



Welcome to the September 2018 Mental Capacity Report. Highlights this month include:

- (1) In the Health, Welfare and Deprivation of Liberty Report: life-sustaining treatment and the courts, fertility treatment in extremis and an update on the Mental Capacity (Amendment) Bill;
- (2) In the Property and Affairs Report: inheritance tax planning and the MCA;
- (3) In the Practice and Procedure Report: a new Vice-President, a case study in poor care planning and its costs consequences, deprivation of liberty of children – the Court of Protection or Family Division?;
- (4) In the Wider Context Report: an important decision on disability and challenging behavior, guidance from the LGA, ADASS and RCN, and deprivation of liberty looked at overseas;
- (5) In the Scotland Report: disability discrimination and unfavourable treatment, AWI consultation response analysis published, and judicial training as part of increasing access to justice for people with disabilities;

You can find all our past issues, our case summaries, and more on our dedicated sub-site [here](#).

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The picture at the top, "Colourful," is by Geoffrey Files, a young man with autism. 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

Life-sustaining treatment: the Supreme Court pronounces

An NHS Trust v Y & Ors [2018] UKSC 46 (Supreme Court (Lady Hale, President; Mance, Wilson, Hodge and Black SCJJ))

Best interests – medical treatment – practice and procedure (Court of Protection) – other

Summary

Background

Ever since the decision of the House of Lords in *Bland*, it has been recognised that CANH constitutes a medical treatment and that (as with any other medical treatment) it can be withdrawn where it is no longer in a patient's best interests without the medical practitioners being guilty of the offence of murder. Indeed, in *Aintree*, the Supreme Court made clear that the continued provision of CANH (or any other medical treatment) which was not in the patient's best interests would be actively unlawful.

The House of Lords in *Bland* suggested that it would be good practice for applications to be made to (then) the High Court for endorsement of the decision to withdraw CANH from those patients in a permanent vegetative state, at least until a body of experience and practice had built up which would obviate the need for such an application. That would be so even where there was agreement between the families and the treating clinical team that continuing CANH was not in the person's best interests. Through a process of accretion described in the judgment of Lady Black in *Y*, the suggestion became crystallised into what was understood by many (in particular clinical practitioners) to be a legal requirement, and extended to include similar decisions in relation to those in a minimally conscious state. And so this position would have remained, causing, in many cases, considerable distress to families at the delay caused by the need to go to court in order to get endorsement of an agreed decision, had it not been for a series of awkward questions asked in 2017 as to the precise basis upon which the Code of Practice and Practice Direction 9E appeared to mandate that such decisions went to court.

Those awkward questions were ultimately posed in stark form in *Y's* case, where the NHS Trust responsible for the care of man in an MCS, whom both the family and treating team agreed should no longer receive CANH, went to the High Court to get a declaration that it did not need to approach the Court of Protection for endorsement of this position. The Trust went to the High Court rather than the Court of Protection, so that there could be no suggestion that it was accepting the jurisdiction of the Court of Protection to make the decision (as had had happened in *Re M*, leading to somewhat sterile arguments as to whether the resulting decision that the Trust need not have come to court was, or was not, obiter).

O'Farrell J held at first instance that the Trust did not, as a matter of law, have to seek the endorsement of the Court of Protection where the decision to withdraw CANH was an agreed one. The Official Solicitor, acting as Y's litigation friend, sought and obtained leave to 'leapfrog' the decision to the Supreme Court, albeit, by the time that the case reached the Supreme Court Mr Y had died after contracting acute respiratory sepsis. The Supreme Court nonetheless determined the appeal should go ahead because of the general importance of the issues raised.

The arguments

The Official Solicitor submitted that, in every case, court approval had to be sought before CANH could be withdrawn from a person with PDOC, thus ensuring that the patient's vulnerable position was properly safeguarded by representation through the Official Solicitor, who could obtain independent expert medical reports about his condition and prognosis, and make submissions to the court on his behalf if appropriate. The Official Solicitor derived this requirement essentially from the common law and/or the European Convention on Human Rights (ECHR), in particular Article 2 and Article 6. He also submitted that his position found support in the statutory Code of Practice to the MCA 2005, and it was irrelevant that neither the MCA 2005 nor the Court of Protection Rules specifically impose the requirement for which he contended. The intervenor Care Not Killing supported the Official Solicitor, drawing particular attention to difficulties in diagnosis.

The Trust and CCG (the latter as the body funding Y's cases, and jointly represented with the Trust) argued, in response, that (1) Bland established no more than a rule of practice, (2) it was time for that blanket rule of practice to be dispensed with, and replaced by adherence to the detailed available professional guidance, and (3) there was no breach of human rights involved in withdrawal of CANH from a patient in a PDOC if continuation was not in their best interests. The British Medical Association, the Intensive Care Society and the Faculty of Intensive Medicine, intervening, supported the Trust/CCG's arguments, and also put before the court relevant professional guidance, material setting out the realities of decision-making in different clinical situations, highlighting the difficulty of carving out CANH withdrawal in PDOC from other forms of decisions routinely taken by doctors in conjunction with families.

The decision

In a detailed tour d'horizon, taking in the common law, the MCA 2005, the jurisprudence of the Court of Protection, the ECHR and relevant medical guidance, Lady Black, delivering judgment on behalf of the Supreme Court, concluded in clear terms that there was no requirement either at common law or under the ECHR for court approval to be sought in the way contended for by the Official Solicitor. Importantly, Lady Black also then took a step back from her "*intense focus upon the law*" to consider the issue in its wider setting. At paragraphs 116 ff, she held as follows:

116. It is important to acknowledge that CANH is more readily perceived as basic care than, say, artificial ventilation or the administration of antibiotics, and withholding or withdrawing it can

therefore cause some people a greater unease. However, it was decided as far back as the Bland case that CANH is in fact to be seen as medical treatment. It is not easy to explain, therefore, why it should be treated differently from other forms of life-sustaining treatment, and yet that is the consequence of the legal position for which the Official Solicitor contends.

*117. Furthermore, the Official Solicitor's focus is on only one sub-set of patients who are, for one reason or another, unable to take their own decisions about their medical care and in respect of whom life-sustaining treatment is under consideration. This is a point that Peter Jackson J made in *In re M (Incapacitated Person: Withdrawal of Treatment)*, and it emerges with some force from the written submissions of the BMA and of the ICS and the FICM. It is not only those, such as Mr Y, who suffer an acute episode and are then stabilised, who may require CANH. The need for it can arise also, for example, in the advanced stages of a degenerative neurological condition such as Huntington's disease or multiple sclerosis, or in the advanced stages of dementia, where there may be a recognised downward trajectory. Presently, the BMA say, in the case of patients who have suffered a severe stroke, or are significantly cognitively impaired but conscious, or are suffering from a degenerative neurological condition or other condition with a recognised downward trajectory, decisions to withhold or withdraw CANH are made on a regular basis without recourse to the courts. The BMA can see no principled or logical reason for requiring court review in relation to patients with PVS and MCS but not for a patient with a different condition. Similarly, it can find no logical reason why one form of medical treatment, CANH, is treated differently from other forms of medical treatment such as artificial ventilation.*

118. The submissions of the ICS and FICM are illuminating as to what occurs in units delivering critical care to patients. Most admissions to such units occur as an emergency, without the patient having made any advance decision about treatment, and possibly already so unwell that he or she has impaired consciousness or is unable to communicate wishes. Most decisions relating to medical treatment in the critical care setting, including as to whether life-sustaining treatment is withheld or withdrawn, have to be made without the participation of the patient. They are, we are told, "almost invariably taken on the basis of (in England & Wales) best interests and (in Scotland) benefit, on the basis of consensual decision-making as between the clinical team and the patient's family and carers". In that critical care setting, CANH is not considered differently from any other form of life-sustaining treatment. This is said to reflect "the reality in critically ill patients that it is the withdrawal of invasive or non-invasive ventilation, vasoactive medical and renal replacement therapy, and the 'double effect' from administration of medications to ensure patient comfort towards the end of life, that leads to the natural death of the patient, rather than cessation of CANH." It is likely, where CANH is withdrawn from a patient who is clinically stable but suffering from a prolonged disorder of consciousness, that death will result from the withdrawal of CANH, so to this extent there is a difference between the two groups of patients. However, once CANH is seen as medical treatment, there is a parallel between the cases.

In an important passage finally dispelling what has become something of a myth that the diagnosis is all in determinations as to whether life-sustaining treatment should be continued, Lady Black made it clear that:

119. 119. *In any event, I have difficulty in accepting that there are readily apparent and watertight categories of patient, with PDOC patients clearly differentiated from, say, patients with a degenerative neurological condition or critically ill patients, in such a way as to justify judicial involvement being required for the PDOC patients but not for the others. The dilemmas facing the medical team and those close to the patient may well be very similar in each of these cases. It would be a mistake to think, for example, that the intensive care doctor simply does whatever is necessary to stop the patient dying, no matter what the cost to the patient, any more than does the doctor looking after a PDOC patient or the stroke patient or the patient with Huntington's disease. In all of these cases, the medical team take their decisions as to treatment, whether it is CANH, or some other form of treatment such as artificial ventilation or cardio-pulmonary resuscitation or the administration of antibiotics, by determining what is in the patient's best interests. In so doing, the doctors will often have difficult diagnoses to make, reaching a prognosis may be challenging, and the evaluation of the patient's best interests may not be entirely straightforward. All these tasks may call for considerable professional skill and individual judgement.*

Lady Black made clear that she was sceptical as to whether it would, in fact, be possible to obtain a speedy court judgment in every case, as the Official Solicitor submitted should be the case, and, moreover, that:

121. *As King LJ observed in In re Briggs, quite apart from the pressure that court cases place on the overstretched resources of NHS trusts, they add greatly to the strain on families facing acutely distressing decisions. In a case where all the proper procedures have been observed and there is no doubt about what is in the best interests of the patient, there is much to be said for enabling the family and the patient to spend their last days together without the burden and distraction, and possibly expense, of court proceedings. In addition, I do not disagree with Peter Jackson J's observation that there is a risk that the need to go to court might deflect clinicians and families from making true best interests decisions and might lead in some cases to inappropriate treatment continuing by default. Equally, it is not inconceivable that it might, as the BMA suggest, generate a reluctance, in some cases, to start CANH because of the procedures attending its withdrawal.*

Although Lady Black accepted that diagnosis was not straightforward, and that developments in medical science "inevitably create new challenges of diagnosis and management, new uncertainties, for the medical profession," she noted that the survival of patients such as Anthony Bland, then so unprecedented, "is now a well-established feature of medical practice." Importantly, Lady Black then went on to outline how decision-making should happen:

124. [...] *The documentation supplied to us¹ shows that the difficulty that there is in assessing the patient and in evaluating his or her best interests is well recognised. The process is the subject of proper professional guidance, covering vitally important matters such as the involvement in the decision-making process of a doctor with specialist knowledge of prolonged disorders of consciousness, and the obtaining of a second opinion from a senior independent clinician with no prior involvement in the patient's care. The second opinion, as contemplated in the guidance (see*

¹ Including separate guidance from the GMC, Royal College of Physicians, BMA and joint interim guidance from all three.

paras 79 and 80 above, for example), is, in my view, a crucial part of the scrutiny that is essential for decisions of this sort, and the guidance sets parameters which should ensure that it is an effective check, in that the clinician who provides the second opinion must (so far as reasonably practical in the circumstances of the case) be external to the organisation caring for the patient, and is expected to carry out his or her own examination of the patient, consider and evaluate the medical records, review information about the patient's best interests, and make his or her own judgement as to whether the decision to withdraw (or not to start) CANH is in the best interests of the patient. Thus the interests of patients and their families are safeguarded, as far as possible, against errors in diagnosis and evaluation, premature decisions, and local variations in practice.

125. If, at the end of the medical process, it is apparent that the way forward is finely balanced, or there is a difference of medical opinion, or a lack of agreement to a proposed course of action from those with an interest in the patient's welfare, a court application can and should be made. As the decisions of the ECtHR underline, this possibility of approaching a court in the event of doubts as to the best interests of the patient is an essential part of the protection of human rights. The assessments, evaluations and opinions assembled as part of the medical process will then form the core of the material available to the judge, together with such further expert and other evidence as may need to be placed before the court at that stage.

Lady Black therefore concluded that:

126 [...] having looked at the issue in its wider context as well as from a narrower legal perspective, I do not consider that it has been established that the common law or the ECHR, in combination or separately, give rise to the mandatory requirement, for which the Official Solicitor contends, to involve the court to decide upon the best interests of every patient with a prolonged disorder of consciousness before CANH can be withdrawn. If the provisions of the MCA 2005 are followed and the relevant guidance observed, and if there is agreement upon what is in the best interests of the patient, the patient may be treated in accordance with that agreement without application to the court. I would therefore dismiss the appeal. In so doing, however, I would emphasise that, although application to court is not necessary in every case, there will undoubtedly be cases in which an application will be required (or desirable) because of the particular circumstances that appertain, and there should be no reticence about involving the court in such cases.

Comment

Practical implications

Following this decision, the position in England and Wales is now entirely clear. Where the provisions of the MCA 2005 are followed and the relevant guidance observed, and if there is agreement upon what is in the best interests of the patient, life-sustaining treatment (whether CANH or another form of such treatment) can be withdrawn (or withheld) without needing to make an application to the court. Of course, as Lady Black observed, if at the end of the process of decision-making the way forward is finely balanced, or there is a difference of medical opinion, or a lack of agreement to a proposed course of action from those with an interest in the patient's welfare, a court application can and should be made – so that the court can be asked to make this crucial decision on behalf of the patient. One

immediate practical implication is that the joint guidance being worked on by the BMA, GMC and RCP can proceed to publication on the same basis that the interim guidance had been predicated; that guidance will set out a detailed decision-making process along the lines identified by Lady Black in her judgment.

Whilst the Supreme Court did not engage – as some had hoped it might – with the slightly Delphic observation of Lady Hale in *N v ACCG* that the general authority in s.5 will usually suffice to act in relation to the care and treatment of a person lacking capacity “*unless the decision is so serious that the court itself has said it must be taken to court,*” the same logic as set out by Lady Black in relation to life-sustaining treatment would, on its face, apply equally to other decisions that might fall to be made under the umbrella of s.5 (for instance, moving a person from their own home), with the added condition that, in many such cases, the person themselves may well be able to express wishes and feelings which should feature heavily in the mix in terms of identifying whether a court application is mandated.

Wider observations

One might ask whether the House of Lords in *Bland* that their (understandable) desire for caution merited the delay that ensued – and the return to the Supreme Court – before, in essence, it could be confirmed that a sufficient body of experience had been built up, and codified in clinical guidance, and the court could hand decision-making back to clinicians to undertake in conjunction with families. Be that as it may, this judgment now makes the position absolutely clear.

Whilst the judgment is undoubtedly welcome at many levels, the handing back of this responsibility does carry with it the real need to ensure that the MCA is understood and applied with care and with attention to its spirit, as well as its letter, in the clinical context. The BMA/GMC/RCP guidance outlined above will undoubtedly help in the specific context of CANH withdrawal. One might also think that the decision of the Supreme Court only makes it more important that careful consideration is given by Parliament during the passage of the Mental Capacity (Amendment) Bill as to whether s.5 needs to be given the additional ‘teeth’ in relation to decisions relating to serious medical treatment that had been proposed by the Law Commission but which the Government, at least at present, does not consider to be necessary.

Constructing consent to fertility treatment

Y v A Healthcare NHS Trust, the Human and Fertilisation and Embryology Authority and Z [2018] EWCOP 18 (Knowles J)

Best interests – practice and procedure (Court of Protection) – other

Summary

This was an application brought by Y, the wife of a dying man, Z for declarations that:

-
- notwithstanding Z's incapacity and his inability to consent, it was lawful and in his best interests for his sperm to be retrieved and stored prior to his death;
 - An order pursuant to s.16 Mental Capacity Act 2005 directing that a suitable person should sign the relevant consent form for the storage of Z's sperm on his behalf.

Y and Z had been married for four years and had one child. They wanted a second child, but had been unable to conceive. They were referred to a fertility clinic by their GP for an appointment, prior to which Z provided a sperm sample for sperm analysis. Also prior to the appointment the couple filled out a number of forms directed to identifying the type of fertility treatment the couple wanted. The court made finding that while filling out those forms the couple discussed the storage of Z's sperm, during which discussion Z had stated that if he died in the course of the fertility treatment he was supportive of Y proceeding with the fertility treatment if that is what she wanted to do.

The couple subsequently attended the fertility clinic appointment at which it was decided that they would proceed with IVF. A further appointment was made at which the treatment would begin.

Tragically prior to attending the second appointment, Z was involved in a road traffic accident in which he sustained a catastrophic brain injury. It was agreed that if on brain stem testing, Z had no brain activity, all treatment would be withdrawn and he would die. Y wanted to delay Z's death in order to retrieve his sperm to allow her to pursue the fertility treatment they had both agreed upon.

Given the findings of fact in relation to Z's recently expressed wishes about the IVF treatment, the question of whether it was in Z's best interests for the sperm to be obtained and stored was not a difficult one for the court. Mrs Justice Knowles held that it was.

More difficult was the question of the court giving the necessary consents for Z's sperm to be stored. Schedule 3 of the Human Fertilisation and Embryology Act 1990 ('HFEA 1990') governs the consents for the storage of sperm.

Sub-paragraph 1(1) of the Schedule states that:

A consent under this Schedule, and any notice under paragraph 4 varying or withdrawing a consent under this Schedule, must be in writing and, subject to sub-paragraph (2), must be signed by the person giving it.

Sub-paragraph 1(2) of the schedule states that a consent by a person who is unable to sign because of illness, injury or physical disability may comply with the requirement of sub-paragraph 1(1) as to signature "if it is signed at the direction of the person unable to sign, in the presence of the person unable to sign and in the presence of at least one witness who attests the signature."

The court held that: "the consent provisions are carefully drawn for sound public policy reasons, namely that consent is central to effective regulation in this area. They are couched in the imperative for that very

reason."

The court proceeded on the basis that it was doubtful that the forms that Z had signed were sufficient to comply with paragraph 1(1) of Schedule 3. What the court was therefore being asked to do was to authorise (pursuant to s.16 MCA 2005) a family member (not Y) to consent to the storage of Z's sperm on his behalf pursuant to paragraph 1(2) of Schedule 3. The court gave that consent, noting that, to comply with the provisions of the schedule, the family member would need to execute the consents in Z's presence before he died or was declared to be dead and in the presence of a witness.

The court also, on its own volition, gave consent for Z's sperm to be used for the fertility treatment.

Comment

One could not conceive of a case in which the merits of the application being granted were any stronger. However, we observe that there are two issues which on their face would appear to have stood as a bar to the order being made. Neither were addressed in the judgment, although it may well have been that they were canvassed before the court:

1. The first is that it is difficult to understand from the judgment itself how the court came to the view that the s.16 MCA 2005 order would comply with the terms of paragraph 1(2) of Schedule 3 insofar as that paragraph requires the consent given on behalf of Z to be at his "direction." There is no doubt that the court was of the view that Z himself would have consented to the storage of the sperm had he been able to. Paragraph 1(2) however seems to demand more than simply identifying what the incapacitated person would have chosen to do. It requires the incapacitated person (here, Z) to direct that the third party gives the consent on his behalf. Given the circumstances of Z's loss of capacity (sudden and unpredicted) there would have been no opportunity for such direction.
2. The second – linked – problem is that s.27(2)(i) MCA 2005 specifically prohibits anyone, including the court, from "*giving a consent under the Human Fertilisation and Embryology Act 2008.*" It may have been that the court considered that it was not, in fact, consenting on Z's behalf within the terms of the HFEA 1990, but directing (on Z's behalf) a relative to execute that consent. That undoubtedly represents a purposive (some might say strained) reading of the wording 'consent' in s.27(2)(i) MCA 2005, which on its face and in its context is addressed to the material giving of consent (i.e. the fact of consenting to storage) rather than the technical execution of the written consent document.

Mental Capacity (Amendment) Bill update

The first day of the Lords Committee stage of the [Mental Capacity \(Amendment\) Bill](#) took place on 5 September. The Hansard transcript can be found [here](#) and [here](#) (including a name-check for the [Special Report](#) we published ahead of the debate). For those wanting to understand how, precisely, the government sees the Bill working, the key responses by Lord O'Shaughnessy (Parliamentary Under-

Secretary of State, DHSC) to an extensive series of probing amendments put forward by peers can be found [here](#). All the amendments debated on 5 September were withdrawn (or associated amendments not moved), so no changes were made to the Bill at this stage. The next day of Committee stage will be 15 October; the easiest place to keep abreast of amendments is this page [here](#).

PROPERTY AND AFFAIRS

Gifts for tax planning purposes

Re JMA [2018] EWCOP 19 (Senior Judge Hilder)

Gifts

Summary

In this case Senior Judge Hilder considered an unopposed application for permission to make substantial gifts from P's estate for the purpose of reducing the incidence of inheritance tax.

P was a 72 year old widow with advanced early onset dementia. She lived in a residential care home. She had a substantial estate. The applicant was her only surviving son who is the residuary beneficiary after mainly charitable gifts in P's will.

The application sought permission to make, in effect, an advancement to the applicant of £6m out of P's estate of nearly £19m, together with certain other lesser provisions including a statutory will.

The saving of inheritance tax was calculated at up to £3.2m if P were to survive until 2025.

The Official Solicitor was appointed to represent P and submitted that the application was in P's best interests as did the other parties.

The judgment includes a survey of the leading authorities on the best interests test and its application to gifts. Important considerations were affordability (all sides agreed that P's remaining estate was ample for all her needs) and P's and her late husband's attitudes to tax planning and life time gifting.

The court stated that affordability was a necessary but not sufficient condition (paragraph 64) and that there was no default position or starting point so that each application must be considered on its particular facts according to the requirements of section 4 MCA (paragraph 65/6).

The court then went on to set out a familiar check list of factors and concluded that taking all circumstances into account, the proposals were in P's best interest and would be approved.

Comment

This is an interesting case on how the court approaches an application to make tax planning gifts, confirming that there are no differences in principle to the standard best interests approach. The key factors in the application of that here appear to have been the very substantial size of the estate and previous tax planning and gifting. On the procedural front, a striking feature – not explained in any detail in the judgment – is that the application was made in June 2015, but only reached a hearing in March 2018.

PRACTICE AND PROCEDURE

Hayden J appointed as Vice-President

As if in response to our plea in the last Report for the appointment of a Vice-President, we congratulate Hayden J on his appointment to the position, and look forward with considerable interest to seeing how the Court of Protection moves forward under his guidance and the overall leadership of the new President, Sir Andrew McFarlane.

Holding prisoner in a foreign land

London Borough of Lambeth v MCS & Anor [2018] EWCOP 14; [2018] EWCOP 20 (Newton J)

Summary

In a pair of excoriating judgments, one as to substance, one as to cost, Newton J addressed the consequence of *"disorganised, muddled and unfocused decision making, and what has at times verged on an arrogance,"* leading a Colombian woman into *"years of misery from being kept a prisoner here, against her will."*

On 1 May 2014, whilst waiting at a bus stop, P collapsed and but for the prompt actions of a member of the public who commenced CPR, would likely not have survived. Paramedics arrived, P was found to have suffered a cardiac arrest. She was taken to St Thomas' hospital who diagnosed narrowing of the arteries to the heart; she had emergency bypass surgery the same day. Subsequently P was diagnosed as having sustained hypoxic brain injury as a result of oxygen starvation to the brain when she collapsed. On 1 September 2014 she was transferred to the Royal Hospital for Neurodisability in Putney, where she remained for well over 3 years. She displayed the classic signs of hypoxic injury, that is to say, severe cognitive impairment with memory problems, speech problems and physical difficulties requiring significant care input. Although she lacked capacity to decide upon her future residence, she was *"absolutely consistent, and at every opportunity [...] made abundantly clear her wishes to be able to return to Columbia, where she would have the care and support of a large and concerned extended family."* Over time, she made significant cognitive improvement such as to allow her to vent her frustration, whether it be with language (she was a Spanish speaker and does not understand English), her impairments, or the care plan provided to her. There was, similarly no question but that it was in her best interests to repatriated to Columbia.

A consistent theme recorded in every document was how very much better P functioned, and was so much happier, when she could communicate in Spanish. On 29 October 2014 P's assessed needs recorded *"as detailed in previous sections, a Spanish speaking environment is essential for P's participation, care and wellbeing"* and *"Spanish staff should be available 24 hours a day with regular attendance for monitoring."* However, there was never any formal provision supporting P's need for Spanish speaking staff, which at best was provided on an ad hoc basis. As Newton J noted, *"P is distressed by receiving care from people who cannot speak Spanish, this has happened almost every day, several times a day, for*

over 3 years. It takes very little imagination to consider how additionally miserable and isolated she must have felt. Reports describe her as distressed, feeling like she is drowning, feeling scared, complaining of pain, each impacting severely on her everyday wellbeing."

P was likely to have been ready for discharge in 2014; she was undoubtedly ready by 2 January 2017. She was subject to DOLS, and her RPR – in December 2015 – applied on her behalf *"out of frustration because, despite the local authority and the Lambeth CCG supporting P's wish and desire to return to Columbia, they had simply failed to progress it."* The proceedings were initially met by the response that P now had capacity about decisions about where she should live – as Newton J noted, *"I am not at all sure that that contention does not in fact make the situation worse."* However, a Special Visitor's Report of March 2017 confirmed that she lacked capacity. Matters then progressed very slowly in terms of progressing repatriation; from Newton J's distinctly caustic summary of the procedural history thereafter, we take one example:

In view of the history, the shocking history, I made provision for a "long stop" hearing on 13 December 2017 whilst sitting on circuit (hoping still to retain the transfer date of 20 December 2017). I do not think I ever received a position statement from the applicants, who attended by new counsel, who had been inadequately instructed. No one from the applicants, CCG or solicitors had the courtesy to attend. To say this was unfortunate (leaving aside any other issues) is an understatement. No transfer plan had been filed, and important missing detail prevented any progress being achieved. No one appeared to be qualified to make what in some instances were trifling decisions involving a few hundred pounds, e.g. innumerable communications occurred over the provision of, cost of, source of, import duty on, or who should pay for the transport of a wheelchair so urgently required by P, far, far exceeding the cost of the chair itself. Information was given to the Court in relation to, for example, the air ambulance, which subsequently appeared to be wholly misleading and totally without foundation. The approach taken was unhelpful and, at times, verging on petulant. Despite my best efforts it appeared to reflect a deeper, most unfortunate perspective that has, from time to time, permeated these proceedings. In any event, as I say, no one had the courtesy to turn up, so nothing constructive could be achieved at all.

Finally, on 15 January 2018, *"it was possible to approve a final order. Contrary to previous occasions when either no one attended, or those present had not obtained delegated financial responsibility, on this occasion, what should have occurred much, much earlier, probably years ago, was obtainable, and significant assurances and undertakings were forthcoming for the provision of care in the unlikely event P was taken ill in transit and required hospitalisation en route. All that should have occurred several months earlier and it is entirely symptomatic of the malaise which has beset these proceedings from the outset. For which P has been the unhappy victim, and the Applicant [local authority] entirely responsible."* She left the UK by air ambulance on 25 January 2018:

"The move went very well. There were no health concerns en route. P remained calm, restful and slept during the journey. The ambulance crew were extremely impressive and efficient. The doctor could speak Spanish. Upon arrival P "recognised many of her relatives and smiled all over her face."

In light of this conclusion, it was not surprising that in the second judgment, Newton J was asked by the Official Solicitor on P's behalf to order that the entirety of the costs of the proceedings should be borne by the London Borough of Lambeth and the Lambeth Clinical Commissioning Group on the basis a) that the proceedings should never have been brought and b) their conduct of the proceedings once commenced.

Newton J noted that:

2. Proceedings brought in the Court of Protection almost never attract an enquiry into the issue of costs, essentially since they are inquisitorial in nature, the general costs principles do not sit easily within the parameters of the Court's considerations. However, as the President recognised in Re G [2014] EW COP 5, there will occasionally be cases but there must be good reason before the Court will contemplate departing from the general rule. For example an order for costs was made in Re SW [2017] EW COP 7 where the application was "scarcely coherent ... totally without merit ... misconceived and vexatious". These proceedings would not necessarily be categorised in that way, but what if they were or should have been fundamentally unnecessary, that is to say they should never have been brought? Or what if the conduct of the proceedings been so poor, so incompetent that not only did they take much longer than they should (thus unnecessarily necessitating P remaining for so very much longer in difficult circumstances) and requiring many extra unnecessary hearings? In those circumstances is the Court not able to mark its disapproval by the consideration and award of costs.

He continued:

3. [...] It is obvious that the Court is deeply critical of the manner in which this case was handled both before and after the institution of proceedings. It is further troubling that even within the written submissions are many misconceived assertions or contentions as to fact. The proceedings were instigated by P's RPR in December 2016 because no constructive progress for P was being made. P was unsettled, unable to communicate, frustrated and quite evidently deeply unhappy. A situation which could and should have been avoided. As the chronology in the judgment makes clear, by the end of 2014 or early 2015 at the latest, P was ready for discharge but the enquiries lacked focus or persistence, and whilst I have no doubt that the Applicant and/or Second Respondent believe they worked tirelessly, the bald fact is that they did not. The enquiries were ineffectual, even amateur. Apparent "unexplained difficulties in dealing with the Columbian authorities and organisations" were not subsequently born out. Inexplicably, basic common sense enquiries with the Columbian Embassy had still not occurred many months into the proceedings. As I have found, their efforts were unfocused and superficial. This might be thought to be explained by the apparent novelty of the situation as it presented itself, but what happened during the currency of the proceedings supports the contrary view, that too little intelligent professional focus was brought to bear and bring this most unhappy situation to a conclusion. To submit that the CCG was "throughout commendably assiduous" in seeking the return to Columbia is about as misplaced and offensive a submission as could possibly be contemplated. The judgment records, order after order which was not complied with. Equally, it is submitted "the Applicant and Second Respondent remind the Court of the expressions of satisfaction given by P's family and by the Columbian Government on her behalf". They recognise that the CCG worked tirelessly to repatriate P in exceptional circumstances. It would be unfortunate if those efforts were met with a punitive order for costs. Such a submission is at best

misplaced. How much more satisfied would P have been to have been repatriated years earlier, rather than being kept caged in an environment and jurisdiction where she was so obviously unhappy and did not belong.

4. It should not be thought that I overlook the care that was provided to P, nor, ultimately her successful repatriation, but what is impossible to ignore is the disorganised thinking, planning and management which resulted in her detention here for so very much longer than necessary.

5. Without hesitation I conclude that the circumstances of this case are so poor and so extreme (both in relation to institution of proceedings and their subsequent conduct) that I should make an order that the costs of the proceedings should be born by the Applicant and Second Respondent.

Comment

Repatriation cases are, in our experience, complex, and most public authorities are unlikely to encounter them often, adding novelty to complexity. But the picture painted by Newton J in this thoroughly depressing case is not just one which has all the hallmarks of a situation being put in the “too difficult to handle box” by too many people, but also one where basic consideration of support needs appears to have gone out of the window.

We would also note – given the passage of the LPS through Parliament – that this is undoubtedly a case where the bringing of a s.21A challenge was the only thing which actually unlocked matters, even if at glacial speed. One rather shudders to think what would have happened had P not been subject to a DoLS, and therefore had the benefit of an RPR – would she still be in “prison” here?

HRA claims and the statutory charge

The LAA has finally confirmed that it is possible (and how it is possible) to run an HRA claim arising out of publicly funded welfare proceedings in the Court of Protection without seeing any resulting damages swallowed up entirely by operation of the statutory charge. For more details, see the guest post by Ragani Lindquist on the Court of Protection Handbook website [here](#).

Electronic issue of proceedings in London

From 30 July, the Court of Protection Central Registry (First Avenue House) will allow court users to issue section 16 (Health & Welfare) and 21A (Deprivation of Liberty) applications via email. This will bring the Central Registry in line with the Multiple Points of Entry scheme, which launched nationally on 25 June. For more details, see [here](#).

Deprivation of liberty for 16/17 year olds - the CoP or Family Division?

Re A-F (Children) (No 2) [2018] EWHC 219 (Fam) High Court (Family Division) (Sir James Munby P)

Deprivation of liberty – children and young persons – CoP jurisdiction and powers – interface with family proceedings

Summary

In one of his last judgments as President, Sir James Munby returned to the question of what to do where a 16 or 17 year old with impaired capacity is deprived of their liberty, and, specifically, whether judicial authorisation should be sought in the Court of Protection or the Family Division under its inherent jurisdiction. He had previously addressed the question of the process for obtaining such authority in *Re A-F (Children) (Restrictions on Liberty)* [2018] EWHC 138 (Fam), but that judgment had left opaque the question of which court authority should be sought in the case of a 16 or 17 year old.

As Sir James noted, the Mental Capacity Act 2005 (Transfer Of Proceedings) Order 2007, SI 2007/1899, provides for the transfer of proceedings in relation to children aged 16 and 17 from or to the Court of Protection, Article 3 concerning transfers to that Court. Sir James endorsed the summary of the relevant principles given by Hedley J in *B (A Local Authority) v RM, MM and AM* [2010] EWHC 3802 (Fam), para 28:

That raises the question particularly under Art 3(3)(d) as to what matters the court should take into account in deciding whether to exercise these powers and to adopt this approach. An ex tempore judgment in a case on its own facts is no basis for attempting an exhaustive analysis of these issues; nevertheless, a number of matters suggest themselves, matters which may often be relevant in the relatively small number of cases in which this issue is likely to arise. One, is the child over 16? Otherwise of course, there is no power. Two, does the child manifestly lack capacity in respect of the principal decisions which are to be made in the Children Act proceedings? Three, are the disabilities which give rise to lack of capacity lifelong or at least long-term? Four, can the decisions which arise in respect of the child's welfare all be taken and all issues resolved during the child's minority? Five, does the Court of Protection have powers or procedures more appropriate to the resolution of outstanding issues than are available under the Children Act? Six, can the child's welfare needs be fully met by the exercise of Court of Protection powers? These provisional thoughts are intended to put some flesh on to the provisions of Art 3(3); no doubt, other issues will arise in other cases. The essential thrust, however, is whether looking at the individual needs of the specific young person, it can be said that their welfare will be better safeguarded within the Court of Protection than it would be under the Children Act.

In the cases before the President, the children were already subject to care orders, and he agreed with the position of the parties that their cases should not be transferred to the Court of Protection, for the following reasons:

- i) *There can be no sensible basis for discharging any of the care orders which are already in place. The children require the continuing protection of such aspects of the care regime as LAC reviews and the support of an IRO.*
- ii) *While the care orders remain in place, the Family Court has a continuing, if much reduced, potential role in the lives of the children – for instance, if issues in relation to contact require to be determined in accordance with section 34 of the 1989 Act.*

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- iii) *For the time being, at least until they are approaching their eighteenth birthdays, the children are the responsibility of the local authority's Children's Social Care (LAC) Teams, who are, in the nature of things, much more familiar with practice and procedure in the Family Court and the Family Division than with practice and procedure in the Court of Protection.*
- iv) *The children's guardians will be able to continue exercising that role so long as the cases remain within the Family Court and the Family Division; it is, at the least, doubtful whether they would be able to act as litigation friends in the Court of Protection.*
- v) *It may be easier to ensure judicial continuity if there is no transfer.*
- vi) *Put shortly, the benefits weigh heavily in favour of maintaining the forensic status quo. There are, in contrast, so far as I can see, no reasons for thinking that, to adopt Hedley J's words, the children's welfare will be better safeguarded within the Court of Protection.*

As an annex to the judgment, the President attached three draft forms of order for use in cases where authority to deprive the child of their liberty was being sought from the Family Division: (i) directions on issue; (ii) order following first hearing; and (iii) order following final hearing. These drafts are each in a form compatible with the Compendium of Standard Family Orders. As he noted, “[i]t will, of course, be for Sir Andrew McFarlane, as President of the Family Division, to determine in due course whether they should be formally promulgated as additions to the Compendium.” He further annexed a suggested form of social work template (including the following requirements):

Section 4 Analysis of confinement

(Describe the proposed placement and regime explaining why they are necessary and proportionate in meeting the child's welfare needs and that no less restrictive regime will do.)

Section 6 Child's level of understanding / Gillick competence

(Whether the child is able to consent, by reference to Gillick competence, and the steps which have been taken to ascertain this aspect – details as to any expert assessments which have been undertaken in this respect.)

Comment

The vexed question of when a 16/17 year old should be considered to be deprived of their liberty is to be looked at by the Supreme Court on 3 and 4 October in the D case (in which the Government has now intervened). The question of whether authority is required from a court to deprive a 16/17 year old with impaired capacity is going to remain open for some time, as the Government continues to “consider[...] very actively” whether or not to bring them within the scope of the LPS.

This judgment, and the preceding one in the series, looks at the procedural questions arising where judicial authority is being sought in the event that 16/17 year is considered to be deprived of their

liberty. Where the application is made to the Court of Protection, then the procedure set down in [COPDOL11](#) should be followed. One real oddity of the second judgment, and perhaps reflecting the perhaps unfortunate 'siloing' between family and CoP practitioners that can occur in this zone, is that in neither the social work template nor the draft orders is there any requirement to set out the basis upon which it is said that the deprivation of liberty is justified for purposes of Article 5 ECHR. Simply providing that a deprivation of liberty is lawful and in the child's best interests does not address the fact that Article 5(1) provides an exhaustive list of the bases upon which deprivation of liberty can be justified. Is the deprivation of liberty justified on the basis of Article 5(1)(d) (the detention of a minor by lawful order for the purpose of educational supervision) or 5(1)(e) (i.e. unsoundness of mind?). We would strongly recommend that practitioners seeking orders from the Family Division make clear what basis the deprivation of liberty is to be justified, and to put in evidence accordingly.

Eagle-eyed readers will also note that the annexes to the judgment proceed – unsurprisingly – on the same basis as did the Court of Appeal in *D*, i.e. that *Gillick* competence runs to age 18. Whether that is correct, and how this concept interacts with the statutory presumption of mental capacity in the MCA 2005, is no doubt going to be examined by the Supreme Court in October.

Short note: fact-finding and the burden of proof

In *Re A (Children)* [2018] EWCA Civ 1718, the Court of Appeal reminded practitioners and the judiciary how rare it is that burden of proof will serve as the determinative factor in a fact-finding case. King LJ (with whom the other two judges agreed)

accept[ed] that there may occasionally be cases where, at the conclusion of the evidence and submissions, the court will ultimately say that the local authority has not discharged the burden of proof to the requisite standard and thus decline to make the findings. That this is the case goes hand in hand with the well-established law that suspicion, or even strong suspicion, is not enough to discharge the burden of proof. The court must look at each possibility, both individually and together, factoring in all the evidence available including the medical evidence before deciding whether the "fact in issue more probably occurred than not" (Re B: Lord Hoffman).

She confirmed that the proper approach is that:

i) Judges will decide a case on the burden of proof alone only when driven to it and where no other course is open to him given the unsatisfactory state of the evidence.

ii) Consideration of such a case necessarily involves looking at the whole picture, including what gaps there are in the evidence, whether the individual factors relied upon are in themselves properly established, what factors may point away from the suggested explanation and what other explanation might fit the circumstances.

iii) The court arrives at its conclusion by considering whether on an overall assessment of the evidence (i.e. on a preponderance of the evidence) the case for believing that the suggested event happened is more compelling than the case for not reaching that belief (which is not necessarily the

same as believing positively that it did not happen) and not by reference to percentage possibilities or probabilities.

Guardianship (Missing Persons) Act 2017

The Government has confirmed that implementation of this Act has been delayed indefinitely – thereby depriving the Court of Protection of a small (but very important) jurisdiction to grant a ‘guardianship order’ to relatives or close friends of a missing person so they could manage the missing person's property and financial affairs without having to obtain a declaration of presumed death. As reported by [Family Law](#), a letter from the Ministry of Justice to MPs has revealed that the delays have been caused “*by work on key departmental priorities.*”

THE WIDER CONTEXT

Short note: challenging behavior and disability

The Upper Tribunal decision in *C & C v The Governing Body of a School & Ors* [2018] UKUT 269 (AAC) case, arising in the context of education law, is significant for its interpretation of the meaning of “disability” for the purposes of the Equality Act 2010.

L was a child with autism, anxiety and Pathological Demand Avoidance. When he was 11 years old, he was given a fixed term exclusion from school for 1.5 days for aggressive behaviour. His parents brought a claim in the First-tier Tribunal (“FTT”) under the Equality Act 2010 complaining of discrimination on grounds of L’s disability. The FTT found that L had been involved in a number of incidents over a ten-month period, largely involving pulling, pushing and grabbing others. There was, however, one occasion when he hit a teaching assistant with a ruler, pulled her hair and punched her and another occasion when he hit the same teaching assistant with a book.

The FTT found that L generally met the definition of a disabled person for the purposes of the Equality Act. However, they dismissed this part of the claim because L had been given the exclusion as a result of his ‘tendency to physical abuse’ and so, pursuant to regulation 4(1)(c) of the Equality Act 2010 (Disability) Regulations 2010 (“the 2010 Regulations”), he was to be treated as not falling within the definition of ‘disability,’ that regulation.

L’s parents appealed to the Upper Tribunal (“UT”). There was no challenge to the FTT’s finding that L had a ‘tendency to physical abuse’. Rather, the issue in the appeal was whether the FTT made an error of law in finding that L was not ‘disabled’ insofar as this ‘tendency to physical abuse’ was concerned. There was no dispute that the issue fell within the scope or ambit of Article 2 of the First Protocol to the ECHR (the right to education). The issue was whether the FTT’s interpretation of regulation 4(1)(c) of the 2010 regulations was compatible with Article 14 ECHR (freedom from discrimination).

The UT held that there was a difference in treatment between children with L’s status and others in an analogous situation that fell to be justified. In assessing the justification for difference in treatment, the UT applied the conventional four-stage test. In applying that test, the UT accepted that, as the case concerned an issue of social policy, when considering the first three stages, the ‘manifestly without reasonable foundation’ test was the appropriate one but that the test did not apply to the fourth (‘fair balance’) stage. In answer to the four-stages, the UT considered that the measure had a legitimate aim, that there was a rational connection between the measure and the aim and that a less intrusive measure could not have been used. The central issue in the case was whether it struck a fair balance between the rights of the individual and the interests of the community.

In relation to fair balance, the UT reached the firm view in paragraph 90 that it was not satisfied on the evidence that a fair balance had been struck:

regulation 4(1)(c) comes “nowhere near striking a fair balance between the rights of children such as L on the one side and the interests of the community on the other. The profound severity of the consequences of the measure on the status group weigh extremely heavily and the arguments put in favour of the countervailing public interest by no means counter balance them. Indeed, in my judgment, this is not a case in which the issues are finely poised. Rather, the requirements for the protection of the status group’s fundamental rights comprehensively outweigh the arguments put forward for the protection of the interests of others.

The UT stated its conclusion at paragraph 91 in forceful terms:

In conclusion, I recognise that as a matter of domestic law the current interpretation of regulation 4(1)(c) is clear and well established. It was not questioned before me. However, I am now addressing that regulation in the context of human rights law. In that context, in my judgment the Secretary of State has failed to justify maintaining in force a provision to be made for them. In that context, to my mind it is repugnant to define as ‘criminal or anti-social’ the effect of the behaviour of children whose condition (through no fault of their own) manifests itself in particular ways so as to justify treating them differently from children whose condition has other manifestations.

This is a welcome decision. Although this case did not deal with any issues of mental capacity, it is not difficult to imagine the same or similar issues arising in respect of someone who lacks capacity (due to a disturbance or disorder of the mind or brain) to make certain decisions about their actions. It is clearly right that such people should receive equal protection from discrimination under equality legislation and human rights law.

LGO annual review of local government complaints

The Local Government and Social Care Ombudsman has published its annual review of local government complaints. The total number of complaints (17,452) is up on the previous year as is the proportion of complaints upheld (57%). The Ombudsman has also issued 40% more public interest reports about local authorities and made 21% more recommendations for service improvements. One of the public interest reports published was a themed Focus Report titled “The Right to Decide: towards a greater understanding of mental capacity and deprivation of liberty”. As the annual review explains:

We highlighted that sometimes the proper checks are not happening or safeguards put in place when councils and care providers make decisions on behalf of people who lack mental capacity to choose how they are cared for. Our case studies showed how people were left in situations without the right consent in place and in one case forced to live somewhere against their will for a number of years.

Recourse to the Ombudsman should therefore not be overlooked for complaints relating to the use of the Mental Capacity Act 2005 as a potentially more cost-effective route than going to court.

Ordinary residence guidance

The Local Government Association (LGA) and Directors of Adult Social Services (ADASS) have published a [guide](#), "Ordinary Residence Guide: Determining local authority responsibilities under the Care Act and the Mental Health Act". The guide is aimed at supporting partners to understand and apply the concepts of ordinary residence. The concept is not only of relevance to the Care Act 2014 and Mental Health Act 1983, but also the Mental Capacity Act 2005 and DOLS in particular. The guide explains that, "*The supervisory body will be the local authority in whose area the individual is ordinarily resident, even if the person has been placed by the local authority or the CCG in a care home in a different area.*"

In applying the ordinary residence test, it is always necessary to consider whether the individual had the mental capacity to choose where to live. As set out by the Supreme Court in the case of *R (Cornwall Council) v Secretary of State for Health* [2015] UKSC 46, a modified approach needs to be taken to establish ordinary residence for those individuals who do not have the mental capacity to voluntarily adopt a place of abode.

The 39 Essex Chambers Ordinary Residence Guidance Note, addressing mental capacity issues specifically, is available [here](#).

Short note: suicide and the burden of proof

In a detailed review of the law, the Divisional Court has exposed as – in essence – an urban myth the understanding that a conclusion an inquest that a person took their own life only where it has been proved to the criminal standard of proof. In *Maughan v HM Senior Coroner for Oxfordshire* [2018] EWHC 1955 (Admin), the Divisional Court confirmed that the standard should be the balance of probabilities, bearing in mind that such a conclusion should only be reached if there is sufficient evidence to justify it. As the Divisional Court noted:

[40]. *In circumstances where the function of an inquest is to determine the relevant facts concerning the death as accurately and completely as possible without determining even any question of civil liability, we can see no justification in principle for weighting the fact-finding exercise against any particular conclusion and requiring proof to any higher standard than the balance of probabilities. That is so even if the facts found disclose the commission of a criminal offence. Given that in civil proceedings the standard of proof of criminal conduct remains the ordinary civil standard, we can see no principled reason for adopting a different approach in coroner's proceedings. The position is a fortiori where the conclusion under consideration is one of suicide as, although it was once a crime, suicide has not been a crime for over 50 years since that rule of law was abrogated by section 1 of the Suicide Act 1961.*

Elder abuse: academic research

A special issue has recently been published of the British Journal of Social Work focusing on elder abuse, the articles being [free to read](#) for a limited period of time.

Guides for adult siblings of people with a lifelong learning disability and/or autism

The charity Sibs has recently published a series of useful guides for adult siblings of people with a lifelong learning disability and/or autism, including on: decision-making and mental capacity, managing finances, wills and trusts, and working with care providers.

New safeguarding guidance for healthcare staff

The Royal College of Nursing has published new guidance on safeguarding, on behalf of a wide-ranging collection of bodies, including BASW, the RCGP, the British Geriatrics Society and the RCP, designed to guide professionals and the teams they work with to identify the competencies they need in order to support individuals to receive personalised and culturally sensitive safeguarding. It sets out minimum training requirements along with education and training principles.

The Irish *Bournewood*?

In *AC v Cork University & the HSE* [2018] IECA 217, the Irish Court of Appeal grappled with the question of whether a hospital or other institution can refuse to permit an elderly patient to leave the institution in question on the basis that it considers that she lacks the capacity make a valid request to be permitted to leave. Although filtered through the language of the Irish Constitution rather than the ECHR, the debates will have a familiar ring to those steeped in those provisions.

As Grogan J noted:

36. Outside the special circumstances of the Health Act 1953 (which concerns the detention for those suffering from infectious diseases) and the Mental Health Act 2001 (which deals with the treatment of the mentally ill, including those suffering from severe dementia), the concept of detention is one which really has no place in our system of medical care. In this context, therefore, given our embedded tradition of voluntarism in this sphere of medical treatment – a tradition reflected in the Constitution's guarantee to protect the "person" in Article 40.3.2 - the question of whether somebody is being detained in hospital is something of an unpleasant question to have to ask. Now, however, that the issue has been presented to us in the course of these two appeals, ask it we must.

On the facts of the case, Grogan J had no doubt that Ms A.C. was, in fact detained, as active steps were taken to prevent her from leaving.

The second question – which takes us straight into *Bournewood* territory, the question was whether the detention was lawful. Re-running the case in Irish terms, the first instance judge – the President of the Irish High Court

noted that Ms. A.C. was no longer capable of making decisions of this kind and, by implication, accepted the hospital's submission that Ms. A.C. was free to go save that she no longer had the capacity validly to make that decision, and that the CUH was accordingly entitled to make the

appropriate decisions regarding her liberty and welfare which they considered to be in her best interests.

However, Grogan J took a different view. He did not doubt that a hospital is entitled to take appropriate steps to regulate its own affairs in an orderly way:

the hospital could probably have prevented Mr. P.C. and Ms. V.C. from entering their mother's ward with a view to evacuating her in the middle of the night had they suddenly determined on this course of action. Had this occurred in that fashion the hospital would probably have been entitled to say that this would have been inconsiderate of the needs of other patients and disruptive of good order within the hospital.

But, what the hospital was not entitled to do was:

to prevent Ms. A.C. from leaving the hospital at any appropriate time and place if this is what she wanted to do. As I put it in PL ([2018] 1 I.L.R.M. 441, 452) while "hospital personnel could lawfully attempt to persuade a patient not to leave, this must involve persuasion and not restraint." As matters stand there is currently no statutory power equivalent to s. 23 of the Mental Health Act 2001 ("the 2001 Act") (which enables a psychiatric hospital to detain a voluntary patient leaving the hospital for a 24 hour period) which would enable the hospital to detain the patient in such circumstances. The question therefore must be whether such a power exists under the common law.

Grogan J was clear that there was no such power:

The power claimed by the hospital amounts to a paternalistic entitlement to act in the best interests of the patients whose capacity is impaired and, in effect, to restrain their personal liberty and freedom of movement and, if necessary, to do at the expense of close family members. But ever before the enactment of the Constitution the common law has always rejected the claim that personal liberty could be compromised on such a basis. In a celebrated case dating from the War of Independence, Connors v. Pearson [1921] 2 I.R. 51, the (old) Court of Appeal held that there was no justification for the detention by the police of a small boy which was said to be for his own good. O'Connor L.J. rejected the idea that this might provide a lawful justification for such conduct, saying ([1921] 2 I.R. 51, 91) that:

You cannot incarcerate a man or a boy merely because his going abroad or his doing something that he is minded to do exposes him to some danger. If that were so, the adventurous spirits that sought the North Pole or the interior of Africa or that conquered the Atlantic in flight might have been locked up for their own good.

Framing the argument through the prism of the Irish Constitution, the position was even clearer that no such power could exist. Grogan J could

certainly sympathise with the position of CUH, their self-created power of detention might, if unchecked, lead to widespread abuse. For if the power of detention claimed by CUH was to be judicially accepted, the logical consequence would be that tens of thousands of the infirm elderly who

are suffering from dementia (or whose capacity is otherwise impaired) and who are presently residing in nursing homes and other similar institutions could equally be restrained from leaving. In many cases this would doubtless be for good clinical reasons. In other instances, however, this decision could be simply for reasons of convenience and, perhaps in a small minority of cases, for even less noble motives.

[...]

*52 [...] In many ways, it all comes back to the fundamental proposition so memorably articulated by Hanna J. in *Dunne v. Clinton* [1930] I.R. 336, 372: there is, simply, no “half way house” between liberty “unfettered by restraint and an arrest”. Yet if the power to restrain contended for by CUH in the present case were to be admitted, it would mean that the personal liberty of Ms. C. – and, by extension, the personal liberty of tens of thousands of vulnerable, elderly patients suffering from dementia and residing in institutional care through the State – would be reduced to a half way house of ambiguity, variable and inconsistent grants of permission and subjective paternalism on the part of clinicians, nurses and care-givers.*

53. Those who contend that it would be appropriate that those caring for the elderly should have this power should not come as supplicants to this Court requesting that we should create it, for we lack that power and jurisdiction. If, as a result of this decision, the law is considered to be unsatisfactory, then any change is exclusively a matter for the Oireachtas [Irish Parliament] to determine.

The Oireachtas will, indeed, seek to determine this question when long-awaited legislation to seek to provide the equivalent for DoLS is placed before it. Whether and how that legislation seeks to comply with the CRPD is going to be an open – and very interesting – question, especially in light of the Irish Government’s declaration in respect of Article 14 CRPD to the effect that “*the Convention allows for compulsory care or treatment of persons, including measures to treat mental disorders, when circumstances render treatment of this kind necessary as a last resort, and the treatment is subject to legal safeguards.*”

New Zealand and the Bournemouth gap

Moving even further afield from our last item, those scarred by the DoLS wars in England and Wales may be interested to read “*Not my home: a collection of perspectives on the provision of aged residential care without consent,*” recently compiled and published by the New Zealand Human Rights Commission, starting the journey towards identification (and closure?) of the equivalent of the *Bournemouth* gap in that jurisdiction.

SCOTLAND

Office of the Public Guardian: Guardianship questionnaire form

The Office of the Public Guardian recently commenced issuing guardianship questionnaire forms to applicants for guardianship, upon intimation of their applications to OPG. Various concerns and representations about this development were passed to OPG. Following taking over as Public Guardian, Fiona Brown has reviewed the comments and views that she has received and instructed her team to stop issuing the form to potential financial guardians, pending further consultation and discussion.

Adrian D Ward

Disability discrimination: what is “something”?

In *City of Edinburgh Council v R*, [2018] CSIH 20; 2018 S.L.T. 652, the Inner House of the Court of Session (2nd Division) refused an appeal by City of Edinburgh Council against a decision of the Additional Needs Support Tribunal for Scotland that failures by the Council in relation to provision of a Coordinated Support Plan (“CSP”) amounted to unfavourable treatment constituting discrimination in terms of section 15 of the Equality Act 2010. The matters addressed by the court included a point of potential relevance in any case concerning the proper interpretation of section 15(1)(a) of the Equality Act 2010, which provides that: “[a] person (A) discriminates against a disabled person (B) if A treats B unfavourably because of something arising in consequence of B’s disability ...”. What is the “something” referred to in this provision? This Report concentrates on that question.

The child at the centre of the case, referred to as C, had an autistic spectrum disorder and mental health issues. Her mental health and behaviour had deteriorated significantly in the summer of 2013. She had not attended school regularly since December 2013, and she had not attended at all since 22nd December 2015. In April 2014 her mother had requested assessment for a CSP in terms of section 2 of the Education (Additional Support for Learning) (Scotland) Act 2004. Following failure by the education authority to provide a CSP, the tribunal directed that a CSP be issued no later than 6th January 2016. On that date the authority issued a CSP which the tribunal found to be inadequate. The authority was required to amend it by 11th November 2016. It was common ground that the final CSP was inadequate. The authority attributed the inadequacies to the child’s lengthy absence from school. The submissions for the authority on appeal included a contention, as described by the opinion of the court delivered by Lord Malcolm: “*that there had been no identification of the basis for the conclusion that, in terms of s.15(1)(a) of the 2010 Act, the authority had treated the pupil unfavourably ‘because of something arising in consequence of (the pupil’s) disability.’*” It was submitted that this provision meant that the delays and inadequacies in respect of the CSP required to be caused or contributed to by the pupil’s disability, rather than any other factors, and that the tribunal had not addressed the cause of the unfavourable treatment.

The court held that this approach to the construction of section 15(1)(a) was erroneous. It was not the intention of the legislation that the disability itself must be a cause of treatment being unfavourable. As Lord Malcolm put it: *"In the present case the 'something' was the delayed and then inadequate CSP. While as a generality a CSP can be required in respect of a pupil without a disability, in the context of this claim, if the pupil had not been disabled there is no reason to suppose that there would have been a CSP. It was the disability which resulted in the need for the CSP, and it was the CSP which was the unfavourable treatment."*

The court concluded that the tribunal had not erred in its key finding on this point. Translated into generalised language, the tribunal's finding was that where a person, in consequence of disability, has needs which require provision in terms of a statutory obligation, and the responsible body either fails to make that provision, or makes provision which is not adequate, that is unfavourable treatment in terms of section 15 of the 2010 Act.

Adrian D Ward

Review of AWI: summary and analysis of consultation responses

In the [May Report](#) we reported that the period for response to the Scottish Government consultation on reform of adult incapacity law ended on 30th April 2018. We provided links to the responses by some key bodies. In the [July Report](#) we reported on the presentation given by the Scottish Government team on its initial analysis of the content of all 316 responses to the consultation at a meeting in Edinburgh on 28th June 2018. We concluded that Report by anticipating a full analysis of responses to the consultation by way of a report from the Scottish Government team. That analysis has now been [published](#). Working parties have been established to consider particular topics. The three topics are (a) definition of deprivation of liberty, (b) graded guardianship and support training, and (c) supervision of guardians and attorneys. The augmented Scottish Government team will work on other aspects in-house. A further targeted consultation is expected in January 2019. It is hoped that legislation may be presented to the Scottish Parliament by the end of 2019.

Adrian D Ward

Training judges about disability when the system is a work in progress

"The most dangerous phrase in the language is 'we've always done it this way'."

Rear Admiral Grace Hopper

I was pleased when Alex drew my attention to Ward and Curk's [Judicial Training: Access to Justice For People With Disabilities](#). It is well worth a read. This research was conducted by a lawyer and a psychologist and I am all in favour of lawyers and psychologists teaming up. I have highlighted a few of my favourite bits.

Their paper for Scotland's Judicial Institute aims "to assist the judiciary in its primary duty to ensure that justice is done". The authors' starting point is the *United Nations Convention on the Rights of Persons with Disabilities* ("CRPD") and the *Optional Protocol to CRPD* ("the Protocol") ratified by the United Kingdom Government on behalf of all jurisdictions in the United Kingdom. Article 13 of CRPD is in the following terms:

Article 13 – Access to justice

1. States Parties shall ensure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age-appropriate accommodations, in order to facilitate their effective role as direct and indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages.

2. In order to help to ensure effective access to justice for persons with disabilities, States Parties shall promote appropriate training for those working in the field of administration of justice, including police and prison staff.

This exploratory work with recommendations that are "preliminary" runs to 65 pages and the authors have covered a lot of extremely useful terrain – legal obligations, anecdotal accounts as well as some of the relevant peer-reviewed publications.

Chapter 1 considers the evolving concept of disability and the wide range of impairments that result in disabilities and needs. The authors could also flag up the basic lack of agreed terminology: Special measures are now known as measures in the family court in England and Wales, and are also variously referred to as adjustments/reasonable adjustments, accommodations and adaptations (and probably other things besides). In this chapter the reader will also find the start of an important thread that runs throughout the paper; the recommendation for a court system of improved "universal design" which could "ensure full equality before the law".

In Chapter 2 the European Convention on Human Rights Articles 14 (prohibition of discrimination), 8 (respect for private and family life), 5 (right to liberty and security) and 6 (right to a fair trial) are discussed. I suggest Article 3 (prohibition of torture) has a place here too. "No one shall be subjected to torture or to inhuman or degrading treatment or punishment"; there is always the potential for cross-examination to be degrading if judges do not apply appropriate control.

The Scottish Bench Book is reviewed in Chapter 4 as well as the England and Wales counterpart, The Equal Treatment Bench Book (ETBB). The authors are at pains to point out that these books are useful and important, but they also call for some new thinking. For example, on oaths:

...there cannot be any good reason to assume that raising the right hand (and the ability to do so – if indeed one has a right hand) will enhance the accuracy and honesty of evidence given. Simply to observe the likelihood of a relevant physical disability, and to excuse someone from doing something required of others, can make the excused person feel that they are being treated as "lesser", affecting

their confidence from then on, bearing in mind that such a person is already more likely than average to feel intimidated and disadvantaged by the court environment.

I agree with the authors; the ETBB “is massive” and they may be right that there is “a question as to whether judges can reasonably be expected to find their way through it to relevant provisions when that may be necessary with some urgency.” My own additional concern is that the ETBB may be so dauntingly huge that judges will be put off browsing it. That would be more than a shame since the content is so valuable. If the ETBB is to judgecraft what the Highway Code is to driving, shouldn't there be the e-equivalent of a carry-around guide that can be browsed in one sitting?

The authors point out that Scotland and England and Wales' Bench Books have the words “Equal Treatment” in their titles, but they actually recommend “precisely the opposite”. It reminds me that in 2012 when I was assisting one of the ETBB contributors, I half-seriously suggested renaming it the Unequal Treatment Bench Book! Ward and Curk suggest changing the system rather than the title of the book. On the current long lists of special adjustments, they say:

They put people into various categories requiring long lists of adjustments in order to squeeze them into the archaic rituals of court practice. Many of the recommendations really come down to ways in which courts can better do their job, by avoiding unnecessary intimidation, disadvantage, discomfort and so forth. One might suggest that a better approach would be to review rigorously all of the recommendations in both Bench Books to assess the extent to which there would be any disadvantage in adopting them as general good practice, rather than as special practice for particular groups and categories. By accommodating particular characteristics of some people within general good practice, the proclaimed objective of “equal treatment” would be achieved rather than falsified; and needs which are specific to particular people and which can only be met by special provision would be identified, and better focused.

Along with the authors of this paper, in recent years I and others (see for example, [Cooper & Mattison 2017](#) and [Cooper et al 2018](#)) have called for:

- more research to tell us what works in the courtroom, and what doesn't,
- universal changes to create accessible justice for all, and
- an evidence-based approach to court practices.

At a time when HMCTS (in England & Wales) seems dead set on court digitisation with barely any evidence on the ramifications for disabled participants, the need for research is urgent and vital. Ward and Curk's paper will leave the reader in no doubt that in Scotland achieving a system that is providing accessible justice is a *work in progress*. The Judicial Institute of Scotland will no doubt find this research very helpful. However, and this goes for England and Wales as well, there is only so much the judiciary can do when the system itself has so many bolt-ons, tweaks and in-the-event-of fixes that it requires an operating manual which is hundreds of pages long. Added to this, lawyers and judges frequently adopt rituals, the benefits of which have never been scientifically proven.

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Conferences

Conferences at which editors/contributors are speaking

Switalskis Annual Review of the Mental Capacity Act

Neil is speaking at the 10th Annual Review of the MCA in York on 18 October 2018. For more details, and to book, see [here](#).

Taking Stock

Neil and Alex are speaking at the annual Approved Mental Health Professionals Association/University of Manchester taking stock conference on 16 November. For more details, and to book, see [here](#).

Other events of interest

Peter Edwards Law has announced its autumn programme of training in mental capacity and mental health, full details of which can be found [here](#).

Advertising conferences and training events

If you would like your conference or training event to be included in this section in a subsequent issue, please contact one of the editors. Save for those conferences or training events that are run by non-profit bodies, we would invite a donation of £200 to be made to the dementia charity [My Life Films](#) in return for postings for English and Welsh events. For Scottish events, we are inviting donations to Alzheimer Scotland Action on Dementia.

Our next edition will be out in early October. 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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