest in medical treatment – the court is not a rubber stamp for clinical views

University College London Hospitals NHS Foundation Trust v PK & Anor [2025] EWCOP 17 (T3) (McKendrick J)

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.

PROPERTY AND AFFAIRS

Professional Deputy Costs

The Office of the Public Guardian and the Senior Courts Costs Office have published a good practice guidance, Professional Deputy Costs. Its purpose is to *'explain[] the approach the SCCO takes when assessing bills submitted by professional deputies. It covers good practice, OPG's role, complaints, appeals and guidance on general management costs.*

The guidance contains:

- *reminders of what to consider when incurring GM costs against P's estate*
- *advice on submitting bills of costs for assessment*
- *OPG's reporting requirements*

It should be read in conjunction with the relevant Civil Procedure Rules (CPR), CoP Practice Direction PD19B, section 23 of the SCCO Guide (2023), the Mental Capacity Act 2005 Code of Practice (the Code) and OPG professional deputy standards…

It does not replace any of these documents.'

The guidance emphasises the need for deputies to reflect on the level of costs they incur, particularly if P's funds are depleting:

> *This includes considering the amount of involvement they expect to have in P's affairs in the next deputyship year and how much the professional deputy fees are likely to cost P's estate. In addition, the deputy has a responsibility to make a professional assessment if it is in P's best interests for them to continue in their role, resulting in a reduction of P's estate. If P's affairs are sufficiently well organised and unlikely to undergo significant change, the professional deputy may consider if an application to the CoP for appointment of a willing member of P's family or a friend would be appropriate.*
>
> *Both OPG and the SCCO are clear that any professional deputy who does not follow the published guidance will be expected to explain the reason for their actions and in particular, demonstrate how their actions are in P's best interests.*

The guidance also states that in submitting the OPG105 form on costs, *'The completion and submission of OPG105 should not require any further information gathering activity by the deputy and is not anticipated to add any further cost burden to P. Completing the form should take no longer than 30 minutes.'*

The guidance notes that if costs bills submitted are *'are 20% or more above the estimate it will also be necessary to provide reasons to the SCCO as to why there is a difference. Should there be changes in P's circumstances during the year (and therefore costs to their estate), the deputy should alert OPG if the fees are likely to be 20% or more than the submitted estimate. It is not necessary to file an update with the OPG if the increase of 20% or more is due solely to a change in the guideline hourly rates.'*

The Guidance provides a helpful outline of 'the approach taken by the SCCO when assessing bills.'

> ### *Hourly rates*
>
> *Except in the most exceptional circumstances, the hourly rates charged within the GM bill should be as described in the SCCO Guide to the summary assessment of costs (CPR Vol.1). Rates should be claimed in accordance with the Guideline Hourly Rates for the period in which the work was undertaken and evidence provided of compliance with the indemnity principle as appropriate. Current and historic Guideline Hourly Rates for Solicitors are readily available online, for example at the Gov.uk website.*
>
> ### *Delegation of duties*
>
> *Professional deputies are expected to delegate work to the appropriate level of fee earner.*
>
> *That means routine GM activities such as paying bills or checking bank statements should be carried out by an administrative assistant or a Grade D fee earner at best.*

The deputy will need to justify any bill where a higher grade of fee earner is claimed. There are times when the use of a non-fee earner would be considered more appropriate, for example, if delivering goods or money to P.

When considering any time claimed for the act of delegation the SCCO will consider if the time clamed is reasonable, proportionate, progressive and that it serves to reduce costs. For regular, routine activities it is expected that systems will have been put in place to avoid the need for repetitive or excessive delegation.

Paying bills

Three-minute units will usually only be allowed in respect of paying bills either by electronic transfer, cheque or enclosure letter. No further time will usually be allowed for updating records with details of any payment or for any letter advising of payment.

Reconciliation of Bank statements

Reconciliation of Bank statements will only usually be allowed at Grade D.

Levels of contact

The SCCO's usual practice is to allow one home visit in each 12-month period, which is considered to be appropriate in cases which are stable.

It is accepted that more visits may be necessary to meet the particular needs of the case, but deputies should be prepared to justify this with reference to their duties under the Mental Capacity Act.

The SCCO allows the cost of one fee earner to visit in all except the most exceptional cases. Professional deputies should try to limit excessive contact with all parties, including P, their family members, case managers and case workers.

In all cases, professional deputies are expected to use their judgement in deciding the most cost-effective method of communication and take a balanced approach to meeting P's needs against incurring excessive costs.

Welfare work

Where a property and affairs deputy is appointed to manage P's finances, work in respect of welfare is not recoverable from P's estate without permission from the CoP.

If the professional deputy for property and affairs is finding that a large proportion of their time is being taken up in health and welfare related matters, they should ensure they engage with appropriate professionals who can meet those needs (for example, alert agencies to safeguarding concerns).

They may also consider it is in P's best interests for an application to be made to the CoP for the appointment of a health and welfare deputy.

Re ACC Judgment

For work that falls outside of the general authority of a deputy further authority for the assessment of costs may need to be applied for.

Please refer to the Re ACC Judgement: ACC & Ors (property and affairs deputy; recovering assets costs for legal proceedings)

Financial beauty parades

Generally, only one senior fee earner will be allowed to attend such meetings to discuss the best investment strategy for P in large damages awards.

Estimated costs

If no documentary evidence is provided in support of the bill, for example attendance notes and copies of the documents to which the attendance note refers, such costs are likely to be disallowed.

Overheads

Research, reading incoming routine correspondence, internal communication if it is considered to be routine and non-progressive, supervision and routine updating of records are taken to be included in the deputy's overheads, except in exceptional circumstances.

These examples are not comprehensive and there may be other items that are considered to be overheads in individual assessments.

OPG expects all deputies to provide a certain level of service and has systems in place to monitor this, such as Assurance Visits and ensuring compliance with deputy standards. Time associated with these obligations is considered by OPG and the SCCO to be part of a deputy's overheads and will not be allowed on assessment.

Routine correspondence out

A three-minute unit is usually allowed for very short straightforward letters, emails or duplicate letters, for example to a financial institution or P's family.

Litigation costs

Costs will be disallowed which could properly be claimed within the context of ongoing litigation, for example, interim payments on account of damages or providing information for the purpose of conducting litigation. See also ACC above.

Costs drafting fees

Apart from in exceptional circumstances, a Grade D rate fee earner will be allowed for drafting bills of costs.

The costs of preparing excessively long schedules that replicate the file notes are likely to be disallowed.

The short form bill must be used for costs claimed of under £3,000 (excluding VAT and disbursements).

Limited value estates

Where P's net assets are below £20,300, a professional deputy is expected to act according to the directions given in Sections 10 and 12 of PD19B.

Professional costs on P's death

On P's death, the deputyship is at an end. As such, the Court of Protection (CoP) no longer has any jurisdiction, and the SCCO has no authority to assess a professional deputy's bill, for any costs incurred post-death.

However, the SCCO can continue with an assessment that has partially progressed before P's death without requiring further authority from the CoP.

This is because the original deputyship order will authorise detailed assessment of the reasonable deputyship costs incurred during P's lifetime.

The deputy should refer to an executor to see if the costs can be agreed (Practice Direction 23(b) paragraph 10).

Where a professional deputy is also the executor for P's estate, there is a potential conflict of interest, and the bill should be submitted to the SCCO for assessment. In such circumstances, the SCCO will NOT need permission from the CoP to carry out a final assessment, as explained above.

Can a deputy pay a drug debt for P?

EM and JG v P [2024] EWCOP 80 (T3)
(Mcfarlane J)

Best interests – Property and affairs
Capacity – Property and affairs

This ex tempore judgment from December 2024 which has only just been published involves an application by financial deputies for guidance from the court in circumstances where P, who had an acquired brain injury but was able to function at a high level, had become involved in drug dealing. P had been arrested, and quantities of Class A and B drugs had been seized from his

home and a friend's home. The drug dealer who had supplied some of those drugs to P was demanding a payment of £17,000 from P, which represented the value of the drugs.

The President held that if P lacked capacity to decide whether to pay the drug debt, then there could be no best interests decision or authorisation from the court to pay the debt, as that would involve the deputies in criminal activity. Specifically, the deputies would be potentially liable for a money laundering offence under s.328 Proceeds of Crime Act 2002 and conspiracy to commit that offence: "*the short point is that…it is likely the deputies will have become drawn into engaging in payment of what will be seen under the 2002 Act as the proceeds of crime, although obviously at the moment, the money is not such: it sits in a bank account managed by the deputies on P's behalf.*" [6] Further, the deputies would be placing themselves in jeopardy under the Solicitors Regulations as the SRA Principles and Code of Conduct also applied to solicitors when acting as deputies, and solicitors cannot accept instructions that involve them in criminality.

If P had capacity, then he could ask for any sum he liked from the deputies and they would not be at risk of criminal proceedings, since they would be legally obliged to abide by his instructions.

On the facts of the case, P lacked capacity as he could neither hold in mind nor weigh up the salient information. There was no prospect of the court sanctioning the payment in P's best interests: '*the court would effectively itself be engaging, albeit at arm's length, in serious criminality*', [19] and so the court refused to declare that the payment should be made.

Comment

It is very unfortunate that this judgment does not contain a reasoned explanation of why the payment of the £17,000 would constitute an offence under POCA 2002, and does not include any of the relevant caselaw on the provisions of that statute.

The purpose of this application as brought is fairly elusive. The judgment records that the application on the papers appeared to seek a best interests decision. However, where the deputies' own position appeared to be that they would be committing an offence by paying this debt (and thus, it would be presumed, unwilling to do so), it is unclear what available option the court was being called on to consider. The deputies had obtained multiple opinions from criminal counsel which took this position, but the rationale of these opinions are not discussed at length. Where multiple opinions had already been obtained on this point, it does not appear that directions were sought or given for the Official Solicitor to obtain yet another advice on the same point of law, and the court does not appear to have heard any contested argument on the point. On the issue of P's capacity (which eventually became the focus of the hearing), the deputies had an expert opinion on P's capacity which the court described as 'a thorough and very impressive account of his assessment establishes that P lacks capacity' which did not appear to lend itself to any credible challenge. It is thus quite difficult to discern why the deputies brought this matter before the court at all, and what the benefit to P was where P will have born the full cost of two represented parties.

In the absence of a description of any contested hearing or endorsed statement of the relevant law, we are not clear on what if any conclusions were reached by the court in relation to its reasoning about the Proceeds of Crime Act; in the absence of such reasoning, this judgment does not appear to have any precedent value.

From what appears to be the logic of the judgment, the use of 'clean' money to pay for drugs is a money laundering offence. If that is right, then it is unclear why P having capacity would remove the risk of the deputies committing a criminal offence. S.328 POCA refers to a person becoming '*concerned in an arrangement which he knows or suspects facilitates (by whatever means) the acquisition,*

retention, use or control of criminal property by or on behalf of another person'. There is no defence of being required to give the money to the person by virtue of some other legal obligation, unless that obligation relates to the enforcement of POCA 2002 or some other enactment relating to criminal conduct.

If the judgment is correct, it would also appear to follow that any payment of 'clean' money to a drug dealer is a money laundering offence, whether through a deputy or otherwise. Anyone buying illegal drugs, or any other illegal substance or product, would be committing the s.328 offence, because their 'clean' funds would automatically become criminal property. That does not sit easily with POCA caselaw in the criminal context which makes clear that money laundering offences involve the acquisition of criminal property, not the criminal acquisition of property. In *R v Porter and Stanley* [2023] EWCA Crim 1485 the court said '*the property in question must already have the quality of being criminal property by reason of conduct distinct from the conduct alleged to constitute the actus reus of the money launder offence*'.

It is to be hoped that there will be a future case in which the points are argued fully and a reasoned judgment given – which may or may not reach the same conclusion. The implications of the judgment for cases where deputies know that P is using an allowance to buy drugs from time to time will also need to be worked out in a future case.

The Law Commission: Report on Modernising Wills

On 16 May 2025, the Law Commission published its recommendations to reform the law of wills in its Report: Modernising Wills Law, which provides draft bill intended to replace the Wills Act 1837. The Law Commission considered that *'the law surrounding this important topic is not as clear as it could be, which may put people off making wills altogether. In some cases, the law is preventing people's clear wishes about what should happen to their property when they die from being given effect. The law is also outdated – it is largely a product of the Victorian era.'* To address these issues, the Law Commission has recommended several strands of reform:

Testamentary freedom

Testamentary freedom –an individual's ability to determine how their estate will be distributed after their death – is a guiding principle throughout the Report. We make several key recommendations which are particularly focused on this aim.

- *Giving the court the power to dispense with the formality requirements to make a valid will, to be used on a case-by-case basis. This power will allow the court to deem a document or record to be a valid will where the court is satisfied that the document reflects the person's settled testamentary intentions. This will address the strictness of the current law, under which non-compliance with the formality rules makes a will invalid no matter how clear the person's intentions were . Creating an power to be used in exceptional circumstances, while maintaining the current formality requirements, ensures that the important protective functions the formalities serve are not lost.*
- *Reducing the minimum age at which a person can make a will from 18 to 16. Currently, a person must be 18 years old to make a valid will. A child who is terminally ill and who does not wish one of their parents to inherit from them or decide what happens to their body when they die, for example because the parent has not played a role in their life, has no ability to set out their binding wishes. Other countries allow children under 18*

to make wills, and the law presumes that children from age 16 have capacity to make other types of decisions.

Protecting testators

We also make recommendations to protect testators, bearing in mind the serious problem of financial abuse, particularly of the elderly.

- *Abolishing the existing rule that a person's will is automatically revoked when they marry or enter a civil partnership. This rule can be exploited by those who enter a predatory marriage with a vulnerable person – marrying them in order to inherit from them. Predatory marriage is a form of financial abuse which has devastating consequences for the victims and their families.*
- *Increasing protections for those who are coerced into making a will. It is currently too difficult to challenge the validity of a will based on undue influence (meaning that someone made a will that they did not want to because of another person's influence). Evidence of undue influence can be hidden because it often happens behind closed doors and by someone close to the person making a will, and the law places a high evidential burden on anyone alleging undue influence. As a result, the law is not adequately protecting vulnerable people from financial abuse. For that reason, we recommend that it should be possible for the courts to infer that a will was brought about by undue influence where there is evidence which provides the court with reasonable grounds to suspect it.*

Clarity and certainty

We have sought to clarify the law where possible. A significant part of our work has been to create a draft Bill for a new Wills Act, which is intended to replace the existing legislation – the Wills Act 1837. As well as enacting our recommendations, the draft Bill comprises a modern, comprehensive and accessible piece of legislation to govern wills law.

We also make recommendations to clarify the law and make it more certain.

- *Making specific provision to enable electronic wills to be formally valid – an important update to the law of wills to make it fit for the 21st Century. However, we also recommend that electronic wills should have to meet specific requirements to ensure that they are safe and reliable.*
- *Clarifying the law on testamentary capacity. There are currently two tests which apply to the question of testamentary capacity, depending on the issue being decided. The common law test applies if the question is whether the person has capacity to make their own will, and the test in the Mental Capacity Act 2005 applies if the question is whether the court has the power to make a will on the person's behalf. This confusing anomaly is the product of the law's historical development. We recommend that only one test should apply: the modern test in the Mental Capacity Act 2005.*

PRACTICE AND PROCEDURE

Webinar: A protocol regulating communications between judges in Scotland, England & Wales, and Northern Ireland in children's cases

In our May Practice and Procedure Report, we covered the new protocol regulating communications between judges in Scotland, England & Wales, and Northern Ireland in children's cases. There will be a webinar on 24 June 2025 from 16:30-17:30 on this new protocol (which has been the subject of invitations to COPPA and CPBA members):

> *The President of the Family Division and Court of Protection, Sir Andrew McFarlane, is pleased to invite you to:*
>
> *A Webinar celebrating Judicial Collaboration in cases involving children, and adults who lack capacity across the United Kingdom*
>
> *Presentations will be given by Sir Andrew McFarlane (England & Wales), Lady Morag Wise (Scotland) and Master Hilary Wells (Northern Ireland)*
>
> ***Tuesday 24 June 2025, 16:30-17:30, via MS Teams***
>
> *This Webinar marks the launch of a newly published protocol regulating communication between judges in Scotland, England & Wales, and Northern Ireland in cases involving adults who lack capacity.*
>
> *It also celebrates the release of the accompanying Judicial Handbook and an updated Judicial Handbook on family law relating to Scotland and England & Wales.*
>
> *The event will be chaired by Lady Wise, President of the Scottish Tribunals and a Senator of the College of Justice. Sir Andrew, Lady Wise and Master Wells will discuss the value and benefits in having intra UK judicial cooperation and collaboration.*
>
> *The discussion will be followed by a live Q&A session. We invite attendees to submit questions in advance by 16 June 2025.*
>
> *The event will be available to all those who register at the link below.*
>
> *Please click the following link and complete the registration form in order to attend.*
>
> *You are encouraged to register early as there is limited capacity for attendees.*

Capacity to conduct proceedings

Lioubov Macpherson v Sunderland City Council [2025] EWCOP 18 (T3) (Theis J)

Aina Khan Law Ltd v The Legal Ombudsman [2025] EWHC 1319 (Admin) (29 May 2025) (David Pievsky KC, sitting as a Deputy High Court Judge)

These two cases concern the assessment of capacity to conduct proceedings.

In the first case, Ms Macpherson had been involved in CoP proceedings for some time and had been found in contempt of court due to publishing information about her daughter online. She issued an application for permission to appeal in the committal proceedings, and the Court of Appeal was asked to deal with concerns raised by her legal representatives that she may not have capacity to instruct them. The Court of Appeal determined pursuant to s.48 MCA 2005 that there was reason to believe Ms MacPherson lacked capacity to conduct the proceedings, and sent the issue of her current capacity and her capacity a year previously to be determined at Tier 3.

Ms MacPherson did not want to undergo a face to face capacity assessment, so the only evidence available to Theis J was an assessment by a psychiatrist based on consideration of the papers. The psychiatrist had decided that Ms MacPherson had persistent persecutory delusions relating to professionals and institutions which prevented her

being able to use and weigh information concerning the proceedings. Theis J disagreed, saying that his evidence was undermined by the lack of face to face assessment, the limited paperwork and absence of medical records, and a lack of balance or analysis of the paperwork that did exist given the previous examples of hearings at which the court had been satisfied that Ms MacPherson did have capacity. Ultimately, misguided and entrenched opinions did not amount to a mental impairment and did not give rise to a lack of capacity.

The second case, *Aina Khan Law Ltd*, was an application for judicial review by a family law firm which had been found by the Legal Ombudsman not to have adequately assessed a client's capacity to give instructions and directed to repay significant sums to the client. The claim was successful in that the finding of a failure to assess capacity was quashed. The court held that the Legal Ombudsman had conflated the existence of a mental health condition and the client's involvement with a psychiatrist with a lack of capacity, and had failed to explain why it was not adequate for the solicitor to have formed a view on capacity herself and discussed it with leading counsel, and why it was the case that an expert assessment of capacity had been required. As in the first case, the court flagged the dangers of letting hindsight affect the assessment of a person's capacity.

Varying a transparency order when material is already in the public domain

Norfolk County Council v CA & Ors [2025] EWCOP 16 (T3) (Arbuthnot J) 11 April 2025

Media – Anonymity

Summary

This case is a useful reminder to look to what material is already in the public domain when considering the appropriate terms of a transparency order in committal proceedings.

The Judge had presided over a contested fact finding in the COP in October 2024, in which she found a number of allegations proved against DA including that she had both verbally and physically abused CA, her 79-year-old mother as well as subjected her to undue influence over a number of months. The Judge handed down a judgment on 10 October 2024 (*Norfolk County Council v CA & Ors* [2024] EWCOP 64 (T3)). That judgment is available on the National Archives. In accordance with standard practice, the judgment identifies the local authority, but not CA or DA. It is clear from reading the judgment, what the relationship between CA and DA is.

On the last day of that fact finding hearing, the Court made injunctions against CA. CA also gave undertakings to the Court. As a result of CA's subsequent breaches of these orders and undertakings, committal proceedings were brought by Norfolk County Council. The committal proceedings, were held in public. During the course of those proceedings, there was argument about whether or not DA should be identified in the judgment. The Judge decided that she should be, but that CA was not to be named, and nor should the nature of the relationship between DA and CA be made public. In order to give effect to this decision, a transparency order was made preventing "any material that identifies or is likely to identify the specific relationship between DA and the defendant" from being published.

The unintended consequence of this order is that reporters have been unable to link the committal judgment with the fact-finding judgment of 10th October 2024. This led Professor Celia Kitzinger to apply to the Court to vary the order made in the committal proceedings, by deleting the paragraph preventing the identification of the relationship between CA and DA from being made public. The main thrust of the application was that the public interest required the decision in relation to the committal proceedings to be linked to the fact-finding judgment of 10th October 2024 which was in the public domain to enable *"continuity of reporting between the 2024 blogs (and judgment) and the 2025 committal hearing."* [24] It was said that the danger to a reporter of linking the two sets of proceedings was that it would be likely to identify the victim as being the mother of DA, the defendant in the committal proceedings, and thus amount to a breach of the Court order.

Professor Kitzinger's application was supported by Norfolk County Council but opposed by DA and CA's litigation friend, the Official Solicitor. The Official Solicitor's concern was that if the application was granted, it would be very easy to identify CA given that DA's name was already in the public domain.

In weighing up CA's Article 8 ECHR rights, Arbuthnot J accepted that if the proceedings were reported in CA's local newspaper, CA would be likely to read about it. The Judge also accepted that granting the application may lead to local gossip and that as CA still had a small, but nevertheless important social circle, she may feel embarrassed about details of the abuse she has suffered at the hands of her daughter being made public. The Judged accepted that *'such a light being thrown on CA's home life and her daughter's behaviour would be a significant interference with her right to privacy."* [50] In conclusion on Article 8, the Judge held that *"the risk of CA being identified by neighbours and her congregation is high but the risk of any consequential harm is very low."* [55]

Set against CA's Article 8 rights were the Article 10 rights of the press and the public at large. Ultimately Arbuthnot J was persuaded that it was important for the public to have a complete understanding of the proceedings that were in the public domain, which could only be achieved if the link between the COP and the committal proceedings was made public. Arbuthnot J came to the view that the public had a *'need to understand the context of the contempt proceedings. They have a right to understand the proceedings as a whole.'* The Judge therefore acceded to the application to amend the transparency order. She also agreed that the judgment on the contempt application should be published as it is of particular interest given that the sentence was a fine.

Comment

While committal proceedings arising from breaches of Court of Protection orders are still relatively rare, there is a real tension between the very strong presumption that such proceedings should be held in public (see COP rule 21.8) and the COP practice of protecting the anonymity of the subject matter of the COP proceedings, where the contemnor is related to P. This is because the publication of the identity of the contemnor significantly increases the risk of P being identified. This is particularly the case where there is already a COP judgment in the public domain.

The cost of inadequate disclosure

Birmingham Women's and Children's Hospital NHS Foundation Trust v KB & Ors [2025] EWHC 1292 (Fam)[1]

Costs

Morgan J considered the threshold for costs in circumstances where a party's failure to make adequate and timely disclosure risked jeopardising the timetable of a final hearing.

KB's original case (reported as *Birmingham Women's And Children's Hospital NHS Foundation Trust v KB LB Fatima and others* [2024] EWHC 3292 (Fam)) is unusual, being one of the very few applications by a treating hospital to withdraw treatment from a seriously ill child which has not succeeded (see also *Tafida Raqeeb v Barts NHS Foundation Trust* [2019] EWHC 2531 (Admin)).

Difficulties arose in the course of serious medical treatment proceedings as a result of poorly reproduced and partial records which did not include salient information such as records of MDT meetings. This gave rise to the need for an additional, unplanned case management hearing and a delay of the scheduled start date of the final hearing by two days. Some three thousand pages of previously undisclosed material was produced by the Trust within seven days of the final hearing. The quality remained poor, much of the copying having been outsourced to an outside provider, and there was a lack of proper indexing to allow for easy understanding of the material.

[1] Katie Scott, having acted in this case has not been involved in writing this report.

Morgan J invited further submissions on the issue of costs alone. She made the following observations:

> *18. i) It is enormously disrespectful to families whose child is the subject of such an application to have repeated hearings at which there is focus on whether material does or does not exist / has or hasn't been produced/ will or won't be available in time to make effective a hearing which has been listed weeks perhaps months in advance, at which they know that the most serious of decisions is to be made about their child.*
>
> *ii) It is unacceptable to take so casual an approach as there appeared to be here, to ensuring that the records required and directed are before the court. It has been in this case unacceptable also to put Ms Scott – in whose word both the court and the other counsel rightly have confidence – in the position of saying on instructions one thing only to have to within days, sometimes hours, correct the position.*
>
> *iii) That sort of approach to the production of material which everyone who acts in this sort of litigation knows will be needed so as to assess (in the case of the court) and argue (in the case of the parties) the best interests analysis is not good enough. Health Trusts are almost invariably both the applicants, and the holders of the records. There is no question that the significance of the material is not understood or that the applicants are not in the position to have that material ready or near ready as they come to make the application. That is not to say that 'everything' must be disclosed, but a Trust making this sort of application should be on notice that if not at the first then likely at the next hearing, the Judge is likely to be making directions for disclosure of at least some of the medical records and other information held*
>
> *iv) It is unreasonable – and professionally beyond discourteous- to put Counsel in the position of having to spend time making applications for material with which they should already have been provided when that time has been set aside for preparation.*
>
> *v) It is not right that decisions such as the one which fell to be made for this child in this case are made in circumstances where all involved are placed under unnecessary and unreasonable additional pressure. Neither is it acceptable to risk either that decisions might be made, or just as significantly may be perceived to be made, in a way which is rushed.*

Ultimately, Morgan J decided not to make a costs award – not least, it appears, because of the Trust's clear acknowledgement of its failings, its steps to change its systems and practices, and the hard work done by its counsel to manage the litigation in a timely manner (see [20-21]). She did, however, provide a helpful list of "suggestions" of how such issues might be avoided in future.

> *[21] i) An index at an early stage should be compiled by the applicant of the records held by the Trust including, as well as the clinical and medical records, any therapeutic records. A senior person at the Trust should be responsible for reviewing whether all categories of material have been included.*
>
> *ii) It is likely to be helpful to identify a person with responsibility for ensuring that the index is kept up to date.*
>
> *iii) If records are duplicated or held in more than one place, this should be indicated on that index.*
>
> *iv) At the first hearing of the application the index should be available to the court.*
>
> *v) Once disclosure into proceedings (or to the parties) is directed from the index the material disclosed should be indexed and paginated. Ideally pagination should be in a form which is then added to rather than changed.*
>
> *vi) Once disclosure into proceedings (or to the parties) is directed any material which*

is copied from paper records should be inspected (and a person from the Trust identified to have responsibility for inspection) to ensure that the copies are of sufficient quality, before it is added to the indexed and paginated material.
vii) Recognising that human error may occur in any organisation a senior person should be identified with responsibility to ensure that material readied for disclosure is sent out.
viii) It is likely to be helpful at the first hearing of any application for the parties to have discussions before disclosure of material as to whether it is reasonably possible for that material to be disclosed in a form which makes it text searchable. It will not always be realistic, but it is an issue to be raised early rather than later in the process of disclosure into proceedings.

Comment

Costs applications appear to us to be being made and succeeding more frequently. This very reasonable judgment is, however, a helpful reminder that (a) the presumption remains in the welfare jurisdiction that there will be no order for costs (b) the threshold for the award of costs remains high (c) there are obvious case management steps that all parties in COP proceedings need to follow, absent which costs applications will be considered. And of course, even in cases such as this where the costs application is not ultimately successful, there will be additional costs incurred in fighting the application.

Covert Recordings in Family Law proceedings

The Family Justice Council has published 'Covert recordings in Family Law proceedings concerning children.' The guidance *'follows an increased use of covert recordings in family law proceedings and the need for clear guidance, and the protection and privacy of those subject to the recording.*

In summary, the guidance:

- *Outlines considerations undertaken by the court, referencing relevant laws and statutory frameworks involved with covert recordings in legal proceedings – including, the covert recording of children, professionals, and other family members.*
- *Explores the consequences and potential issues that may arise from the use of covert recordings in family law proceedings and provides guidance to promote consistency in the approach to these recordings.*
- *Emphasises the need for more guidance across professional bodies and organisations regarding the use of covert recordings in legal proceedings in the family justice system.*
- *Analyses key considerations of the courts when assessing covert recordings in legal proceedings, such as the authenticity and completeness of the recording, probative value, and relevance to the case.*

MENTAL HEALTH MATTERS

Capacity in Tribunal proceedings

KH -v- Nottinghamshire Healthcare NHS Foundation Trust; AH -v- Avon & Wiltshire Mental Health Partnership NHS Trust (HM) [2025] UKUT 128 (AAC) (UTJ Church) [2]

The Upper Tribunal has given guidance on what a mental health tribunal must do when faced with a patient for whom a representative has been appointed under rule 11(7) but where there is a conflict on whether or not the patient has regained capacity to appoint a representative or there is a dispute/refusal of engagement with the said representative.

In both KH and AH's cases, a legal representative had been appointed but there was an issue regarding capacity or engagement. KH, a restricted patient with convictions of manslaughter and attempted murder, refused to engage with the representative but the representative continued to act in his best interests. AH, also a restricted patient, was also found to lack capacity to *"make the decisions required of him in the context of his involvement in the proceedings"* [37] but the tribunal considered the involvement of a representative against his will would be contrary to his best interests such that the representative was discharged. In light of the far-reaching nature of the issues, the Law Society was joined into proceedings as an Interested Party.

Summing up the law, UTJ Church recorded that *'[t]he proper approach to assessing mental capacity as established at common law and confirmed in the MCA 2005 is set out by the Supreme Court in Dunhill v Burgin (Nos 1 and 2) [2014] UKSC 18, [2014] 1 WLR 933 at §13).'* [44] In the context of assessing capacity to conduct proceedings before a mental health tribunal, the test is that set out by Charles J in YA v Central and North West London NHS Trust [2015] UKUT 37: *"The identification of the specific decision, issue or activity that is the subject of the capacity assessment is important because it identifies the matters that have to be sufficiently understood, taken into account and weighed by the decision maker."*

> *47…there are three principal matters that are relevant to patients involved in mental health proceedings:*
>
> *a. the initial decision of whether to make an application to the tribunal;*
> *b. once an application or referral has been made, the decision whether to appoint a representative, or to conduct their own case; and*
> c. *conducting the proceedings, whether in person or through a representative…*
>
> *51. The power to appoint a representative under rule 11(7) Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 is discretionary ("the Tribunal may", not "shall" or "must"). Whenever a tribunal considers exercising its discretion under rule 11(7) it must ask itself three questions:*
>
> *a. whether the patient lacks capacity to appoint a representative (the first limb of rule 11(7)(b));*
> *b. the second question depends on the answer to the first question in a. above:*
> *i. if the answer to a. is "yes", it must then ask whether it is in the patient's best interests to be represented (the second limb of rule 11(7)(b)).*
> *ii. if the answer is "no", then the tribunal must consider instead whether to make an appointment under rule 11(7)(a), which is available only if the patient has stated that they do not wish to conduct their own case or they wish to be represented; and*
> *c. whether the discretion should be exercised in favour of the appointment (the first sentence in rule 11(7))*

[2] Neil Allen, having acted in this case, has not been involved in writing this report.

As per Charles J in *YA,* capacity "to appoint" a representative and capacity to conduct proceedings are "inextricably linked" and the distinction between them can be "theoretical rather than real" (see *YA* §57-60). When assessing capacity to appoint a representative (and to conduct proceedings), the nature of the proceedings and the demands they make on participants must be considered: *"Capacity to appoint a representative" may, therefore, include "capacity to conduct proceedings"* [55].

As UTJ Church observes at [55], given the equivalence of capacity to appoint a representative and capacity to conduct proceedings, *"the Tribunal Procedure Committee may wish to consider amending the HESC Rules to make this explicit"* [55]. At paragraphs [56] to [82], UTJ Church gives detailed guidance on (a) when to assess capacity (ideally at an early case management stage but ultimately this may be done on the day of the hearing), (b) the implications for a Rule 11(7)(b) appointment of fluctuating capacity – *"the appointment continues unless and until the representative is discharged from the appointment by the tribunal"* [61]; where possible, a decision may be delayed until capacity is regained [62]; (c) the duties of the representative, (d) the nature of the capacity assessment to be undertaken and (e) the duties of the rule 11(7)(b) representative who considers their appointment not to be in the patient's best interests or to be otherwise inappropriate. Particular interest should be given to UTJ's observations at paragraph 80-82:

> *80….In principle, a patient would benefit from being represented at a tribunal hearing. In practice, however, if the patient has no trust in a representative imposed on him or her by the tribunal and is not willing to co-operate or engage with the representative, the theoretical advantages of representation will clearly not be realised. The situation risks resulting in a representative unable to represent and a patient who is unable to participate. That is inimical to the objective of rule 11(7)(b), and inimical to the overriding objective of the tribunal.*
>
> *81. If the representative considers that their continued appointment is not in the best interests of the patient, they should make submissions to the tribunal, identifying their reasons why. If, conversely, the representative considers that their appointment is in the patient's best interests, despite the patient's objecting to it, the representative should set out why they take that view and also set out the patient's reasons for taking the contrary view.*
>
> *82. In any case where a tribunal is making a determination of capacity to appoint a representative or to conduct proceedings, or is deciding whether the continued appointment of a representative is in the best interests of an incapacitous patient, it must give clear reasons for what it decides. These should address each of the three preconditional decisions required for exercise of the rule 11(7)(b) discretion identified in paragraph 51 above.*

As UTJ Church observed at [98], a finding of a lack of capacity to appoint a rule 11(7)(b) does not lead inevitably to a conclusion that one should be appointed in the patient's best interests in any event:

> *98. The discretion under rule 11(7)(b) about whether the patient should be represented applies even where the tribunal has concluded that representation would be in the patient's best interests. That might seem like an odd provision to anyone not familiar with mental health tribunals, but not to those who have participated in them. Those who have participated in hearings before the mental health tribunal will appreciate that hearings are not just about whether the patient will achieve discharge or a statutory or extra-statutory recommendation: often it is more about being seen and heard, and being afforded an opportunity of agency. That right might be less obvious than the right to liberty, but its importance should not be underestimated to someone who finds him or herself detained, especially if they are thought to have a delusional disorder, and especially if they do not agree with their diagnosis.*

Comment

We consider that the wording of paragraph 98 could be, respectfully, better formulated. Clearly, the jurisdiction of the MHT is different from that of the COP so that it is not bound to act only in a patient's best interests. That said, the implications of paragraph 98 are clear and, self-evidently, correct: whether or not it might be in a patient's best interests to have representation generally, the case management decision must include a broader reflection on whether or not it is in their best interests to have representation forced upon them in circumstances where they are vehemently opposed to it.

Calocane inquiry: Questions to be asked

The questions to be asked by the Calocane Inquiry have been published, which include a set around capacity. The questions are non-exhaustive, and include consideration of:

- Information-sharing between public bodies which encountered Valdo Calocane, including the police;
- Valdo Calocane's discharges from primary and secondary mental health services and consideration of risk;
- Missed opportunities for action, both in the long-term and on the night of the murders;
- Data breaches on sharing of sensitive information;
- Consideration of detaining Valdo Calocane under the MHA;
- Whether 'lack of compliance on medication taken into account and the potential for a Community Treatment Order ("CTO") considered' and '[w]hat aftercare services were provided?'
- Whether Valdo Calocane's *'capacity to make decisions about his care and medicine regime considered? Was insight or lack of insight considered in relation to capacity to make such decisions? If so, when and what criteria were used? Would assessment of capacity under the regime of the Mental Capacity Act 2005 have provided alternative approaches to ensuring compliance with medication?'*
- The adequacy and appropriateness of Valdo Calocane's care and treatment;
- Further measures which could be taken to improve multi-agency working, including any legal barriers to improvement.

CHILDREN'S CAPACITY

Deprivation of liberty and children: considering all of the options before invoking the inherent jurisdiction

A Local Authority v LB & Ors [2025] EWHC 1264 (Fam) (David Lock KC, sitting as a DHCJ)

Article 5 ECHR – Children and young persons

Summary

The local authority sought continuation of an order to authorise the deprivation of liberty of a 15 year old under a care order in a placement. She wanted to return to live with her mother.

(i) Exploring s.25 accommodation

Rather than considering whether LB met the criteria for a secure accommodation order under s.25 Children Act 1989, and if so whether such accommodation was available, the local authority applied under the inherent jurisdiction. DHCJ Lock held:

> *12. I consider that, consistent with the approach taken by the Supreme Court in Re T, s25 accommodation and DOLS orders should not be seen as alternatives to be used by local authorities at their option. Where a child could be accommodated in secure accommodation under the s25 route, that option should be used where available. Use of the inherent jurisdiction should thus be limited to cases where a local authority provides clear evidence to explain why the s25 statutory framework, with its protections for the child, has not been used.*

(ii) Permission for inherent jurisdiction

Permission to invoke the inherent jurisdiction requires, inter alia, *"reasonable cause to believe that if the court's inherent jurisdiction is not exercised with respect to the child he is likely to suffer significant harm"*: s100(4) Children Act 1989. In this case there was no evidence of any such harm when she previously went back to live with her mother:

> *16 … I consider that evidence has to provided which allows the court to confidently conclude that the child is "likely to suffer significant harm" on the facts of a case. It is not sufficient for the court to be provided with general concerns about the parents or even the risks to which the child would be exposed if she were to return home because the court needs to be satisfied, bearing in mind the test in s31(10) of the Children Act 1989, if any harm is likely to be significant.*

The court adjourned the application for the social workers to provide further evidence on the statutory test.

(iii) Grounds for detention

Article 5(1)(d) ECHR permits *"the detention of a minor by lawful order for the purpose of educational supervision"*. On the other hand, the local authority accepted that, at least to date, the basis relied upon was a welfare reason and, as the court decided, *"depriving a child of their liberty for pure welfare reasons or to prevent a child absconding could not come within article 5(1)"* (para 20). After discussing the relevant ECtHR and domestic case law on educational supervision, DHCJ Lock held:

> *25. I fully accept that the term "educational supervision" in article 5(1) has to be widely interpreted and is far wider than formal classroom based education. However, whilst educational supervision encompasses a wide concept, in my judgment it cannot be wholly equated with a child's welfare and restrictions and a deprivation of liberty cannot be justified under this part of the convention primarily to prevent a child absconding. A Local Authority is fully entitled to advance a case to say that a child has been accommodated in a specific placement where the purpose of the placement is to provide educational support to the child across a wide range of life skills and to*

> *show that sufficient resources have been allocated to the placement so as to ensure that the education is a central focus of the placement. As part of that case, it could show that appropriate trained staff have been allocated so as to ensure that this educational provision is delivered. It is also open to a Local Authority to provide evidence to show that (a) in the particular circumstances of the case, this educational support can only be delivered to the child if the child is subject to restrictions on his or her liberty, (b) that those restrictions amount to a deprivation of the child's liberty and (c) that this is both necessary and proportionate. However, absent such evidence, I do not see how a court could properly conclude in a case like the present that the matter comes within article 5(1)(d) as interpreted by the ECtHR in the various cases set out above.*

Given the lack of evidence justifying it, there could be no authorisation to deprive liberty on this ground, and the case was adjourned for two weeks for further evidence.

Comment

This case makes clear that "best interests" or "welfare reasons" cannot justify a child's deprivation of liberty under Article 5(1). It emphasises the importance of applying one's social work mind to the statutory scheme in s.25 first, before contemplating recourse to the inherent jurisdiction. And, if permission is granted, it helpfully sets out the educational evidence required if detention on the grounds of educational supervision is to be made out.

THE WIDER CONTEXT

Litigation capacity – and what happens if you never had it?

Johnston v Financial Ombudsman Service [2025] EWCA Civ 551 (Asplin LJ, Coulson LJ, Baker LJ)

Johnston v Financial Ombudsman Service [2025] EWCA Civ 551 is a case with a particularly complicated procedural history, but for present purposes the critical questions for the Court of Appeal were: (1) whether Mr Johnston lacked litigation capacity at the material times; and (2) whether, if he did lack that capacity, he could have brought proceedings against the Financial Ombudsman Service at all.

In relation to the first question, Baker LJ gave a very helpful recap of the law relating to litigation capacity / capacity to conduct proceedings as it stands in light of the decision of the Supreme Court in *A Local Authority v JB* [2021] UKSC 52, [2022] AC 1322, with its focus on (1) starting with identifying the decision, and the relevant information; and (2) only if the person is unable to understand / retain / use and weigh the relevant information or communicate their decision, moving on to ask why. He continued:

> *39. There are three further relevant general principles, identified in my judgment in A Local Authority v P [2018] EWCOP 10at paragraph 15, cited by Lewis LJ in his judgment in Cannon v Bar Standards Board [2023] EWCA Civ 278 (considered below).*
>
> *First:*
>
> > *"Capacity is both issue-specific and time-specific. A person may have capacity in respect of certain matters but not in relation to other matters. Equally, a person may have capacity at one time and not at another. The question is whether at the date on which the court is considering the question the person lacks capacity in question."*
>
> *Secondly,*
>
> > *"In assessing the question of capacity, the court must consider all the relevant evidence. Clearly, the opinion of an independently instructed expert will be likely to be of very considerable importance, but as Charles J observed in A County Council v KD and L [2005] EWHC 144 (Fam) [2005] 1 FLR 851 at paras 39 and 44, "it is important to remember (i) that the roles of the court and the expert are distinct and (ii) it is the court that is in the position to weigh the expert evidence against its findings on the other evidence… the judge must always remember that he or she is the person who makes the final decision."*
>
> *Thirdly,*
>
> > *"The court must avoid the "protection imperative" – the danger that the court, that all professionals involved with treating and helping P, may feel drawn towards an outcome that is more protective of her and fail to carry out an assessment of capacity that is detached and objective: CC v KK [2012] EWHC 2136 (COP)."*
>
> *40. Prior to the implementation of the MCA 2005, the leading common law authority on capacity to conduct proceedings was Masterman-Lister v Brutton and Co and another[2002] EWCA Civ 1889 in which Chadwick LJ said, at paragraph 75:*
>
> > *"For the purposes of … CPR 21 – the test to be applied, as it seems to me, is whether the party to legal proceedings is capable of understanding, with the assistance of such proper explanation from legal advisers and experts in other disciplines as the case may require, the issues on which his consent or*

> *decision is likely to be necessary in the course of those proceedings. If he has capacity to understand that which he needs to understand in order to pursue or defend a claim, I can see no reason why the law – whether substantive or procedural – should require the interposition of a next friend or guardian ad litem (or, as such a person is now described in the Civil Procedure Rules, a litigation friend)."*

41. An example of the application of the MCA 2005 principles to a decision whether a person lacks capacity to conduct litigation is the judgment of Burnett J (as he then was) in V v R [2011] EWHC 822 (QB). Having set out the statutory provisions, the judge said (at paragraph 10):

> *"It is common ground in these proceedings that the claimant suffers from an impairment or disturbance in the functioning of the mind or brain. The question is whether she is unable to make decisions for herself in connection with the litigation. In considering that broad question, the statutory scheme requires the presumption of capacity to be displaced on the balance of probabilities. The principles in section 1 distinguish capacity to make a decision from the wisdom of a decision made. The principles also require that all practicable steps are taken to help the person concerned make the relevant decision. The underlying policy of the Act is to avoid concluding that incapacity is established unless, after careful enquiry, it is necessary to do so. That is underpinned by the various cautions found in the Act relating to age, appearance and behaviour, by the requirement to convey information in a way appropriate to the individual's circumstances, and by the recognition that retention of information for but a short period may be sufficient for the purposes of establishing capacity. The underlying policy of the Act is unsurprising and reflects the earlier common law approach very substantially, given that the finding of incapacity in any environment substantially curtails the individual's right of action. In the context of litigation, a finding of incapacity curtails the right of unimpeded access to the law."*

42. In that case, having carefully considered the medical and other evidence, Burnett J concluded (paragraph 34) that the claimant had "difficulties rather than a straightforward inability to weigh the evidence and make relevant decisions". He concluded that those difficulties were "capable of being ameliorated, if not entirely overcome, by the careful and structured support that the statute contemplates". In those circumstances, he was not satisfied on the balance of probabilities, that the claimant was unable to use and weigh information as part of the process of making litigation decisions. He therefore refused the application for a declaration that she lacked capacity to conduct the litigation.

43. In this case, the Court is considering Mr Johnston's capacity over a number of years. In Public Guardian v RI and Others [2022] EWCOP 22, a case concerning a donor's capacity to execute a lasting power of attorney, Poole J observed (at paragraph 27): "… Ideally, where there is a dispute about past capacity which the court is required to determine, it would be helpful to have evidence as to,

1. *The certificate provider's experience …*
2. *Evidence from carers and family members …*
3. *Medical evidence, capacity assessments, assessments for benefits, records from carers or activity centres, or other professional*

evidence roughly contemporaneous with the relevant date …

4. *An assessment by a suitably qualified and experienced person of P's current capacity and reasoned opinion as to their capacity … at the relevant time, such opinion being informed by review of relevant medical records, contemporaneous assessments, and the evidence from carers and family members."*
5.

44. In Cannon v Bar Standards Board [2023] EWCA Civ 278, the appellant sought to appeal against findings of a professional disciplinary tribunal, contending amongst other grounds that she lacked capacity to conduct litigation at the time of the tribunal proceedings. Lewis LJ, in a judgment with which the rest of the Court agreed, noted (at paragraph 25) that the psychiatric reports on which the appellant relied did not address the test, or all the relevant factors, for assessing capacity, that the psychiatrist had access to some but not all of the appellant's medical records, and had not addressed the various actions the appellant had undertaken in relation to the disciplinary proceedings in order to consider whether she was able to understand, retain use, or weigh the relevant information. The psychiatrist's opinion amounted simply to an assertion that because the appellant had post-traumatic stress disorder, she lacked capacity. Lewis LJ concluded (paragraph 27) that the medical evidence did "not itself provide a proper evidential basis for rebutting the presumption that the appellant had capacity to take the decisions necessary to enable her to participate" in the proceedings. He added, at paragraph 34, that there was a difference between questions of capacity and the fairness of proceedings and that a party may have vulnerabilities arising from underlying mental health conditions which required adjustments to ensure that proceedings are fair. In that case, however, there had been no challenge to the fairness of the proceedings before the tribunal.

Baker LJ was not impressed with the evidence put before the Court of Appeal concerning Mr Johnston's litigation capacity. The evidence was put forward by a consultant psychiatrist, Dr Attavar, who also signed a certificate that he had lacked capacity to conduct proceedings since 2010. Baker LJ was "wholly unpersuaded" (paragraph 58) that this was the case.

59. There are a number of deficiencies and difficulties in the evidence about capacity presented to this Court. A preliminary point is that none of the reports complies fully with the requirements for expert evidence in CPR rule 35.10 and Practice Direction 35. In addition, and more importantly, there are deficiencies in the evidence of Dr Attavar on which Mr Johnston relies to rebut the presumption of capacity. As Ms Morris KC pointed out on behalf of the FOS, these deficiencies are similar to those identified in Cannon v Bar Standards Board. In some respects, they are even more substantial.

60. First, there are deficiencies in the manner in which Dr Attavar was instructed to conduct the assessment. As Ms Morris pointed out, there is no letter of instruction either for the report produced in July 2023 or for the certificate signed in September 2023. Furthermore, it seems from the July report that Dr Attavar only had access to some of the relevant medical records. There is nothing in the September certificate to suggest that, before signing the certificate, he had an opportunity for a comprehensive review of the records recommended by Poole J in Public Guardian v RI and Others.

61. Secondly, the certificate signed by Dr Attavar failed to identify at all the proceedings in respect of which he was certifying that Mr Johnston lacked capacity. Mr Johnston has engaged in a number of proceedings – according to Dr Rao's September report, he spoke of being involved in sixteen court cases. The question of capacity to conduct proceedings depends in part on the proceedings involved. Whether or not a litigant is able to understand, retain,

and use or weigh the information relevant to the decision may vary depending on the decision and the information involved. Dr Attavar's certificate does not identify which of the various cases in which Mr Johnston was apparently involved is covered by the certificate.

62. Thirdly, the certificate does not explain how Mr Johnston's mental disorders affected his capacity to understand, retain, and use or weigh the information so as to leave him unable to make decisions and conduct the proceedings. Some of the comments in the certificate amount to no more than a repetition of the diagnosis with no or no sufficient explanation of how the disorders affect his abilities. Indeed, it is unclear from the certificate whether Dr Attavar was in fact saying that Mr Johnston was unable to understand, retain, and use or weigh the information. In some respects, the text inserted in the boxes in Part 2 suggested that his abilities depended on whether he was supported and provided with reasonable adjustments.

63. Fourthly, the certificate referred to the earlier report prepared a few weeks prior to the certificate in July 2023. The conclusion in that report, however, was that, whilst Mr Johnston did not have capacity to conduct legal proceedings by himself without a legal representative, he did have the capacity to instruct a lawyer to act for him in his legal affairs.

64. Fifthly, the bald assertion in the certificate that Mr Johnston has been unable to conduct litigation since 2010 was unsupported by any analysis or explanation. An assertion that he had lacked capacity for thirteen years required some explanation, by reference to the evidence considered by Dr Attavar who had not met Mr Johnston before July 2023. The certificate contained no such explanation, and the July letter to which it referred contained only a brief summary of extracts from the medical records which had been supplied by Mr Johnston himself. There was, for example, no reference to anything between 2010 and 2016. In those circumstances, it is difficult to understand how Dr Attavar was able to say that Mr Johnston had lacked capacity since 2010.

Dr Attavar's opinion was also not supported by the subsequent opinion of another consultant psychiatrist, a Dr Rao:

65. […] *Less than three weeks after Dr Attavar saw Mr Johnston and signed a certificate that he lacked capacity to conduct unspecified proceedings and had done so since 2010, Dr Rao assessed him and concluded that he needed "reasonable adjustments … in the form of clear verbal communication and allowing him sufficient time to understand while sending written material." It is true that Dr Rao was not at that stage asked to assess his capacity, but there is nothing in his report to support Dr Attavar's conclusion. In March 2024, Dr Rao conducted a capacity assessment and reached the clear conclusion that Mr Johnston did not lack capacity to conduct any of the various proceedings in which he was engaged. It was Dr Rao's view that Mr Johnston needed a range of reasonable adjustments which he spelt out in his report, but not that he lacked capacity. In my view, Dr Rao's clear and well-presented opinion is to be preferred to the opinion expressed by Dr Attavar.*

As Baker LJ reminded himself:

66. The presumption of capacity is a fundamental principle in our law. As Burnett J observed in V v R, "the underlying policy of the Act is to avoid concluding that incapacity is established unless, after careful enquiry, it is necessary to do so". Furthermore, "in the context of litigation, a finding of incapacity curtails the right of unimpeded access to the law" – a further fundamental principle. The evidence adduced on this appeal comes nowhere near rebutting the presumption.

67. Accordingly, I conclude that Mr Johnston has failed to prove that he lacked capacity at

any stage in these proceedings. He was therefore not a "protected party" under CPR rule 21.1. I would therefore dismiss the appeal on the ground for which permission has been granted.

As to the second question, Baker LJ noted that, had Mr Johnston made out his case that he lacked capacity to conduct proceedings since 2010:

> *57.* […] *the effect would in fact be more far reaching than contended for by Mr Matovu. For under CPR rule 21.3(4), "any step taken before a… protected party has a litigation friend has no effect unless the court orders otherwise". If Mr Johnston lacked capacity for the period of 13 years asserted by Dr Attavar, he had no capacity to start the proceedings against the FOS when he filed the claim in December 2020, with the result that every step in the proceedings from the filing of the claim onwards would have no effect unless the court ordered otherwise. No application has been made for the court to make such an order.*

Coulson LJ gave a short concurring judgment:

> *79. One of the oddities of this case is that, unlike all the authorities to which we were referred, this was a situation where a claimant – not a defendant – sought to argue that he did not have capacity during the relevant period. Since, on his case, that period extended back to 2010, the effect of his argument appeared to be that not only the intervening court orders, but the entire proceedings (which he started), were a nullity. Mr Matovu appeared to accept that point during the course of argument.*
>
> *80. Entirely properly, Ms Morris KC, on behalf of the respondent, drew our attention to CPR 21.3. That provides:*
>
> > *"21.3.*
> > *(1) This rule does not apply where the court has made an order under rule 21.2(3).*
> > *(2) A person may not, without the court's permission —*
> > *(a)make an application against a child or protected party before proceedings have started; or*
> > *(b)take any step in proceedings except—*
> > > *(i)issuing and serving a claim form; or*
> > > *(ii)applying for the appointment of a litigation friend under rule 21.6, until the child or protected party has a litigation friend."*
>
> *81. Ms Morris said that, on one reading of r.21.3(2)(b)(i), a person who did not have capacity could commence proceedings by issuing a claim form, even if the lack of capacity invalidated all the subsequent court orders.*
>
> *82. I do not agree with that interpretation of the rule. In my judgment, r.21.3(2) is concerned with the position where a child or protected party is a defendant. It is designed to give the child or protected party proper protection once they have been served with a claim form. The first two sub-rules of r.21.3 are not concerned with the position where a party without capacity wishes to bring a claim in their own name. I note that, at paragraph 21.3.1, the learned editors of this part of the White Book take the same view as to the scope of the rule.*
>
> *83. That must also be right as a matter of common sense. A child of 8 does not have capacity, so could not validly commence proceedings on his or her own. Furthermore, if a lack of capacity invalidates orders made by a court at a time when it was not appreciated that the party in question did not have capacity, then it would be absurd if the same rule did not apply to the commencement of the proceedings themselves, if those proceedings had been commenced by somebody who lacked capacity.*

In her two sentence concurring judgment, Asplin LJ expressly identified her agreement with Coulson LJ's interpretation of CPR Part 21.

Comment
The review of the law relating to capacity to conduct proceedings (or litigation capacity as it is often called) by Baker LJ is extremely useful as a stock take. The – detailed – dissection of the failings of the evidence put forward to support Mr Johnston's incapacity is also very helpful as a case-study in what not to do, both in terms of the process of assessment, and in terms of writing it up (in which regard, more broadly, it may be useful to see our updated guidance note).

In terms of the construction of CPR r.21.3, Coulson LJ's construction must be correct, but it does reinforce what very practical problems can stand in the way of a person with impaired decision-making capacity seeking to bring proceedings. There is clearly a balance to be struck, but Strasbourg has recently reinforced how vital it is to make sure that the impairment of decision-making capacity should not stand as an improper bar to access to justice. If and when further steps are taken (as I hope that they will) to respond to the report of the Civil Justice Council on The Procedure for Determining Mental Capacity in Civil Proceedings, I would very much hope that thought can be given about whether CPR r.21.3 strikes the right balance.

Get Me to Hospital

SCIE has published Get me to hospital: When and how to use the Mental Capacity Act to convey a person to hospital for physical health treatment, a very helpful toolkit (with the help of Tor, Nicola and Alex) of resources *'for individuals with a cognitive impairment and that may draw on care and support, their families and health and social care practitioners. It may be used to forward plan and help in situations when an individual may need conveyance to hospital.'* The summary states:

> *This guide originated from evidence which demonstrates that practitioners struggle to make these decisions and focuses on issues of supporting people under the Mental Capacity Act (MCA), not the Mental Health Act – who are assessed as unable to make their own decision to be conveyed to hospital for physical treatment, and require a decision to be made, in their best interests.*
> *The focus of this guide is to support both the individual when they are at the centre of decisions relating to conveyance to hospital, and the practitioner responsible for arranging, or undertaking, conveyance of the individual. It also looks to address potential health inequalities where individuals have been known to die from preventable conditions because professionals have not used the MCA, correctly.*

Palliative Care Commission

The Palliative Care Commission has been established to consider a range of issues:

> *The Commission's work aims to produce recommendations for solutions to the current difficulties and gaps in access to high-quality palliative care that can meet the extensive range of needs of our diverse population in all areas of the UK. The evidence we receive will be carefully read and analysed, as will evidence heard from witnesses and roundtable meetings. Commissioners are not there to represent their own organisation, but to take a broad overview to find ways forward that can feed into the ten-year plan.*
>
> *Following the analysis of research and evidence gathered by the Commission, a report will be written to present to the Secretary of State for Health and Social Care, Members of the Houses of Commons and Lords, and service commissioners, and will be available for providers, clinicians and the public.*

Guidance to support implementation of the Mental Capacity Act in acute trusts for adults with a learning disability

In what may be one of its last such documents, NHS England has published Guidance to support implementation of the Mental Capacity Act in acute

trusts for adults with a learning disability. The Guidance states:

> *This guidance support trusts and community providers to enable front line staff to fulfil their legal requirements around the Mental Capacity Act (MCA) 2005; specifically when supporting people with a learning disability.*
>
> *A Health Services Safety Investigations Body report in 2023 on the care of acute hospital inpatients with a learning disability in England, found variation in staff understanding and application of the MCA in the care of people with a learning disability.*
>
> *Trusts leadership are asked to ensure they understand the guidance, take the actions indicated and make these resources available to all frontline staff.*
>
> *To make this guidance as useful as possible for trusts and clinicians, we provide practical tools and resources that can be downloaded:*
>
> - *a flowchart to help you decide how to assess capacity*
> - *a checklist for preparing to assess the mental capacity of someone with a learning disability*
> - *advice on how to undertake the 2-stage test for mental capacity*
> - *reasonable adjustments that can support assessment of capacity of people with a learning disability*
> - *template forms for recording mental capacity assessment and best interests decision including balance tables*
> - *a poster about Mental Capacity Act assessments*
>
> *This guidance supports and complements NICE guidance on decision-making and capacity assessment.*

An International Comparison of Psychiatric Advance Directive Policy: Across eleven jurisdictions and alongside advance directive policy

In the context of the start of the Public Bill Committee stage of the Mental Health Bill in the Westminster Parliament, some may be interested to see this article which has just appeared and to which Alex contributed: An International Comparison of Psychiatric Advance Directive Policy: Across eleven jurisdictions and alongside advance directive policy. As the abstract puts it:

> *The present work provides a comparative policy review of psychiatric advance directives, considering 1) variation across eleven international jurisdictions and 2) differentiation from other advance directive policy. The aim is to support well-founded legal and clinical practice when it comes to psychiatric advance directives by 1) clarifying the range of present approaches and 2) highlighting differential treatment of those with mental health conditions. Applicable statutes in England and Wales; Germany; India; the Netherlands; New South Wales (Australia), Northern Ireland, Virginia (USA); Washington (USA); Switzerland; Scotland; and Victoria (Australia) were reviewed by a team with expertise in law, clinical practice, and ethics. Policy variations were identified related to requirements for validity, activation, amendment, revocation, and override of preferences expressed. Psychiatric advance directives tend to be more strictly regulated and have less legal force than medical advance directives, with more restrictive guidelines and more conditions allowing advance preferences to be overridden. Psychiatric advance directives also tend to be less uniform across jurisdictions, sometimes reflecting varied functions of the directive and sometimes suggesting varied framing of the appropriateness of coercion in psychiatric care. More work is needed to evaluate the validity of distinct psychiatric advance directive policy. Stricter regulation and weaker legal force can serve as barriers to*

use, and coercion carries associated harms; psychiatric advance directive policy, especially choices that differ from other advance directive policy, should be well-justified.

Dr Margaret Flynn reappointed as chair of the National Mental Capacity Forum

Our warm congratulations to Dr Margaret Flynn reappointment for a further three-year term as the chair of the National Mental Capacity Forum.

Book review

An Introduction to Health and Welfare Disputes involving High Net Worth Individuals, Ian Brownhill (Law Brief Publishing, 2025, 80 pp, paperback, £49.99)

"All happy families are alike; each unhappy family is unhappy in its own way" (Leo Tolstoy, Anna Karenina).

Some of the most difficult and intractable cases I am involved in as a practising barrister are those engaging welfare issues relating to high net worth individuals. All too often such cases involve families (and 'significant others') who feel that, because they are not beholden to either the NHS or local authorities to provide care and treatment for P, they can opt-out of the Mental Capacity Act 2005 as well. They can also all too often involve the working out of complex and messy family dynamics through the prism of P – with, often, lurking in the background views about P's assets.

My Chambers colleague, Ian Brownhill, has done more than his fair share of such cases, and his new book is a very practical and grounded reminder that the Mental Capacity Act 2005 applies equally to all (even if, frequently, the options that may exist for those with more resources are greater). In ten crisp chapters, he addresses such thorny issues as the (very limited) scope of property and affairs deputies to make welfare decisions, the approach to privately funded medical treatment (including cosmetic procedures), deprivation of liberty (often an issue overlooked when the cage is particularly glittering), predatory marriages, and the breakdown of relationships. In brief, but very wise compass, he provides a powerful tool for ensuring that the particular unhappinesses which can be found in the families of high net worth individuals are resolved in ways which do not lose sight of the interests of P.

Alex Ruck Keene

Book review

Wards of Court and the Inherent Jurisdiction Rob George *(Hart, 2024, 293 pp, hardback, £90, ebook free)*

I have spent quite a bit of time with the wet towel around my head recently working out precisely how the recent Supreme Court decision in *Abbasi & Haastrup* translates across to the Court of Protection (for some thoughts with Hannah Taylor of Bevan Brittan, see here). Part of our discussions revolved around whether the reliance placed by the Supreme Court upon the *parens patriae* jurisdiction to justify the orders made providing for anonymity of clinicians in serious medical treatment cases translated across to the situation where the Court of Protection is considered such cases involving adults with impaired decision-making capacity. In this context, I reminded myself that I had yet to review the book published by Professor Rob George (now KC) last year on the strange history of the inherent jurisdiction in relation to children and adults. So, with apologies that it is slightly overdue, here it is.

The first thing to note about the book is that it is available for free in electronic form here, which is hugely to the credit of all those involved, because it is a book which deserves to be read very widely.

The second thing to note is that it comes with a foreword from Baroness Hale which strongly endorses the central – and very challenging –

message of the book, namely that the High Court's inherent jurisdiction is being used improperly. Both George and Baroness Hale reserve some of their strongest criticisms for the use of the inherent jurisdiction in two particularly controversial areas:

- In relation to the deprivation of liberty of children, Baroness Hale noting her view that: "[t]his flies in the face of the statutory scheme [set out in s.25 Children Act 1989] and may well violate article 5 of the European Convention on Human Rights because the power to do this is not sufficiently precise to be 'in accordance with the law'. Perhaps worse, it lets the government off the hook for their failure to provide adequate placements for some very troubled children."[1]
- In relation to the adults who have capacity but are in some way vulnerable. Baroness Hale describes this as the "bare-faced invention of a jurisdiction which does not exist," and goes on note her view that "Parliament deliberately decided not to enact a limited protective scheme, preserving the autonomy of the person concerned, which the Law Commission had proposed in 1995."

Taking these together, she goes on to wonder whether she:

had wasted most of my time at the Law Commission – helping to devise carefully thought-out schemes for the care and upbringing of children and for decision-making on behalf of adults unable to make decisions for themselves. I well remember how controversial our recommendations for strictly limited emergency protection for adults who did not lack capacity were within the Commission. Of course, the great majority of cases are dealt with under those statutory schemes, which were certainly necessary. But what is the point of devising principles, criteria and limits if the High Court can simply ignore them? Is the undoubted wisdom and goodwill of the High Court Judges a good enough excuse.

There is a huge amount packed into the nearly 300 pages of the book, which benefits hugely from the author's portfolio career as both a practising barrister and a Professor of Law and Policy at University College London.

Right from the outset, it is notable for the clarity both of thought and of exposition – the discussion of what, exactly, the concept of the court's inherent jurisdiction means in the introductory chapter is a model of lucidity. It then gives a fascinating history of how the courts have shaped the "great safety net" of the inherent jurisdiction over time in relation, before turning to set out the principles, the procedure (in children's cases – as he notes later in the book, the procedure in relation to adults is still remarkably murky), and examine how some other common law jurisdictions have used it (spoiler alert – very sparingly).

Having laid the groundwork, it is in Part II that George really starts to move onto the offensive, challenging not just how it is used, but in some cases whether it is even legitimate to use it, in relation to a range of specific areas.

Each of these chapters merits careful reading by those who are asked both to argue and to determine cases falling with their scope, but for present purposes I want to focus on Chapter 14, "Vulnerable Adults with Mental Capacity." Of particular assistance here is the way in which George places matters in a historical perspective (relying in significant part upon, but at a number of points critiquing, Sir James Munby). I anticipate that many who have got this far in the review might have been scratching their heads as to what Baroness Hale was talking about by reference to the Law Commission's work in the 1990s, and what that could have to do with this issue, as most people now only remember it for leading to the MCA 2005 – i.e. a jurisdiction over those lacking material decision-making capacity. What George reminds is that there was a whole part of its Mental Incapacity report which was specifically addressed to public law protections of "vulnerable adults." Those recommendations were not enacted. George, along Baroness Hale, takes the view that this represented a "clear policy decision not to legislate in relation to vulnerable, capacitous adults – as David Lock puts it, it was 'deliberately left out' of the Mental Capacity Act 2005 ('MCA 2005') scheme" (page 201).[2] Further, as George suggests "[i]t has no historical basis – as

recently as 2003, the authorities were categorically against there being such a jurisdiction. As Hewson noted, '[a] perceived need for a remedy does not thereby endow judges with power, however worthy their motives', and some of the authorities deployed in support are used in a positively misleading way, cited to support points in direct opposition to their ratio" (page 223). His conclusion is damning:

The jurisdiction in relation to vulnerable adults is the archetypal example of the protective imperative in action – and of the dangers of this 'intuitively appealing' approach. The subjects of the applications are invariably in sympathetic situations, where human instinct is to want to help – but from this desire to protect, the court has created an entire jurisdiction with no clear definition as to who may be subject to it, no established principles, no predictability of application, and no safeguards. While potentially well-meaning, it is dangerous and constitutionally inappropriate: it should be 'no function of the courts to legislate in a new field' in this way. If there is to be such a jurisdiction, it should come from Parliament. There should be a clear structure; those who fall within its scope should be known and predictable; coherent principles must exist addressing how the powers can be exercised; and limitations on the court's powers should be expressly stated (including P's right of veto). These requirements are ill-suited to development by the judiciary from scratch, as the existing state of the law demonstrates.

Some of the most difficult questions I get asked wearing my hat as a practising barrister are as to whether and when the inherent jurisdiction can be used in relation to an adult understood to have capacity but to be vulnerable (my attempt along with others in my Chambers to give some guidance can be found here). But Baroness Hale's ringing endorsement of George's detailed critique might be thought to raise real questions about whether the exercise is even a legitimate one at all.

That is not to say that those judges who have taken the view that capacity is necessary but insufficient for the exercise of true autonomy (which lies at the heart of the invention of the jurisdiction) are wrong. We only need to see the debates about the Terminally Ill Adults (End of Life) Bill to recognise the truth of this (and the work of Kevin Ariyo has also really helped expand our understanding of interpersonal influence in the legal context). But this book might be thought to make more urgent the question of whether this is not a matter which not just *could* be thought about by Parliament, but *must* be thought about by Parliament.

I have focused on this part of the book because it is an area that I have found troubling for many years; others will no doubt focus in other parts and will either have their concerns reinforced or start spluttering that George must be wrong (and, in the process, will be helpfully forced to think precisely why that must be the case). Overall, therefore, this is indeed, as Baroness Hale says in her introduction, a "remarkable book."

[1] The book, current to June 2024, pre-dates the introduction of the Children's Wellbeing and Schools Bill, which may (through clause 11, expanding s.25 Children Act 1989), address Baroness Hale's concerns as to the procedural aspects, if not her concerns about the adequacy of provision.

[2] I have some considerable sympathy with this view, but the historical record is remarkably sparse for something quite so (relatively) recent – as George notes (at page 201), the "1997 consultation Green Paper stated that the government was 'not convinced that there is a pressing need for reform'. By the time of the White Paper, all mention of this part of the Commission's report had disappeared." It feels like quite a bit might lie between those two sentences.

Alex Ruck Keene

SCOTLAND

AWI reform into the long grass – but still rolling

In the May Report we explained that the First Minister was due to announce the 2025-2026 Programme for Government on 6th May 2025, after the May Report went to press. In May, we reported that it was anticipated that the First Minister would cover the Scottish Government's policy and legislative ambitions for the period until the parliamentary recess ahead of the elections to the Parliament on 6th May 2026. We suggested that while it was entirely for Ministers to decide what to include in the announcement, it might reasonably be anticipated that this would provide the First Minister with the opportunity to offer an update on the promised AWI Amendment Bill. We did cover the announcement on 2nd May 2025 by Maree Todd MSP, Minister for Social Care, Mental Wellbeing and Sport, that the promise by the First Minister in the Programme for Government for 2024-2025 to introduce an AWI Amendment Bill during this current session would not be fulfilled, but the Minister indicated her "expectation of bringing forward an Amendment Bill early in the next parliamentary term". In a massive understatement, she acknowledged that "this decision may be disappointing", but she did re-affirm her commitment "to modernising the legislation, to reflect international standards on human rights in particular", indicating that more time would be needed to get it right.

While her acknowledgement that her decision "may be disappointing" was a massive understatement, it has been equally massively overshadowed by the outrage caused by the First Minister's statement on 6th May. The major human rights issue facing Scottish Government has been, and is, the massive violation of basic human rights of people with relevant disabilities, coupled with the vast amounts of expensive professional and managerial time – almost all of it at direct or indirect costs to public funds – arising from unconscionable failures to implement increasingly urgent updates and reforms ever since the last updating in 2007, and throughout that period from failure to implement governments' clear obligation to make clear and efficient provision enabling deprivations of liberty to be effected lawfully. More shocking than anything that the First Minister might have said is that in fact, on these topics, he said absolutely nothing; creating the clear impression for many that the endemic discrimination against people with relevant disabilities, on which we have commented previously, has extended to these urgent needs dropping out of the consciousness of Scottish Ministers altogether, with the topic consigned into the long grass.

Such a conclusion, however, would have been inconsistent with the statement a few days earlier by Maree Todd, the Minister responsible, despite the curiosity that her title does not in any way encompass the topic of adult capacity/incapacity (remembering that responsibility for the original 2000 Act correctly rested with the Parliament's Justice Committee, with input from the Health Committee only in relation to Part 5).

In these circumstances, it is particularly helpful that Amy Stuart, Head of Mental Health and Incapacity Law, Scottish Government, has issued to me the following statement, with authority to share the points in it as I see helpful. It is also much appreciated that she was aware that I wished to use it in this Report, and cooperated to ensure that I had it ahead of the deadline for this Report. To make clear the distinction between the Scottish Government's position, and my comments in the light of it, I have given those two aspects separate headings.

The statement

1. *The Minister for Social Care, Mental Wellbeing and Sport confirmed to the Scottish Parliament on 2 May 2025 that*

that further work must be taken forward ahead of bringing forward an AWI Amendment Bill. In practice, this means that an AWI Bill will not be introduced this year as had been expected. I am aware that the Minister wrote to you directly on this matter, but the links below will also take you to a letter issued to relevant parliamentary committees and a written parliamentary question.

Adults with Incapacity (Scotland) Act 2000 | Scottish Parliament Website

Written question and answer: S6W-37425 | Scottish Parliament Website

2. *The First Minister announced his Programme for Government for the coming year on 6 May 2025, including the 2025-26-year 5 legislative programme. Following the Minister for Social Care, Mental Wellbeing and Sport's communication to Parliament on 2 May 2025, an AWI Bill is not included.*

3. *I do appreciate the disappointment and frustration that this decision will cause, and I would stress that whilst a Bill is not being introduced at this time we are not standing still. The Minister has set out a number of actions already to ensure that the further work required is prioritised with a view to a Bill being introduced early in the next parliamentary term.*

4. *This will see us move from consultation to collaboration, working with key partners on not only the policy aspects of reform but the practical considerations essential to ensure that future legislative change is operationally feasible and fully impacted in terms of resources and system capacity. We are establishing both an AWI Expert Working Group (to advise and collaborate with government on the policy and operational detail required to bring forward, and successfully implement, future legislative change) as well as a Ministerial-led Oversight Group (to monitor and drive progress, bringing both the pace and priority needed). Invites for both groups are expected to issue ahead of summer recess (end-June 2025), with initial meetings to take place in September 2025.*

5. *It will be important that the groups, when established, can inform both the membership and scope of development required but I am happy to share our initial thoughts on the key areas that we wish to collaborate on:*

- *Deprivation of Liberty*
- *Definition of an Adult (UNCRC compatibility)*
- *Forced Detention and Covert Medication*
- *Supported Decision Making / Support for Exercise of Capacity*
- *Powers of Attorney*
- *Access to Funds*
- *Managing Residents' Finances*
- *Guardianships*
- *Medical Treatment*
- *Data Collection*

Within my Unit, we will be working over the summer to prepare initial papers on these areas for discussion with the groups. I should also say that whilst we recognise that legislative change will be required, we would also want to consider any more immediate actions that could be taken in advance of this to deliver shorter -term improvements.

My comments

I stress that these are my own comments, formed from conclusions that I have reached in the light of the total information made public by

Scottish Government, as reflected in successive Scotland sections of the Mental Capacity Report. It seems to me that unacceptable outcomes could have included one or more (in combination) of the following:

- An under-prepared and inadequate Bill completing its parliamentary process within the current session.
- An under-prepared and inadequate Bill completing its parliamentary process before the recess ahead of next year's election.
- A Bill lost altogether because of failure to complete its progress ahead of the election, including a Bill "timed out" because of multiple substantial amendments addressing perceived deficiencies in the Bill as introduced.

Assessment of the course which will be followed by the current government in accordance with the statement above has to be assessed by balancing the above dangers with the following:

- That all the deficiencies of current provision (and lack of it) will continue significantly longer.
- The present government cannot bind, nor directly influence, the relevant policies of the new government after the election, unless it forms a new government, or part of a reconstituted coalition committed to proceeding similarly, after the election.

The principles of the 2000 Act, though they need to be enhanced to make human rights compliance mandatory, have proved their value over the years. My opinion is that they should be applied to the present situation. For the last few years there has been massive consultation with all relevant "stakeholders". The statement confirms the shift, under Amy Stuart's leadership, from consultation to collaboration. That means collaboration in delivering a well-prepared Bill that meets all needs, and which can be presented to the Parliament. My personal view and decision, for what it is worth, is that the necessary collective benefit for adults with incapacities, as defined in the 2000 Act, those planning for the possibility of such incapacities, and all with an interest arising from professional and working responsibilities, and from family and voluntary obligations, will be to provide such collaboration. That benefit cannot be fully and adequately achieved without all necessary collaboration.

There remains the requirement to achieve the commitment for this course of all political parties who could possibly form part of government following the election. Remember that this potentially encompasses small parties, with a small number of seats which, in combination with a party holding many more seats, would achieve a working majority. Such consensus was achieved in relation to the 2000 Act in the run-up to the first-ever elections to the Scottish Parliament. It was easier to achieve then. No party had a record in government for it to defend and others to attack. Any campaigning now must attempt to tread the difficult path of raising the profile of the subject (and nothing works better for that than some controversy), but at the same time with a clear and explicit purpose of rebuilding the consensus of the late 1990s.

Still emphasising that these are matters of my own judgement from what is publicly available, I have the following two concluding points. Firstly, it will probably take some two to three years before we can expect to see amending legislation in force. Secondly, however it is done, that is a reasonable estimate of the time that it will take, starting from "we are where we are now" to achieve that. The consequence of these is an absolute obligation upon all concerned to ensure that existing provisions are operated efficiently and well in the meantime. As we have reported last month and many times before that, that has not been happening, although the "Argyll & Bute case" reported last month, and the "Aberdeenshire case" before it, though not telling us anything new beyond the extremes to which malpractice can descend, seem already to have had a salutary effect in driving improvements.

Adrian D Ward

UK Protocol on Judicial Cooperation

On 7th May 2025 there was published a "New protocol on communications between Judges in Scotland, England & Wales, and Northern Ireland in cases involving adults who lack capacity", and accompanying handbook, available here. The new Protocol is to be welcomed as providing commendably straightforward and clearly expressed procedures for judicial cooperation in such cases, though unfortunately that welcome has to be subject to the apparent blemishes noted in this article, one of them significant and confusing.

Chapter V of Hague Convention 35 on the International Protection of Adults of 2000 contains important cooperation provisions, directed at cooperation among central authorities. The Hague Network of Judges takes that to the level of direct communication among judges. Scotland was the first jurisdiction in respect of which Hague 35 was ratified. It has still not yet been ratified in respect of England & Wales or Northern Ireland, even though – in the case of England & Wales – the text of the Convention, including Part 5 on cooperation, is substantially reproduced in Schedule 3 to the Mental Capacity Act 2005 and thus included within the legislative scheme of that Act. It is common experience that cross-border issues arise in relation to incapacity/capacity jurisdictions with increasing frequency. I would suggest that in all such cases the question should be not so much "Will such assistance assist?", as "Is such cooperation unlikely to assist?". Whichever question is favoured, one or other should always be asked in relation to such proceedings. To take some prominent recent examples, judicial cooperation before any final order was granted could well have avoided the now notorious outcomes in the *Aberdeenshire Council* and *Argyll & Bute Council* cases.

The procedure, in summary, is this. The requesting judge should prepare or approve an information-sharing request and a summary of information for the liaison judge in the requesting jurisdiction, for onward transmission to the receiving jurisdiction a standard request form is provided in Annex II to the Protocol. The liaison judge must provide, for relevant cases, clear lines of communication and form a free flow of relevant information, to facilitate effective case management of those cases. The liaison judge receives the request from the requesting judge, makes any modifications which the liaison judge considers necessary, to the liaison judge in the receiving jurisdiction. Responses from the receiving jurisdiction are returned to the requesting judge through the liaison judge. As noted, however, requests for information from the liaison judge in a receiving jurisdiction should be made through the offices mentioned above.

For provisions providing more detail on the operation of the scheme of the Protocol, see the Protocol itself.

The Protocol does however give rise to some concerns, one of them major, all of them addressed below.

The Protocol has been published along with "a handbook on adult capacity Law in Scotland, England & Wales, and in Northern Ireland". The handbook can be commended without reservation, including for its conciseness and clarity. It does not seek to describe every possible provision that could arise in the context of cross-border cases. In the case of Scotland, it is limited to the provisions of Part 1 of the 2000 Act, entitled "General"; those in Part 2 on powers of attorney; and those in Part 6 on guardianship and intervention orders. The lead contributors were Alex Ruck Keene KC in respect of England & Wales, Sheriff Helen McGinty in respect of Scotland, and Master Hilary Wells in respect of Northern Ireland. Helen McGinty made her contribution while still a practising solicitor. We take this opportunity to welcome her appointment as a sheriff at Glasgow with effect from 16th June 2025, and to congratulate her.

Oddities in the Protocol, particularly when read in comparison with the handbook, include the possibly Anglo-centric statement that the handbook was "prepared by mental capacity law barristers and advocates". In accordance with the very different demarcation between the roles of the relevant parts of the profession, the great bulk of applications under the 2000 Act are conducted in Scotland by solicitors. Sheriff McGinty is a solicitor, not an advocate. Solicitor advocates are now represented in all tiers of the Scottish judiciary, including Lord Scott as a senator of the Scottish Supreme Courts, he – significantly – having led the work of the Scottish Mental Health Law Review ("the Scott Review") including publication of the massive, in both size and importance, Report of the Review.

tem (ii) ambiguously refers to "the local authority involved". That could be a local authority in the "receiving jurisdiction" where the adult retains ordinary residence and the authority is thus still responsible for cost of provision of services, notwithstanding that a court in the requesting jurisdiction may have jurisdiction, on grounds including that the adult has habitual residence there or is in fact present there (subject to the precise terms of the jurisdiction provisions of the Hague Convention); on which see *Milton Keynes Council v Scottish Ministers*, [2015] CSOH 156. One local authority, in one jurisdiction, may be "involved" with responsibility for providing local authority services to an adult, while another local authority in a different jurisdiction may be responsible for meeting the costs of such provision.

It seems odd that facilitation of direct judicial cooperation is through the Scottish International Family Justice Office in the case of Scotland, the similarly titled Office in respect of England & Wales, and the Lady Chief Justice's Office in the case of Northern Ireland. Family courts do not have jurisdiction in adult incapacity matters. I am not aware that any texts on Scots family law, or lists of family law statutes, include the 2000 Act. (The position is different in many European countries.) This may or may not be a factor.

Major puzzlement and widespread disagreement has been caused by Article 2.2 of the Protocol, specifying the persons to whom it relates. In full, it reads as follows:

> *2. In the Protocol,*
>
> *1. for proceedings raised in England and Wales, includes persons who are aged 16 or over (section 2(5) of the Mental Capacity Act 2005);*
>
> *2. for proceedings raised in Scotland, includes persons who are aged 18 or over (section 1(6) of the Adults with Incapacity (Scotland) Act 2000, as glossed by section 1(2), 24 and 29 of the United Nations Convention on the Rights of the Child (Incorporation) (Scotland) Act 2024); and*
>
> *3. for proceedings raised in Northern Ireland, includes persons who are aged 16 or over (section 1(1) of the Mental Capacity Act (Northern Ireland) 2016.*

The unusual wording appears to suggest that the definition of "adult" has effectively been amended from persons aged over 16 to persons aged over 18 by the United Nations Convention on the Rights of the Child (Incorporation) (Scotland) Act 2024 ("the 2024 Act"), and in particular by the provisions quoted of the 2024 Act, and presumably for the purposes of all related provisions including – to pick one example – section 79A which allows guardianship applications to be made three months before attainment of adulthood (whatever that now means!), but such orders only to come into force upon attainment of adulthood. What seriously exacerbates the confusion is that this contradicts the clear statement in paragraph 11 of the Scottish section of the handbook that: "An adult is, simply, a person who has attained the age of 16 years", and also appears to be contradicted in paragraph (v) in the section entitled "Operation of the

principles" of the Protocol itself. It reverses those ages. It reads: "*Courts in Scotland may only request information from England, Wales and Northern Ireland for adults aged 18 or over while the courts in England, Wales and Northern Ireland may request information from Scotland for persons aged 16 and over.*

o, which version is correct? Despite obvious initial reluctance to disagree with a document signed by the heads of the judiciaries of the three United Kingdom jurisdictions, I have to say that upon consideration of the terms of significant relevant legislation, I for my part cannot avoid the conclusion that Helen McGinty (soon to be Sheriff McGinty) is clearly correct, as is the version in the "Operation" section where it appears to contradict Article 2.2. While it is perhaps strictly speaking irrelevant, one notes that prior to announcement of her appointment to the shrieval bench on 27th May 2025, Sheriff McGinty was an experienced and leading AWI practitioner and safeguarder in AWI cases, who reported no difficulties in bridging the requirements of the 2000 Act and the Convention in relation to "young persons" (Scottish 16 and 17 year-olds).

To start with an obvious point, the provisions of the Convention apply in respect of every human being below the age of 18 years "For the purposes of the present Convention" (Article 1), so compliance is required with all provisions of the Convention in respect of Scottish young persons. Is any provision of the 2000 Act incompatible with application of any provision of the Convention? No, although the only cause for doubt might be the requirement that "the best interests of the child [interpreted according to the Convention as including young persons] shall be a primary consideration". It is well known that a best interests test was rejected in favour of the section 1 principles for the purposes of drafting the 2000 Act, and decisions of the courts have rejected use of a best interests test in place of the section 1 principles. However, the 2000 Act does not exclude best interests: it does positively require compliance with the section 1 principles as applying both the provisions of the Convention and the section 1 principles in relation to Scottish young persons, does that give rise to difficulties? The answer from experienced safeguarders appears to be "no". Many of them are accustomed to being appointed curators ad litem, the test of such appointments being a best interests test, albeit in relation to matters in which that is not the test. In at least one sheriff court (Edinburgh), safeguarders are now appointed in all proceedings relating to young persons, and I am not aware that any have encountered difficulties in applying the provisions of the Convention in addition to, rather than in place of, those of the 2000 Act.

Further consideration does not appear to indicate anything to raise doubt as to whether the 2000 Act has been amended. Statutes normally expressly provide for any repeals or significant amendments to pre-existing legislation, with all minor and consequential amendments often to be found in a Schedule. Did the drafters of the 2024 Act omit to address the need to specify necessary consequential amendments of existing legislation? No, they did make provisions for consequential amendments, but only in relation to the Children and Young People (Scotland) Act 2014 (section 22). No such consequential amendments are noted in the "latest available" official versions of the 2000 Act, nor the Age of Legal Capacity (Scotland) Act 1991. As it stands, Scottish legislation contains the duality of "trigger dates" at the ages of both 16 and 18, and indeed 17 as well in relation to certain criminal offences. Such duality is "part of the scene".

Taking in turn the three provisions of the 2024 Act referred to in Article 2.2 of the Protocol, section 1(2) defines "the UNCRC requirements" as meaning the rights and obligations from the Convention, including the first and second optional Protocols. Section 24 deals with interpretation of legislation, not amendment or repeal. Section 24(1) addresses matters of

interpretation ("The following must be read and given effect in a way which is compatible with the UNCRC requirements"), subject to the important qualification "So far as it is possible to do so", and section 24(2) clarifies that subsection (1) "does not affect – (a) the validity, continuing operation or enforcement of any incompatible Act of the Scottish Parliament". Accordingly, if I am wrong in asserting that the 2000 Act is not incompatible, it nevertheless remains in force unamended and section 24 requires "the UNCRC requirements" to be applied "so far as it is possible to do so", in other words in relation to the 2000 Act as unamended.

Section 24(1) refers to the words in an Act of the Scottish Parliament to which section 29 applies, but section 29 does not specify any primary legislation. It merely refers to words in an Act of the Scottish Parliament, and to the route by which those words have appeared in such an Act.

I shall be pleased to hear from anyone who disagrees with my interpretation.

Adrian D Ward

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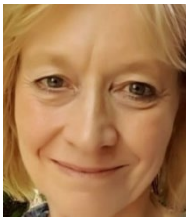

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Conferences

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

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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